



# State of Health in the EU Ireland

Country Health Profile 2023

## 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 policy makers and influencers with a means for mutual learning and voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation 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).

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## Data and information sources

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

and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2023, based on data that were accessible as of the first half of September 2023.

## Demographic and socioeconomic context in Ireland, 2022

### Demographic factors

	Ireland	EU
Population size	5 060 004	446 735 291
Share of population over age 65 (%)	15.0	21.1
Fertility rate <sup>1</sup> (2021)	1.8	1.5

### Socioeconomic factors

GDP per capita (EUR PPP <sup>2</sup> )	82 100	35 219
Relative poverty rate <sup>3</sup> (%)	14.0	16.5
Unemployment rate (%)	4.5	6.2

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

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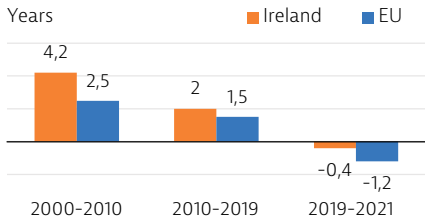
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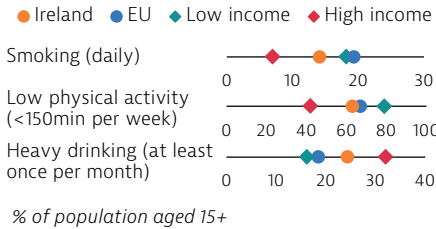
# 1 Highlights



Changes in life expectancy at birth

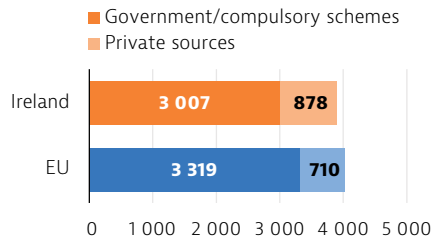
## Health Status

In the two decades before the pandemic, Ireland's life expectancy grew faster than the EU average, and during the pandemic its decline was comparatively less severe. As of 2021, life expectancy at birth stood at 82.4 years – about 5 months below its pre-pandemic level. Cancer was the leading cause of death, followed by cardiovascular diseases.



## Risk Factors

As in most EU countries, prevalence of behavioural risk factors in Ireland tends to follow a socioeconomic gradient. In 2019, smoking was higher among individuals in the lowest income quintile (18 %) than those in the highest (7 %); insufficient physical exercise showed a similar pattern. Conversely, heavy drinking was more common among those on higher incomes.



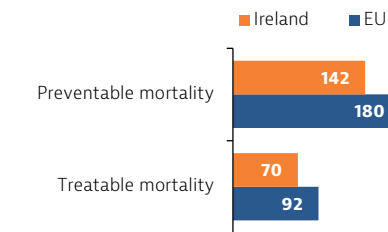
EUR PPP per capita, 2021

## Health System

In 2021, Ireland spent EUR 3 885 per capita on health, which is nearly equal to the EU average. Between 2019 and 2021, health expenditure per capita increased by over 12 %, driven in large part by government funding to address the COVID-19 emergency. Public sources funded 77.4 % of health expenditure in 2021 – a share below the EU average. While inpatient care expenditure exceeds the EU average, public hospitals continue to face significant capacity constraints.

## Effectiveness

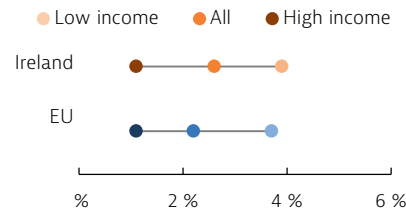
In 2020, Ireland's mortality rates from preventable and treatable causes were about 20 % lower than their respective EU averages. Lung cancer was the leading cause of preventable death, while ischaemic heart disease and colorectal cancer accounted for 40 % of treatable mortality. Over the last decade, mortality rates from treatable causes declined at a faster pace than the EU average.



Age-standardised mortality rate per 100 000 population, 2020

## Accessibility

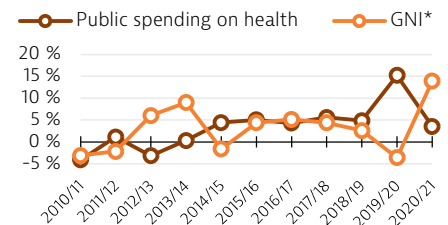
In 2022, 2.6 % of the Irish population reported experiencing unmet medical needs – a share above both the EU average and Ireland's pre-pandemic rate (1.7 %). Long waiting lists were by far the main driver of unmet medical needs, and individuals in the lowest income quintile were nearly three times more likely to report unmet needs due to waiting times than those in the top quintile.



% reporting unmet medical care needs, 2022

## Resilience

Following significant spending cuts post the 2008 economic downturn, government health spending resumed growth in 2015, slightly outpacing economic growth until 2019. The pandemic temporarily upended this trend, as public spending on health surged by 15 % against a 3.5 % decline in modified GNI in 2020. Government spending increased more moderately in 2021, driven mainly by COVID-19 vaccines and increased staff costs.



Annual change in real terms

## Mental Health

Over 1 million individuals in Ireland were estimated to have had a mental health disorder in 2019, accounting for 21 % of the population. Anxiety disorders were the most prevalent, followed by depressive disorders and alcohol and drug-use disorders. During the pandemic, the surge in demand for mental healthcare placed a burden on primary care, resulting in prolonged waiting times for specialist mental health services.

## 2 Health in Ireland

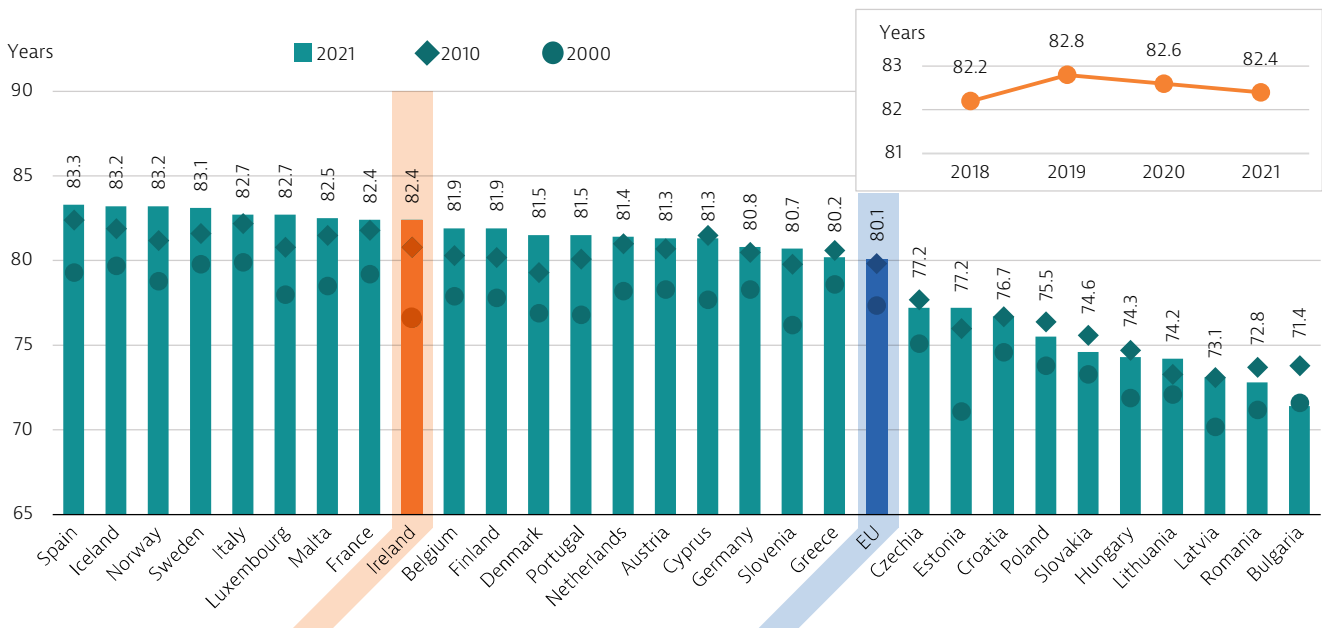
### Life expectancy was about 5 months lower in 2021 than before the COVID-19 pandemic

Life expectancy at birth in Ireland stood at 82.4 years in 2021, surpassing the EU average by more than 2 years (Figure 1). From 2010 to 2019, life expectancy increased by 2 years, outperforming other EU countries with similar levels in 2010. Following the onset of the COVID-19 pandemic, in 2020 life expectancy in Ireland fell by 0.2 years compared to 0.9 years across the EU, reflecting

Ireland's relatively low pandemic-related mortality compared to most other EU countries. In 2021, life expectancy fell further by 0.2 years, a slightly smaller reduction than the EU average (0.3 years).

As in other European countries, men in Ireland tend to live shorter lives than women, although the gender gap in life expectancy is almost 2 years smaller than the EU average. In 2021, women could expect to live, on average, nearly 4 years longer than men (84.3 years compared to 80.5 years).

**Figure 1. The life expectancy drop caused by COVID-19 was smaller than in most other EU countries**



Note: The EU average is weighted.

Source: Eurostat Database.

### Cancer is the leading cause of death in Ireland, accounting for nearly three in every ten fatalities

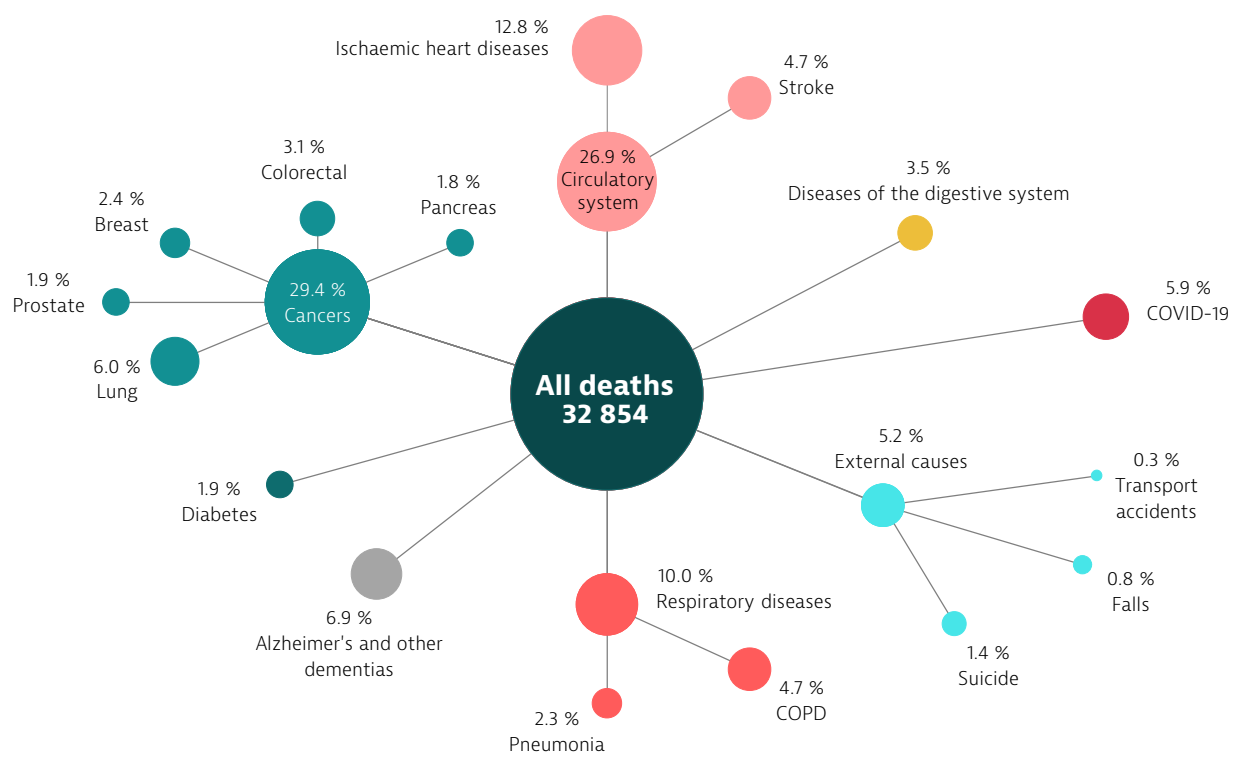
Over the last decade, Ireland's increases in life expectancy were predominantly driven by consistent reductions in mortality from the broad group of circulatory diseases, including ischaemic heart diseases and stroke. Circulatory diseases were the leading cause of death in Ireland until 2019, when their decade-long decline resulted in them becoming the second most common cause of death after cancers. Cancer thus became the largest driver of mortality in Ireland, accounting for more than 29 % of all deaths in 2020 (Figure 2). Among cancers, lung cancer remains the most common cause of death, being responsible for one in every five cancer fatalities. Circulatory diseases

(about 27 % of all deaths) and respiratory diseases (10 %) were the second and third leading causes of mortality in 2020.

In 2020, Ireland reported over 1 900 confirmed deaths due to COVID-19, amounting to 5.9 % of the total number of annual deaths – a lower proportion than the 8.5 % observed across the EU as a whole. Of these deaths, nearly 94 % occurred among people aged 65 and over – a share in line with the EU average.

While Ireland saw one of the most significant relative increases in population size (+8 %) and the largest relative increase in the population aged 65 and over (+27 %) between 2015 and 2022 among EU countries, an additional perspective on the pandemic's mortality impact can still be gained by comparing the number of COVID-19 deaths

**Figure 2. COVID-19 accounted for a comparatively low number of deaths in Ireland in 2020**

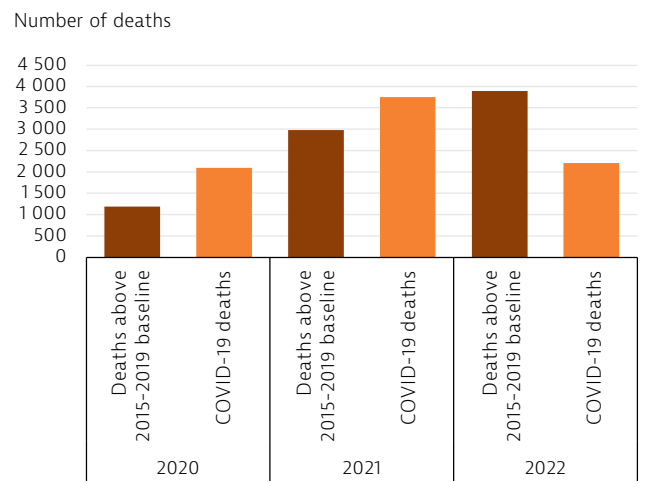


Note: COPD refers to chronic obstructive pulmonary disease.  
Source: Eurostat Database (data refer to 2020).

registered in Ireland to the difference between the number of deaths registered during the pandemic and the average annual number of deaths in the five years before the start of the pandemic. In both 2020 and 2021, the number of confirmed COVID-19 fatalities exceeded the additional number of deaths above Ireland's pre-pandemic baseline, suggesting fewer deaths from non-COVID-19 causes. This difference may be attributed to various factors, including reduced transmission of other infectious diseases due to COVID-19 and public health measures that lowered overall mortality risks.

However, in 2022 Ireland witnessed a rise in the number of deaths surpassing its pre-pandemic baseline, despite a substantial decline in the number of COVID-19 fatalities from its 2021 peak (Figure 3). Several factors are likely to have contributed to this divergence, including an unusually severe seasonal influenza in 2022 (Health Protection Surveillance Centre, 2022a), the direct and indirect effects of COVID-19 on healthcare service quality and accessibility (see Section 5.3), and increased average patient acuity due to pandemic-related care deferrals in 2020 and 2021.

**Figure 3. Despite a significant drop in COVID-19 mortality, the number of all-cause deaths above the pre-pandemic average climbed in 2022**



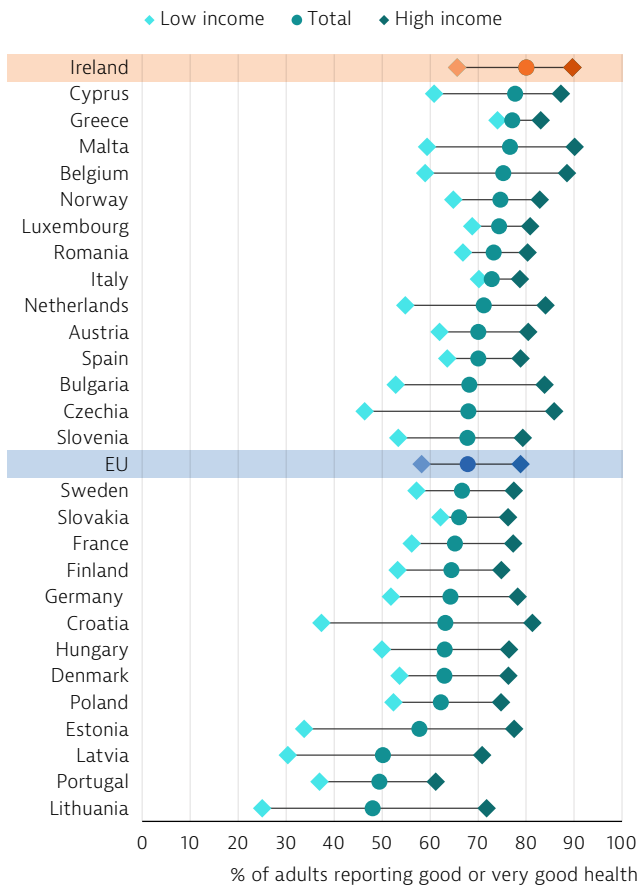
Sources: ECDC (for COVID-19 deaths) and OECD Health Statistics 2023 based on Eurostat data (for the number of deaths above the annual pre-pandemic (2015-19) baseline).

**80 % of Irish people report being in good health, but disparities across income groups are significant and widening**

In 2022, eight out of every ten Irish adults reported being in at least good health – the highest proportion in the EU, owing in part to the Irish population's younger age profile compared to the EU average. While in the EU the proportion of

women reporting good or very good health was 7 % lower than that of males, in Ireland this gender gap was non-existent. Looking at differences across income groups, 90 % of Irish individuals in the highest income quintile reported feeling in good health compared to 66 % of those in the lowest one (Figure 4). This gap was slightly larger than the EU average, and had widened by 13 % compared to 2019, primarily due to a decrease in the share of people in the lowest income quintile who reported feeling in good health.

**Figure 4. Ireland boasts the highest share of people who report being in good health in the EU**



Source: Eurostat Database, based on EU-SILC (data refer to 2022).

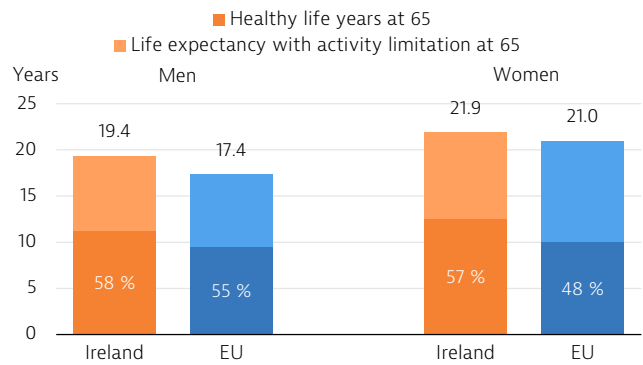
**Irish people at age 65 have the third highest disability-free life expectancy in the EU**

In 2021, Ireland had the youngest population in the EU, with a median age of 38.5 years, in contrast to the EU’s overall median age of 44 years. The percentage of Ireland’s population aged 65 and over increased from 11 % in 2000 to 14 % in 2020, which remains well below the EU average of 21 %. Projections indicate that this proportion is expected to reach 25 % by 2050.

In 2020, Irish women aged 65 could anticipate an average life expectancy of 21.9 years, while

men could expect to live for another 19.4 years – nearly 1 and 2 years longer than their respective EU averages. Furthermore, both men and women in Ireland are likely to spend a greater portion of their post-65 years without disabilities compared to the EU average (Figure 5). These data reflect the relatively low reported prevalence of health-related activity limitations among people aged 65 and over in Ireland for the same reference year. Survey data indicate that less than 40 % of individuals aged 65 in Ireland reported such limitations, whereas the figure was nearly 50 % across the EU.

**Figure 5. Irish people in old age tend to lead longer and healthier lives than their counterparts in most other EU countries**



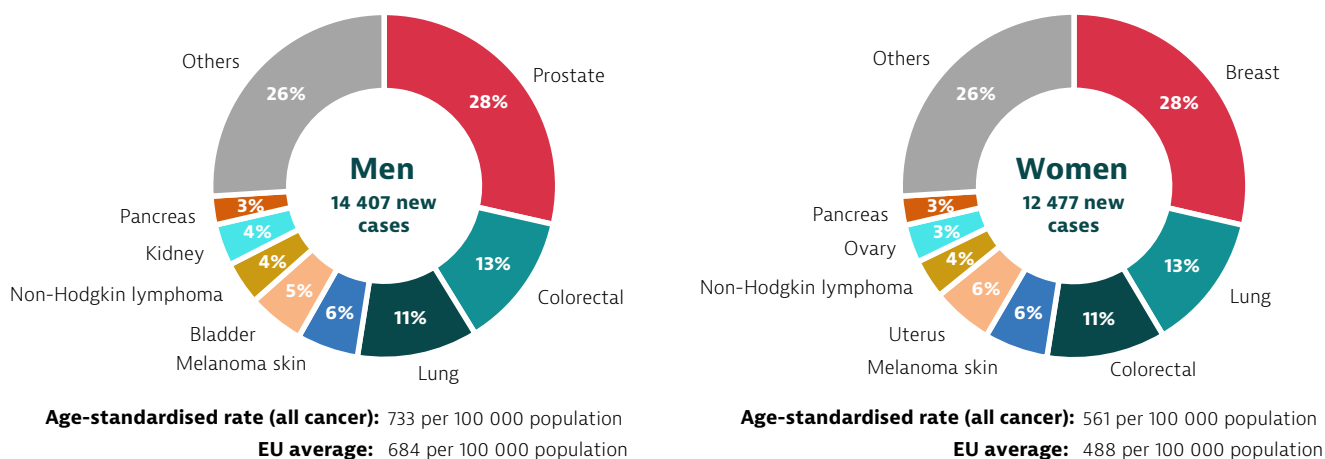
Source: Eurostat Database (2020).

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

According to estimates from the Joint Research Centre based on historical trends, the incidence of cancer in Ireland was projected to be above the EU average for both men and women, with about 26 880 new cancer cases expected to have arisen in 2022. Cancer incidence among Irish men was expected to be about 30 % higher than among women, a smaller gap compared to the EU average, reflecting a comparatively higher projected cancer incidence among Irish women, which exceeded the EU average by 15 %.

Prostate cancer was projected to be the single most common cancer site among men, accounting for 28 % of new cancers in 2022. Among women, breast cancer was expected to account for nearly 30 % of all new cancer cases. Colorectal and lung cancers were anticipated to be the second and third most frequent cancer sites in Ireland, accounting for 13 % and 11 % of all new cancer cases for both men and women (Figure 6). To reduce the incidence of cancer among the Irish population, Ireland’s National Cancer Strategy 2017-26 identifies the implementation of its Tobacco Free Ireland Programme 2025 among its priorities (HSE, 2022a).

**Figure 6. Over 26 800 new cancer cases were expected in Ireland in 2022**



Notes: 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 in Ireland

In 2019, over 35 % of all deaths in Ireland were attributed to behavioural risk factors, including tobacco smoking, dietary risks, alcohol consumption, and low physical activity (Figure 7). Tobacco smoking accounted for about 20 % of all deaths, higher than the EU average of 17 %, while dietary risks were estimated to contribute to about 13 % of all deaths, which was lower

than the EU average. Alcohol consumption was linked to approximately 5 % of all deaths, and low physical activity was related to about 3 %. Although to a lesser extent than in other EU countries, environmental issues in Ireland, such as air pollution in the form of fine particulate matter (PM<sub>2.5</sub>) and ozone exposure, had a non-negligible impact on mortality, being associated with about 2 % of total deaths in 2019.

**Figure 7. Tobacco smoking and dietary risks are major contributors to mortality in Ireland**



Notes: 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<sub>2.5</sub> and ozone alone.  
 Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

## Tobacco smoking rates have stabilised at a relatively low level

The number of daily tobacco smokers in Ireland has declined in the run-up to the pandemic, reflecting the government's resolve to de-normalise tobacco use within Irish society with the introduction of its Tobacco Free Strategy 2013-25 (Department of Health, 2015). In both 2019 and 2022, 14 % of the Irish population reported smoking daily – a rate below the EU average and down from 18 % in 2017. This decline was slightly slower among men, who, as in other EU countries, are more likely to smoke than women. Concurrently, the use of e-cigarettes has grown in popularity, with their use among former cigarette smokers increasing from 11 % in 2015 to over 17 % in 2019.

Among adolescents, tobacco smoking is comparatively low and has also been declining over time. Between 2015 and 2021, the share of children aged 10-17 who reported ever smoking tobacco fell from 16 % to 11 %, and only 5 % reported smoking regularly in 2021, down from 8 % in 2015 (HSE, 2022a). However, the popularity of e-cigarettes among teenagers has surged, with 15 % of 15-16-year-olds reporting regular use in 2019, up from 10 % in 2015 (Sunday, et al., 2020).

## Adult obesity remains a public health concern, but the population is becoming more health-aware

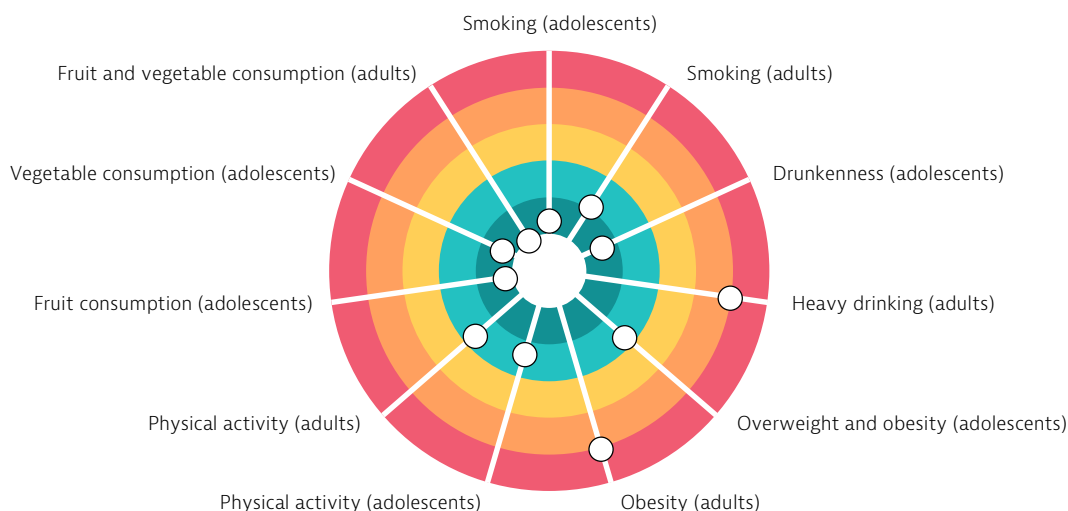
Based on self-reported body mass index data,<sup>1</sup> prevalence of obesity in Ireland stood at 21 % in

2022 – a higher share than the EU average, which nevertheless declined from the 26 % recorded in 2019. In 2019, Ireland reported the highest share of adults consuming five daily servings of fruit and vegetables in the EU – nearly 33 % compared to less than 13 % on average in the EU. Moreover, between 2014 and 2019, the share of Irish adults reporting at least 150 minutes of physical activity per week rose from 29 % to 37 %, exceeding the EU average of 33 %. Survey data from 2022 corroborate these findings, revealing significantly higher rates of regular exercise among Irish adults compared to the EU average (Eurobarometer, 2022). These positive changes in dietary habits and physical activity levels may foreshadow further reductions in Ireland's obesity rate in the near future. Among adolescents, the reported prevalence of overweight and obesity was 19.5 % in 2022 – slightly below the EU average of 21.2 %. Furthermore, rates of daily physical activity and fruit and vegetable intake among adolescents in Ireland exceeded their respective EU averages.

## Despite recent improvements, heavy drinking remains an important risk factor in Ireland

In 2019, nearly one in five adults in Ireland reported regular heavy drinking,<sup>2</sup> marking a significant decrease from nearly one in every three adults in 2014, though still higher than in most other EU countries (Figure 8). In terms of total alcohol consumption per capita, Ireland reached 10.2 litres per year in 2022, slightly surpassing the EU average of 9.8 litres. Among Irish teenagers,

**Figure 8. Adult obesity and regular heavy drinking are important public health concerns in Ireland**



Notes: 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 2022 for adolescents indicators; and EHIS 2019 for adults indicators.

<sup>1</sup> It is important to approach these findings with caution due to some anomalies in the data suggesting low reliability. Notably, Ireland stands out as the only EU country where self-reported obesity rates exceeded measured ones in 2019.

<sup>2</sup> Heavy drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.



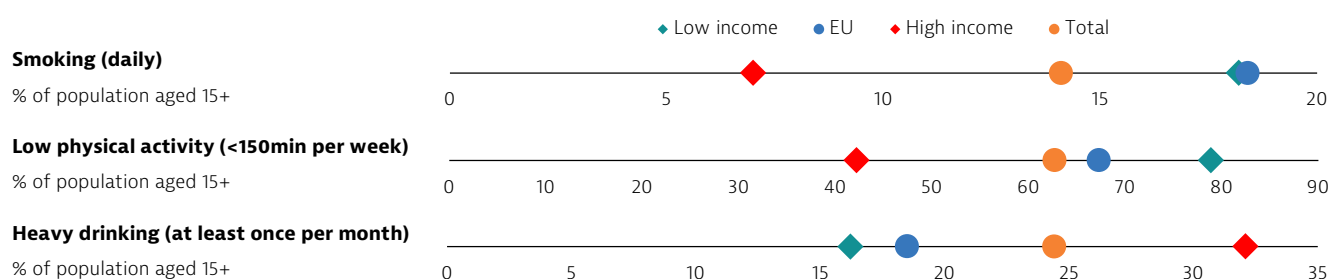
repeated drunkenness is less common compared to the EU average, with only 13 % of 15-year-olds reporting being drunk at least twice in their life in 2022, whereas the EU average was 18 %. Further reducing early drinking initiation is a key objective of Ireland's Public Health (Alcohol) Act introduced in 2018. The legislation has been pivotal in alcohol policy, implementing measures such as minimum unit pricing and structural separation of alcohol products in mixed retail outlets to restrict children's access to alcohol (O'Dwyer, et al., 2021).

In May 2023, Ireland became the first country in the world to mandate comprehensive health labelling for alcohol products. From May 2026, the new legislation will require alcohol labels to include information on calorie content/grams, the risks associated with alcohol consumption during pregnancy, as well as the increased risks of developing liver disease and various cancers from consuming alcohol.

### Socioeconomic inequalities contribute to inequalities in exposure to risk factors for health

As in almost all other EU countries, the prevalence of most behavioural risk factors among the Irish population tends to follow a clear socioeconomic gradient. In 2019, over 18 % of adults in the lowest income group reported smoking daily compared to only 7 % of those in the top 20 % of earners reported the same. A similar gap across income groups can be observed in the prevalence of insufficient physical exercise (i.e. below the recommended 150 minutes per week), where the rate among people in the lowest income quintile was nearly double the one of people the top income quintile. In contrast, heavy drinking was significantly more prevalent among those with the highest incomes (Figure 9).

**Figure 9. The prevalence of behavioural risk factors in Ireland follows a steep socioeconomic gradient**



Note: Low income is defined as the population in the lowest income quintile, whereas high income is defined as the population in the highest income quintile.

Source: Eurostat (based on EHIS 2019).

## 4 The health system

### The governance of Ireland's public health system is gradually becoming less centralised

Ireland's national health service is primarily funded through general taxation. The Department of Health, which provides overall stewardship, policy direction and performance oversight, is responsible for allocating the health budget. Concurrently, the Health Service Executive (HSE) is responsible for managing and delivering health and social care services. In most cases, the HSE acts as both the purchaser and provider of services, using its network of hospitals and community health organisations. However, a purchaser-provider split occurs when the HSE acquires services from general practitioners (GPs), private hospitals and

other private providers, including allied health professionals and homecare services. Private health insurance (PHI) also covers costs for care delivered in public facilities. GPs, who act as gatekeepers to secondary care, are private practitioners offering services to patients, who either pay out-of-pocket or are covered by various reimbursement schemes. Against the backdrop of significant capacity constraints in public outpatient and inpatient care services, nearly half of the population purchases PHI to obtain expedited access to care and some coverage for copayments (see Section 5.2).

As part of the Sláintecare reform programme towards universal care, Ireland plans to improve planning and integration of healthcare services

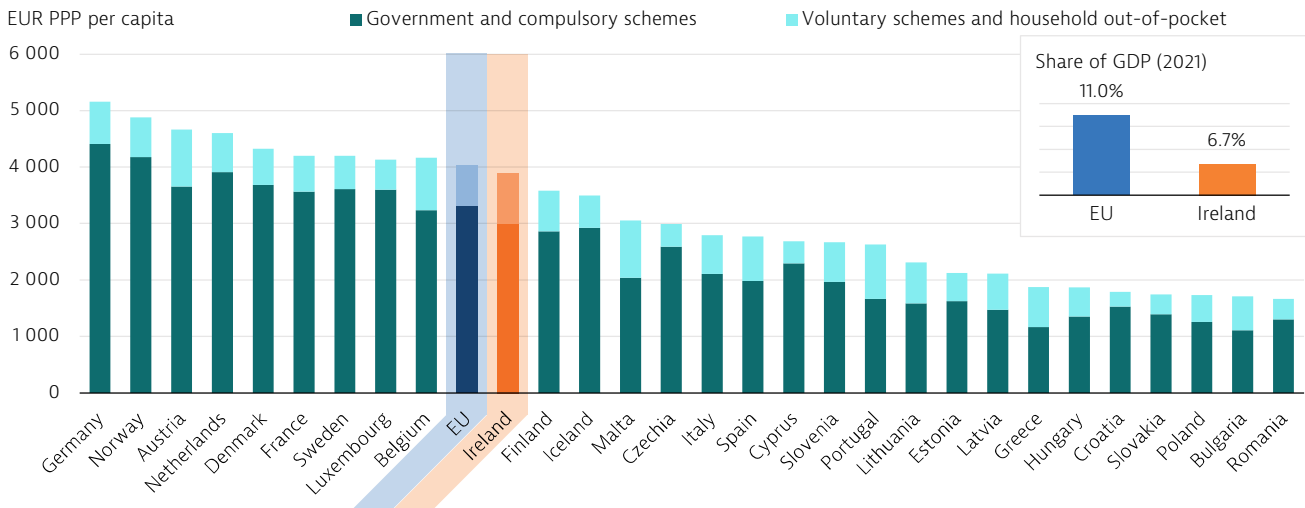
at the regional level through the establishment of six health regions. These new regions, which will become operational in 2024, are expected to provide more localised and responsive healthcare services tailored to the specific needs of their communities, thereby facilitating more efficient and effective healthcare delivery.

**The pandemic led to a rise in health expenditure of over 12 % between 2019 and 2021**

In 2021, Ireland’s health spending per capita adjusted for differences in purchasing power stood at EUR 3 885, which was slightly below the EU average of EUR 4 028 (Figure 10), and accounted for 6.7 % of GDP – a share below the EU average. However, health spending was

12.2 % when measured as a proportion of modified gross national income (GNI\*).<sup>3</sup> Public sources accounted for 77.4 % of total health spending in 2021 – a lower share than the EU average of 81.1 %. Correspondingly, private sources accounted for 22.6 % of total spending on health, reflecting relatively lower out-of-pocket (OOP) financing (10.7 % compared to 14.5 % in the EU) and a significantly larger contribution from PHI (11.9 % compared to 4.4 % in the EU), which ranked as the second highest in the EU after Slovenia. While in Slovenia PHI has a complementary role to cover copayments for services included in the public benefits package, PHI in Ireland is supplementary, offering faster access to care through private and public providers.

**Figure 10. Health expenditure per capita in Ireland is close to the EU average**



Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

Between 2015 and 2019, Ireland registered an average annual growth in health spending per capita of nearly 3 % in real terms. This growth primarily resulted from increased government spending and, to a lesser extent, PHI. In 2020, Ireland’s health expenditure per capita surged by 8.5 % in real terms, driven by a massive 14 % increase in public expenditure required to tackle the COVID-19 pandemic. Concurrently, private expenditure fell by over 7 %, reflecting disruptions in non-COVID-19 care from private providers and changes in patient healthcare-seeking behaviour. In 2021, health expenditure per capita increased by 3.4 %, reflecting continued public spending growth (see Section 5.3) and a 6.4 % rebound in private health expenditure driven by PHI, as

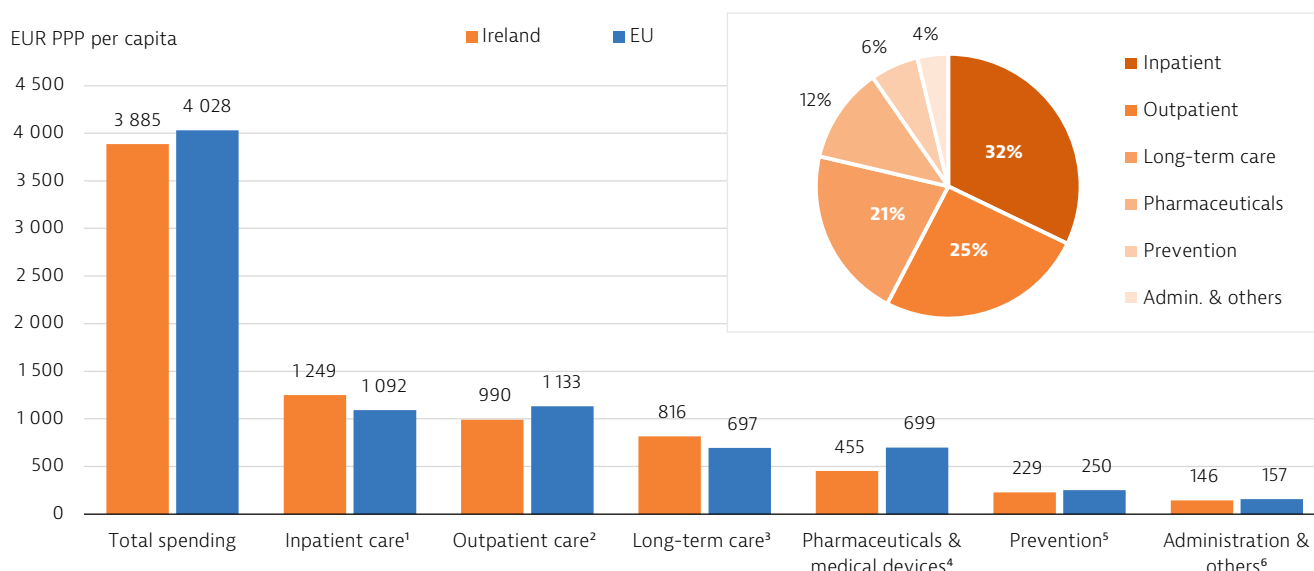
non-COVID-19-related care volumes gradually resumed towards pre-pandemic levels.

**Ireland allocates nearly a third of its healthcare budget to inpatient care**

In 2021, Ireland’s expenditure on inpatient and long-term care surpassed the EU average in both EUR per capita terms and as a share of its total health budget (Figure 11). Conversely, spending on prevention and outpatient care was below average. Expenditure on pharmaceuticals and medical devices was also comparatively lower, constituting less than 12 % of overall health expenditure in Ireland in contrast to the EU average of almost 18 %. Inpatient care was the largest health spending category, accounting for almost one third

<sup>3</sup> GNI\* is an indicator tailored to measure the size of the Irish economy excluding the substantial impact of globalisation on the country’s GDP and other macroeconomic statistics.

**Figure 11. Spending on inpatient and long-term care in Ireland is comparatively high**



Notes: 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; 6. Includes health system governance and administration and other spending.  
Source: OECD Health Statistics 2023 (data refer to 2021).

of total health expenditure, followed by outpatient care, which absorbed over a quarter.

Following the COVID-19 pandemic, the share of Ireland’s health budget dedicated to preventive care increased from 2.7 % in 2019 to 3.2 % in 2020. In 2021, expenditure on prevention almost doubled, reaching nearly 6 % of total health spending – a share in line with the EU average. This increase was entirely attributable to expenditure on COVID-19 testing, tracing and vaccines, which collectively accounted for more than two thirds of Ireland’s expenditure on preventive care in 2021.

**Public hospitals face significant capacity constraints**

The majority of acute care in Ireland is delivered in public hospitals. Because of rising demand, an overly hospital-centric model of care (see Section 5.1) and Ireland having one of the lowest acute bed densities in EU, hospitals face significant capacity constraints, leading to frequent overcrowding (see Section 5.3). To address this problem, the Irish government has allocated substantial funding each year since the start of the pandemic to progressively increase its public hospital capacity. By the end of 2023, the HSE aims to reach a total of 1 179 additional acute care beds (9 % over the pre-pandemic stock) and 352 intensive care beds (138 % over the pre-pandemic stock) operationalised since the start of the pandemic (HSE, 2023a).

While most of the planned additional capacity has come on stream, difficulties in recruiting clinical staff and construction inflation have slowed down the implementation of additional inpatient capacity. Additionally, these planned expansions are projected to fall short in fully addressing the capacity constraints faced by the Irish public hospitals. Recent estimates project a deficit of over 900 hospital beds in 2023, with an additional 330 inpatient beds needed annually until 2030 just to keep up with demand arising from a growing and ageing population (ESRI, 2023).

For 2023, the HSE’s investment plan allocated EUR 976 million to build and enhance healthcare facilities, including hospitals for accommodating additional of acute care beds. Approximately 42 % was specifically earmarked for new projects, with the remainder used to finance ongoing investments initiated in previous years (HSE, 2023a).

**Despite significant health workforce expansion during the pandemic, doctor shortages persist, particularly in general practice**

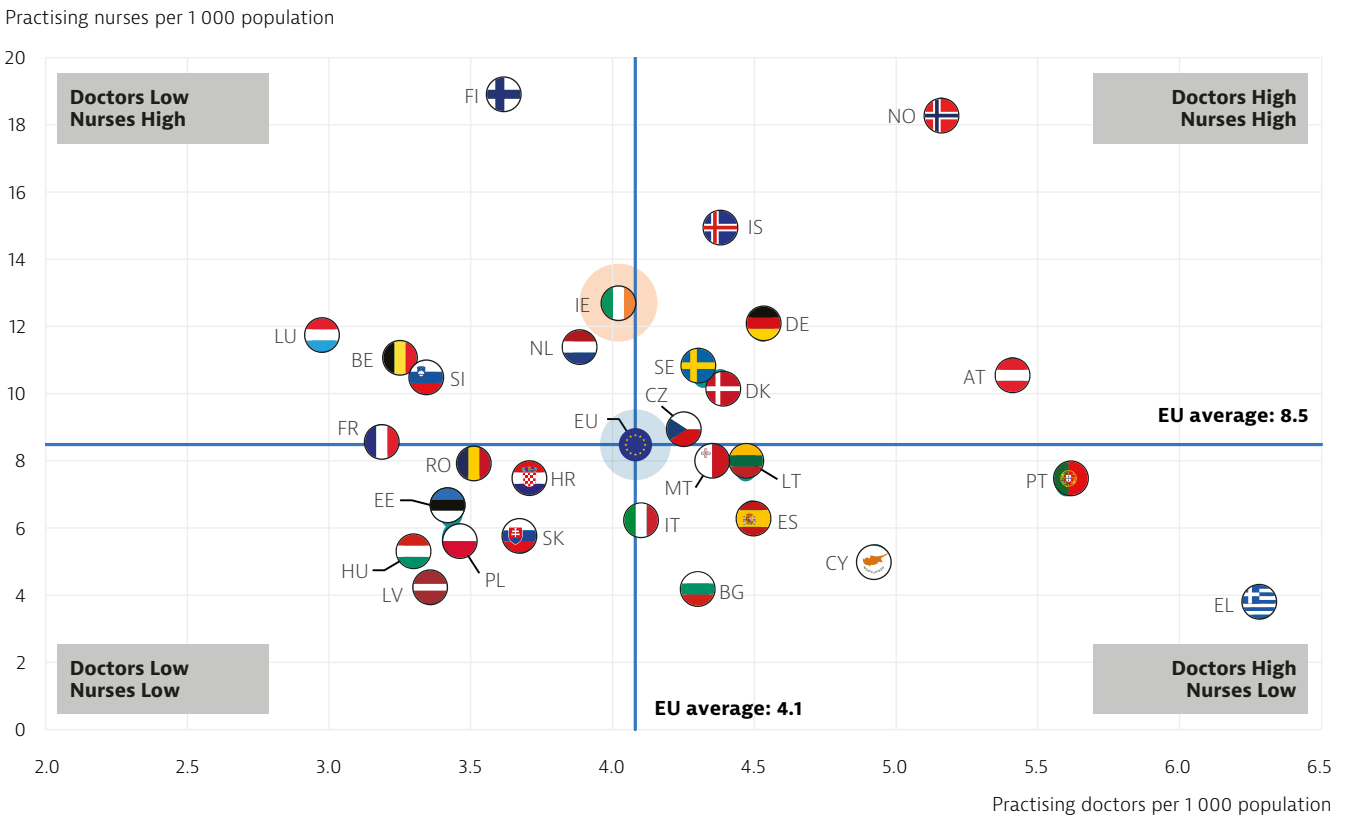
Despite a notable increase in the number of doctors and nurses over the last five years, health workforce shortages continue to pose a challenge in Ireland. As of 2021, Ireland had 4.0 doctors per 1 000 population – a density in line with the EU average and up from 3.3 per 1 000 in 2019. The density of practising nurses was above the EU average, at 12.8 per 1 000 population (Figure 12). During the pandemic, Ireland made significant investments to strengthen the recruitment

and retention of clinical staff, resulting in approximately 20 000 additional staff between 2019 and 2022. Moreover, the HSE’s National Service Plan 2023 outlined a plan to increase the health workforce in the public health system by up to 6 000 full-time-equivalent staff (HSE, 2023a).

Against this backdrop, current and projected shortages of doctors remain substantial, with a non-negligible number of vacancies being filled

temporarily or left unfilled. In December 2022, out of 4 152 total posts, 78 % were permanently filled, 11.5 % were filled on a non-permanent basis and 10.5 % remained vacant. Nearly a quarter of all vacant posts in 2022 had been unfilled for over 12 months, with pathology, intensive care medicine and internal medicine the specialties with the highest proportion of long-term vacant posts (HSE, 2023c).

**Figure 12. Ireland has more nurses than the EU average**



Notes: The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). 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: OECD Health Statistics 2023 (data refer to 2021 or the nearest available year).

Shortages of GPs, which constitute about a fifth of the total physician workforce, are also significant and risk bottlenecking the implementation of some of the elements of the Sláintecare reform towards a universal, more primary care-centred system. Concerns around the future supply of GPs are compounded by the low visibility of general practice in undergraduate education, with a cap on GP training posts resulting in less than 10 % of them choosing to specialise in this field (ICGP, 2022). Several factors contribute to the declining interest in general practice, including the lack of an effective funding model to support medical students’ placements. To alleviate shortages of GPs, the HSE allocated funding in 2023 to expand

the National Specialist GP Training Programme by 12 %, offering a total of 285 places, with a target of 350 to be reached by 2024. Additionally, an international recruitment scheme was established to attract experienced GPs from outside the EU to underserved areas in Ireland (ICGP, 2023). However, this approach poses the risk of exacerbating shortages in the countries from which these GPs are recruited.

# 5 Performance of the health system

## 5.1 Effectiveness

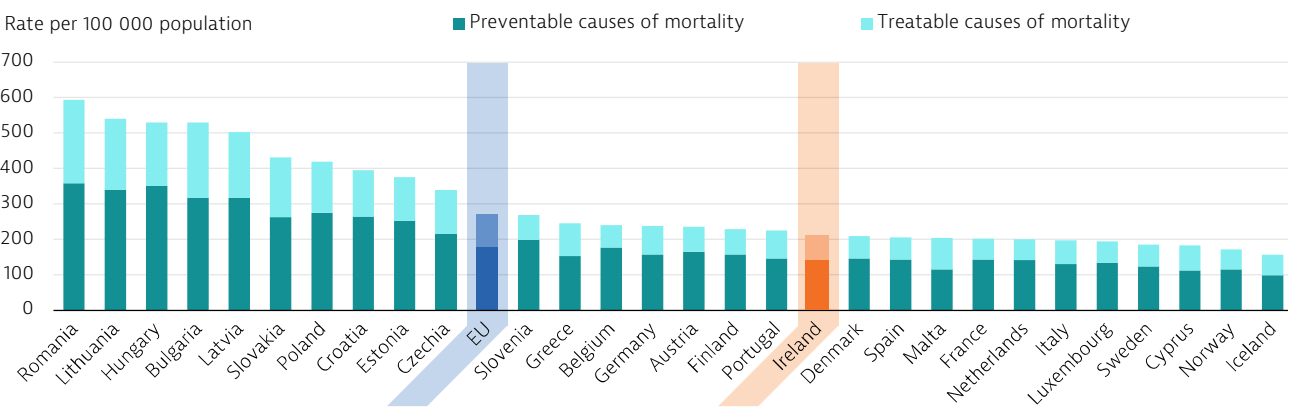
### Preventable and treatable mortality rates remain consistently below the EU average

In 2020, Ireland’s mortality rates from causes deemed to be preventable and treatable were approximately 20 % lower than the EU average (Figure 13). Against the backdrop of a nearly 17 % increase in preventable mortality registered across the EU on average between 2019 and 2020, Ireland’s rate increased by less than 12 %, reflecting lower mortality from COVID-19 compared to most other EU countries. The primary causes of preventable deaths in Ireland were lung cancer and ischaemic heart disease, accounting for one third of all total

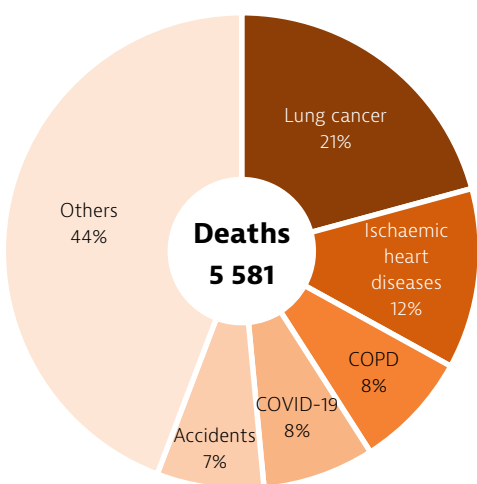
preventable deaths in 2020. The mortality rates for these causes were slightly lower than their respective EU averages.

Regarding mortality from treatable causes, not only were they below the EU average, but also declined at a considerably faster pace compared to the EU average over the past decade, driven in large part by reductions in the number of deaths from ischaemic heart disease and colorectal cancer. However, ischaemic heart disease and colorectal cancer remain the top two single leading causes of death that could be avoided with timely healthcare interventions, together accounting for over 40 % of mortality from treatable conditions in Ireland in 2020.

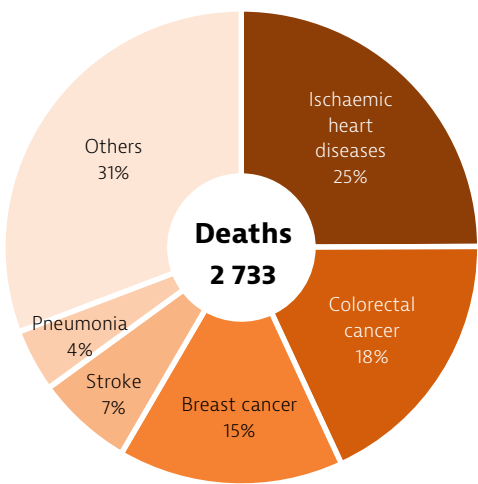
**Figure 13. Ireland’s preventable mortality gap with the EU average widened in 2020, reflecting comparatively lower COVID-19 mortality**



### Preventable causes of mortality



### Treatable causes of mortality



Ireland

Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death. COPD refers to chronic obstructive pulmonary disease.  
Source: Eurostat Database (data refer to 2020).

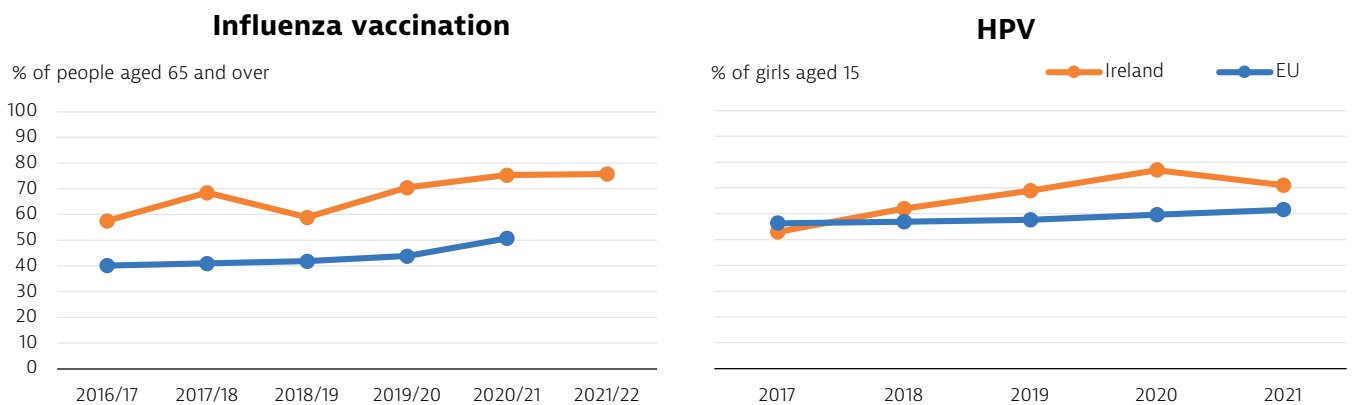
## Influenza vaccination coverage among adults aged 65 and over increased significantly during the pandemic

As in other EU countries, in Ireland the flu vaccine has been recommended for people aged 65 and over for a long time. While Ireland's vaccine uptake for this age group was consistently higher than the EU average in the years preceding the pandemic, it had never reached WHO's 75 % coverage target. Before the pandemic, only medical and GP visit cardholders (see Section 5.2) had free access to flu vaccination. Starting in September 2020, Ireland's HSE extended access to free flu vaccination to all individuals in this age group, regardless of their medical/GP visit card status. In 2020/21, the flu vaccination rate increased significantly and even exceeded the WHO coverage target (Figure 14), and in 2021/22 it reached an all-time-high of 76 %. While the pandemic certainly played a role in boosting interest in the influenza vaccine among those aged 65 and over, the decision to expand eligibility for free vaccination to all people in the

target group was likely an important contributor to this achievement.

In recent years, Ireland has implemented several strategies to enhance human papillomavirus (HPV) vaccine uptake among teenage girls. As a result, the HPV vaccination rate saw a significant increase, rising from 53 % in 2017 to 77 % in 2020. In 2021, the rate dipped to 71 % due to a temporary interruption of the HPV vaccination programme in early 2021 linked to school closures and staff redeployment to the COVID-19 immunisation programme. Nonetheless, this rate remained notably above the EU average of 62 %. Starting in 2019, the HSE expanded the eligibility for free HPV vaccination to include boys in the first year of secondary school. Furthermore, in December 2022 the HSE initiated an HPV vaccination catch-up programme for young adults (HSE, 2023d). In 2023, the HSE published a roadmap with the objective of meeting WHO targets for cervical cancer elimination, which foresees attaining a 90 % HPV vaccination coverage rate among 15-year-old girls.

**Figure 14. Uptake of flu and HPV vaccines among their respective target groups increased significantly in recent years**



Sources: OECD Health Statistics 2023 (for influenza vaccination) and WHO (for HPV).

## Ireland plans to improve diagnosis and management of asthma and COPD patients in outpatient settings

Hospital admissions data for conditions that can generally be managed effectively outside of hospitals provide insights into the availability and effectiveness of outpatient care services. While Ireland's aggregate admission rate for ambulatory care-sensitive conditions was comparable to the EU average in 2019, rates for asthma and chronic obstructive pulmonary disease (COPD) have persistently been much higher than the EU averages over the past decade (Figure 15). The marked decline in hospital admissions for asthma and COPD observed in 2020 and 2021 compared to

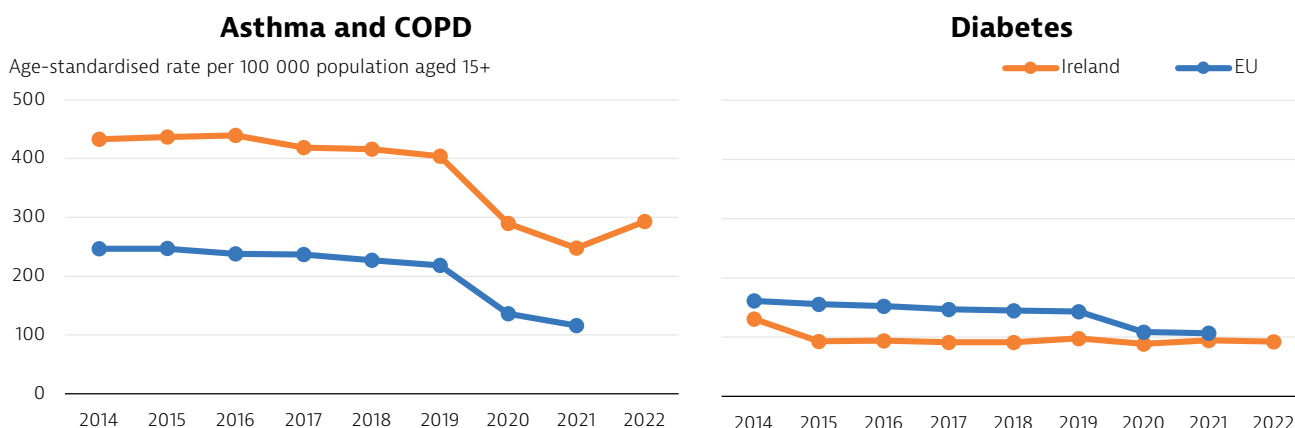
the pre-pandemic level should be interpreted in the context of the disruption caused by COVID-19, which severely impacted the capacity of hospitals to provide acute care and modified patient healthcare-seeking behaviour (see Section 5.3). These declines cannot therefore be understood as indicative of improved accessibility or quality of care for these chronic conditions in outpatient settings.

To some extent, Ireland's high hospitalisation rates for asthma and COPD also reflect their high prevalence compared to most other EU countries, which underlying causes remain unclear. According to HSE estimates, nearly 8 % of the Irish population have COPD and over 9 % have asthma.

Both conditions are target intervention areas of the GP Structured Chronic Disease Management Programme, which was launched in January 2020 to increase the availability of primary care services across the country for patients suffering

from selected chronic conditions. Over 186 200 unique individuals had been visited as part of the programme as of January 2022, with over 12 % receiving a COPD diagnosis and over 9 % receiving an asthma diagnosis (HSE, 2023b).

**Figure 15. Hospitalisation rates for asthma and COPD in Ireland consistently exceed the EU average**



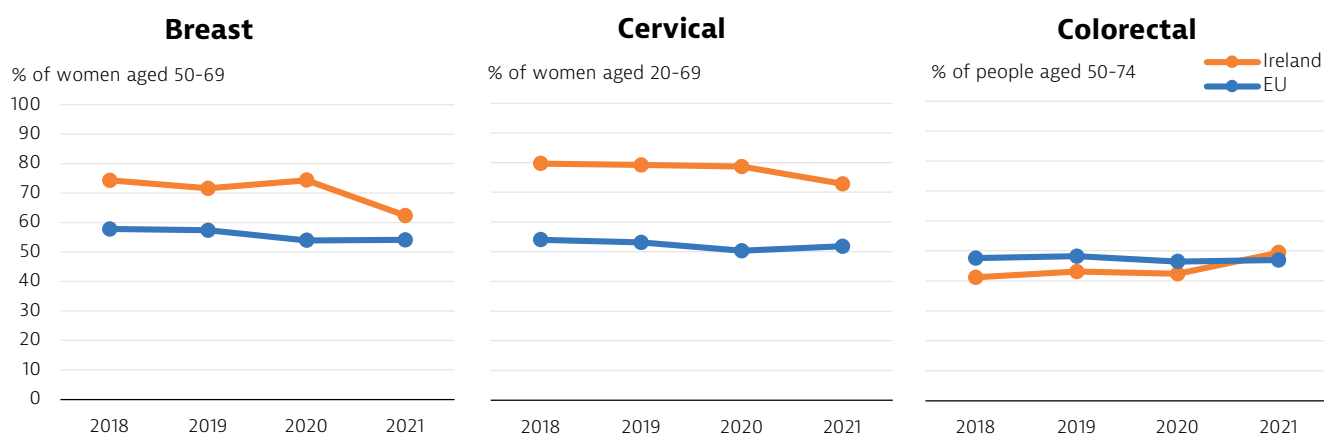
Note: Admission rates are not adjusted for differences in disease prevalence across countries. Source: OECD Health Statistics 2023.

**Efforts are being made to address pandemic-related delays in cancer screening services**

As in most other EU countries, the reconfiguration of health services imposed by the pandemic had a negative impact on the performance of cancer screening programmes in Ireland (OECD, 2023). Screening activities were suspended in March 2020, and resumed intermittently beginning in July. BreastCheck – Ireland’s breast cancer screening programme, was halted twice in 2020 and 2021, resulting in a cumulative loss of nearly one year of screening time. During this time, BreastCheck staff temporarily shifted to symptomatic services, prioritising high-risk patients in the diagnostic

pathway. In 2020, breast cancer screening rates remained in line with the pre-pandemic baseline at 74 % of the target group, a higher share than the EU average. However, delays accrued throughout 2020 manifested in 2021, with the screening rate declining to 62 % in 2021 (Figure 16). Preliminary data from 2022 indicate a steady recovery, although delays persist owing to staff shortages and continued COVID-19 restrictions affecting screening activity in 2021 (NSS, 2022). To alleviate breast cancer screening backlogs, two additional mobile mammography units began operating in May 2022.

**Figure 16. COVID-19 has caused significant disruptions to routine cancer screening programmes**



Note: Rates refer to the share of individuals within the target groups who have undergone screening in the last two years (or within the specific screening interval recommended in each country). Source: OECD Health Statistics 2023 (based on national programme data).

Cervical cancer screening rates followed a similar trajectory, declining from 79 % in 2020 to 72 % in 2021, yet remaining among the highest in the EU. In contrast, the colorectal cancer screening rate increased in 2021 to nearly 50 %. As part of its National Cancer Strategy, Ireland is planning to expand the age range for its BowelCheck screening programme from the current 60-69 to 55-74 years (Department of Health, 2021a).

## 5.2 Accessibility

### Excessively long waiting lists are the primary cause of unmet needs for medical care

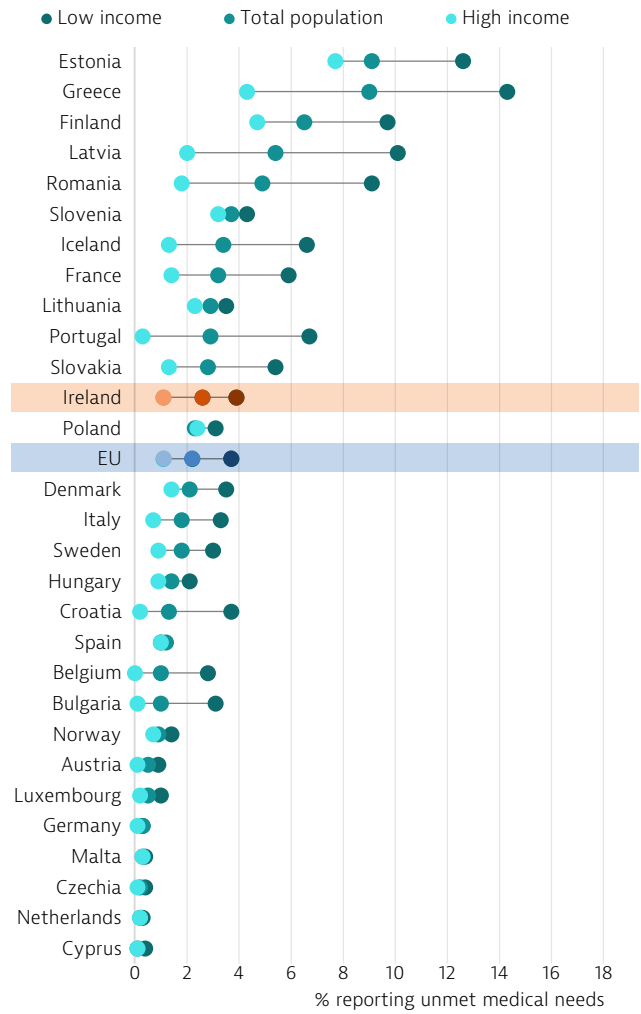
In 2022, 2.6 % of Ireland’s population experienced unmet medical care needs due to excessive costs, travel distance or waiting times. This proportion was slightly higher than both the EU average (2.2 %) and Ireland’s rate in 2019 (1.7 %). Women reported a higher proportion of unmet healthcare needs, and excessively long waiting lists were by far their main driver for both genders.

Differences in healthcare accessibility between individuals with a medical card and those (mainly higher income groups) with PHI granting them expedited access to care (see Section 4) are reflected in the distribution of reported unmet healthcare needs across income groups. Among individuals in the lowest income quintile, 3.2 % reported unmet medical needs due to waiting times compared to 1.1 % of individuals in the highest income quintile. This gap was larger than the EU average gap for unmet needs due to waiting times, where rates were 1.1 % in the lowest and 0.8 % in the highest quintile. However, when considering all possible reasons for unmet medical needs, Ireland’s income gap was comparable to the EU average (Figure 17).

### Coverage for publicly funded healthcare in Ireland is not universal, but is being expanded

The design of Ireland’s healthcare system is unusual within the EU in not providing universal health coverage for all residents. There are two main categories of entitlement to public services. Access to the most comprehensive set of publicly financed healthcare services is reserved for holders of a medical card (Category I), with eligibility subject to a means test. Residents who do not meet the medical card criteria (Category II) may qualify for a similar scheme if they have a long-term condition, or they may be eligible for another card that exempts them from the cost of GP visits if they fall under specific criteria, such as being under 8, over 70 or passing a less restrictive means test. Those who are not eligible for a GP visit card

**Figure 17. Unmet medical needs rates across income groups are in line with the EU averages**



Notes: Data refer to unmet needs for a dental 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 2022, except Norway (2020) and Iceland (2018)).

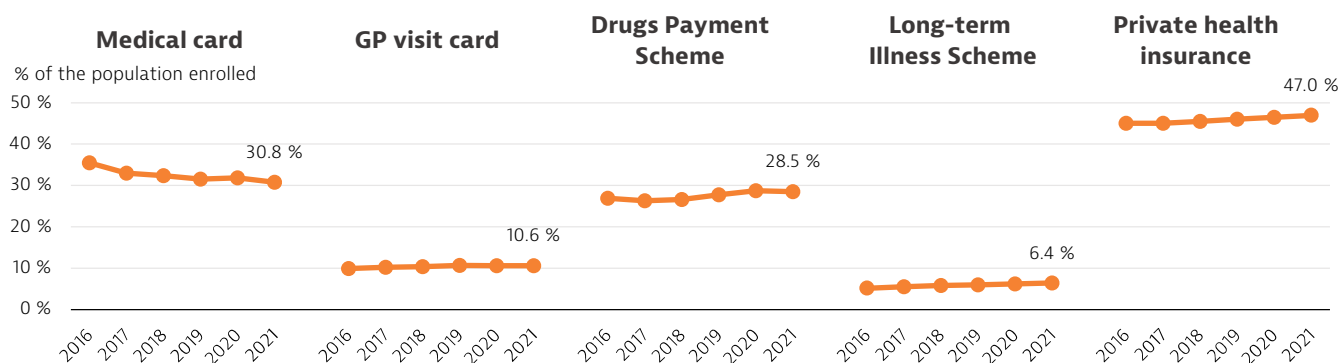
are required to pay the full cost of GP and other outpatient care services. All Category II residents can apply to the Drugs Payment Scheme, which caps monthly payments for prescribed medicines at EUR 80, mitigating the risk of catastrophic OOP spending (Department of Health, 2023a). As of 2021, about 48 % of the Irish population had either a medical or GP visit card or qualified for the Long-term Illness Scheme (Figure 18).

### Sláintecare implementation is gradually building a universal healthcare system, but long waiting lists in public hospitals hinder timely access to treatment

In 2023, Ireland took significant steps to expand entitlement to free public healthcare services. The eligibility for GP visit cards was extended to children aged 6 and 7, with a further 430 000



**Figure 18. Almost half the population is covered by one of the HSE's primary care reimbursement schemes**



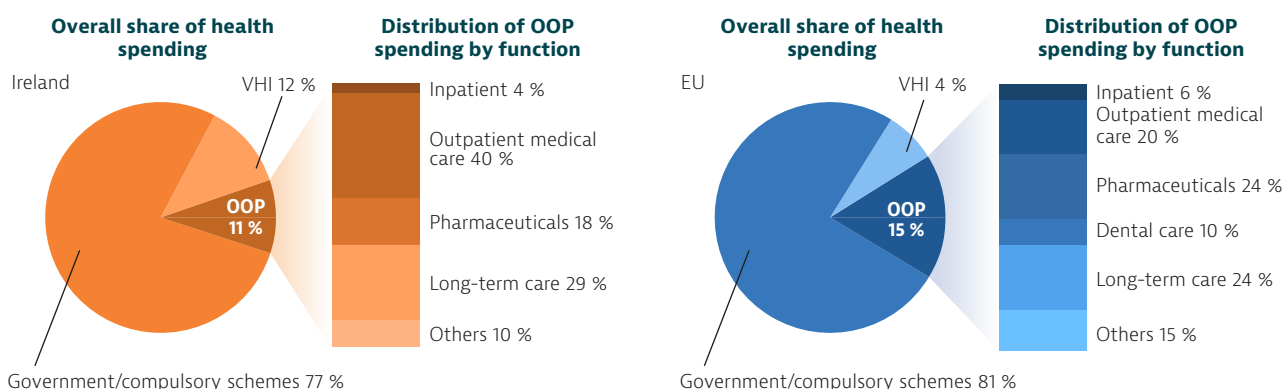
Sources: Department of Health (2023a), Health Insurance Authority (2021) for PHI coverage data.

lower-income individuals to be covered by the end of the year (Oireachtas, 2023a). Additionally, user charges for all inpatients in public hospitals were abolished. However, the limited capacity of public hospitals hinders timely access to services, as the care backlogs accumulated throughout the pandemic compounded already extensive waiting lists (see Section 5.3). Consequently, nearly half of the population purchase PHI to secure expedited access to private hospital care (Figure 17). As part of the Sláintecare Implementation Strategy and Action Plan 2021-23, Ireland has deployed several measures to cut waiting lists in public hospitals and mitigate inequities engendered in the tiered design of the healthcare system (Department of Health, 2021b) (see Section 5.3).

**Outpatient care absorbs an above-average share of out-of-pocket expenditure**

As outlined in Section 4, the financing mix of the Irish healthcare system is characterised by a relatively low share of OOP expenditure coupled with an above-average proportion of spending financed through PHI, reflecting the significant role that the latter plays in Ireland compared to most other EU countries. The distribution of OOP expenditure across services also differs significantly from the EU average. In 2021, outpatient care accounted for 40 % total OOP spending – a share twice the EU average, which partly stems from the fact that the majority of the Irish population accesses GP services on a private basis. Conversely, a comparatively smaller proportion of OOP spending was absorbed by pharmaceuticals (Figure 19).

**Figure 19. Private health insurance accounted for nearly 12 % of health expenditure in 2021**



Note: PHI also includes other voluntary prepayment schemes. Sources: OECD Health Statistics 2023; Eurostat Database (data refer to 2021).

**Recent reforms are bound to increase the extent of public coverage for inpatient care**

Analysing public financing ratios of health expenditure for specific services provides further insight into the scope of financial protection

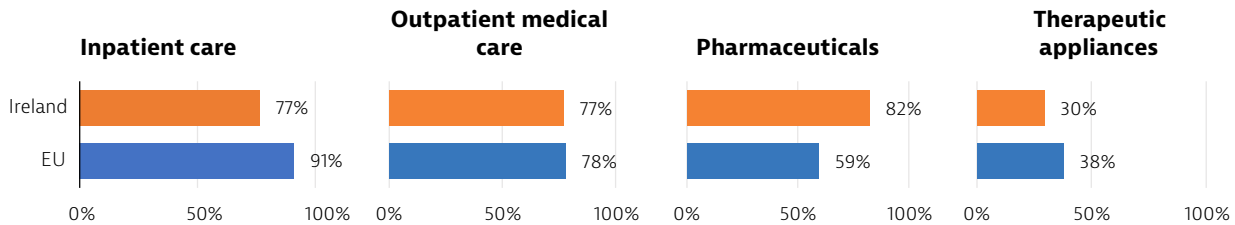
provided by the healthcare system. As shown in Figure 20, Ireland has a high public coverage rate for pharmaceuticals, while ratios for inpatient care and therapeutic appliances are relatively low compared to the EU average. In 2021, Ireland

financed over 80 % of its pharmaceutical spending through various arrangements by the HSE, significantly surpassing the EU average of 59 %.

Ireland's below-average coverage rate for inpatient services reflects the peculiar design of its healthcare system. Until recently, public hospitals charged inpatients without a medical card EUR 80

per day, up to a maximum of EUR 800 per year. However, following the removal of inpatient charges for children in 2022 and their complete abolition in April 2023, the public financing rate for inpatient care is bound to rise significantly (Oireachtas, 2023b).

**Figure 20. Ireland was the only EU country with a lower public coverage rate for inpatient care than pharmaceuticals in 2021**



Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines and medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.

Source: OECD Health Statistics 2023.

### 5.3 Resilience

The COVID-19 pandemic has proved to be the most significant disruption to health systems in recent decades. It has shed light on the major vulnerabilities and challenges within countries' emergency preparedness strategies and on their ability to provide healthcare services to their populations. In response to the enduring effects of the pandemic – as well as other recent crises, such as cost-of-living pressures and the impact of conflicts like the war against Ukraine – countries are implementing policies to mitigate the ongoing impacts on service delivery, invest in health system recovery and resilience,<sup>4</sup> improve critical areas of the health sector, and fortify their preparedness for future shocks.

#### Following a decline of over 13 % in 2020, hospital admissions recovered partly in 2021

Partly stemming from insufficient investment following the post-2008 Irish economic downturn, Ireland's public hospital care is characterised by chronic undercapacity (see Section 4). Acute care hospital beds consistently operated at nearly 90 % occupancy pre-pandemic, surpassing the recommended threshold for maintaining an adequate buffer for emergency situations. Despite a rapidly growing population, public hospital bed capacity in Ireland increased only marginally in the

years leading up to the pandemic. Consequently, the number of public hospital beds per capita remained stagnant at a significantly lower than in most other EU countries. As of 2019, Ireland had the third lowest public hospital bed density in the EU, standing at over 40 % below the EU average (Figure 21).

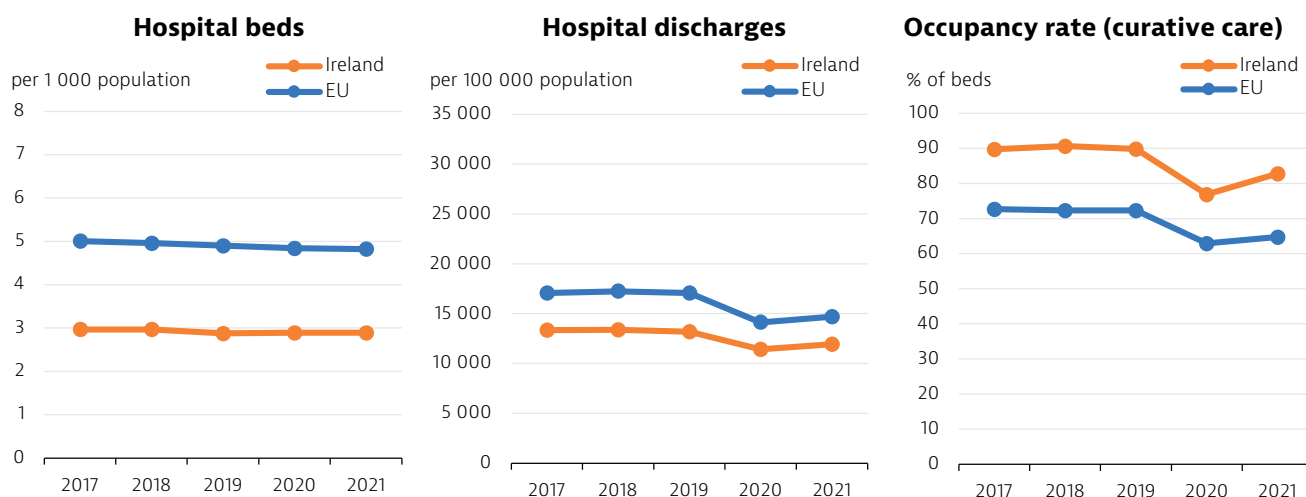
At the start of the pandemic, Ireland swiftly implemented a set of interventions to curtail the spread of the virus and increase hospital capacity for COVID-19 patients. In hospitals, the HSE deferred significant volumes of procedures and brokered an agreement with private hospitals to render their capacity temporarily available to the public system. These measures yielded a marked reduction in hospital activity from April to June 2020, contributing to an 18 % yearly decline in elective discharges and an 11 % decrease in emergency discharges compared to 2019. As a result, the average bed occupancy rate of public hospitals fell just below 80 % for the first time in decades.<sup>5</sup>

In 2021, public hospital discharges partially rebounded to nearly 91 % of their 2019 volume. This increase reflected the gradual resumption of non-COVID-19-related care, albeit against the backdrop of additional deferrals, primarily of surgical activity, due to the arrival of new COVID-19 wave in early 2021. Concurrently,

<sup>4</sup> 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).

<sup>5</sup> If the additional stock of hospital beds temporarily provided by the private sector as a result of the agreement struck by the HSE is included in the count, the total bed occupancy rate in 2020 was even lower (76.9 %).

**Figure 21. Hospital discharge and acute care bed occupancy rates fell by over 10 % in 2020**



Notes: The EU average is unweighted. The data refer to public hospitals only.  
Source: OECD Health Statistics 2023.

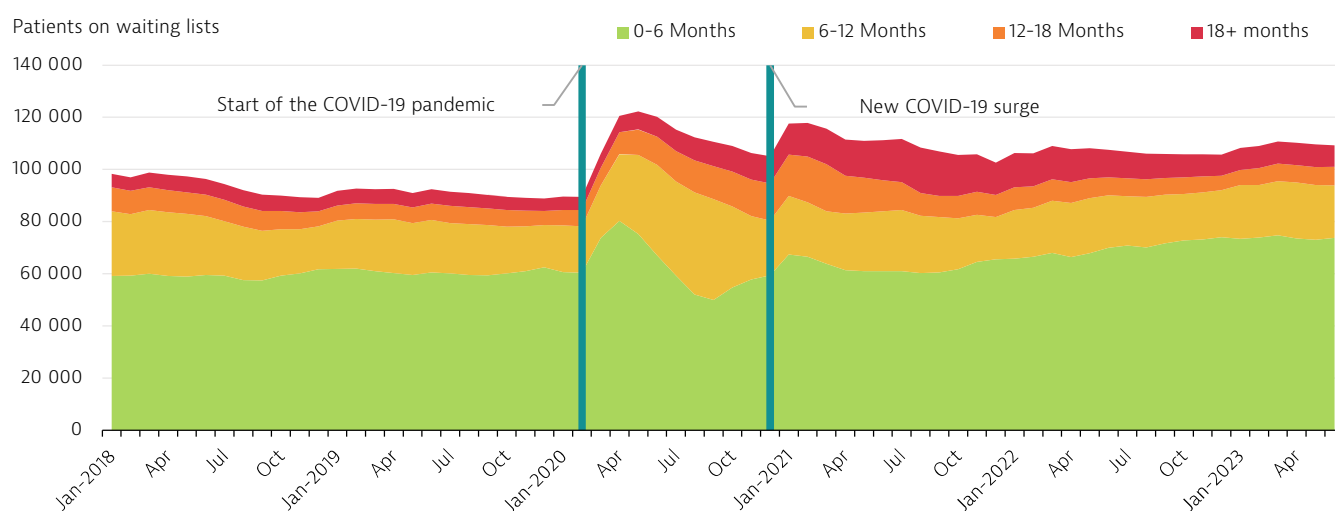
the average bed occupancy rate in public hospitals returned to its pre-pandemic level of nearly 90 %. However, when accounting for the extra bed capacity procured from private hospitals by the HSE, the average bed occupancy available to the HSE was diluted to 82.8 %.

**COVID-19-related hospital disruptions aggravated patient backlogs for elective care**

As in most other EU countries, the deferral of hospital activities during the pandemic had an adverse effect on waiting times for elective care in Ireland. Between February and April 2020, the number of patients on waiting lists for hospital treatment increased by over a third. Although the total number of patients on waiting lists

declined by nearly 11 % from its peak in May to October 2020, this was driven by a sharp decrease in patients waiting for less than 6 months, while the number of those waiting for over 6 months continued to rise (Figure 22). This pattern resulted from a significant drop in new referrals from primary to hospital care, rather than an increase in treatment volume (RCSI, 2021). The pent-up demand generated by changes in referral patterns in 2020 hindered efforts to clear patient backlogs throughout 2021 and 2022, as demand rebounded strongly with the progressive restoration of hospital care capacity.

**Figure 22. The release of pent-up demand from 2020 put pressure on elective care waiting lists in 2021 and 2022**



Source: National Treatment Purchase Fund (2023)

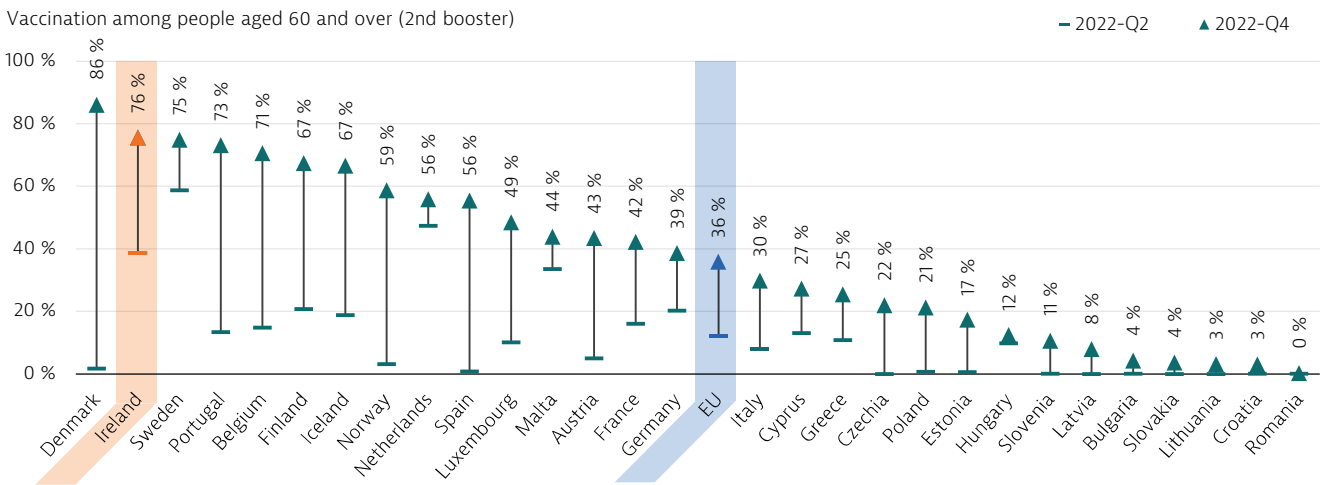
Although the number of patients on hospital waiting lists for more than a year decreased by nearly 45 % between December 2020 and December 2022, in January 2023 the overall number of patients on waiting lists for hospital treatment remained over 20 % higher than in January 2020. To address this issue the government formulated a new Waiting List Action Plan in early 2023. The plan outlines 11 actions to be implemented by end 2023 to reduce waiting lists by over 10 % from the beginning of the year. To support this endeavour, an additional EUR 50 million was allocated on top of the EUR 100 million budget of the National Treatment Purchase Fund to clear waiting list backlogs for selected high-volume hospital procedures (Department of Health, 2023b).

**Ireland’s effective vaccination rollout played a crucial role in reducing COVID-19 mortality**

Ireland’s relatively low number of excess deaths during the pandemic (see Section 2) can be partly

attributed to the successful implementation of its COVID-19 vaccination programme. Throughout the pandemic, Ireland consistently outpaced most other EU countries in all key vaccination uptake metrics, reaching above-average coverage rates for both the first vaccination course and booster doses. By the end of 2022, over 96 % of the adult population in Ireland had completed the primary course of COVID-19 immunisation compared to 82 % across the EU, and over three quarters received a first booster dose, compared to less than two thirds of the adult population across the EU. Among people aged 60 and above, over three quarters had received a second COVID-19 booster dose, which was more than double the average rate in the EU and the second highest after Denmark (Figure 23).

**Figure 23. Irish seniors had the second highest uptake of the second COVID-19 vaccine booster in the EU**



Note: The EU average is unweighted.  
Source: ECDC.

**Amid staffing challenges and high demand, long COVID clinics face sizeable patient backlogs**

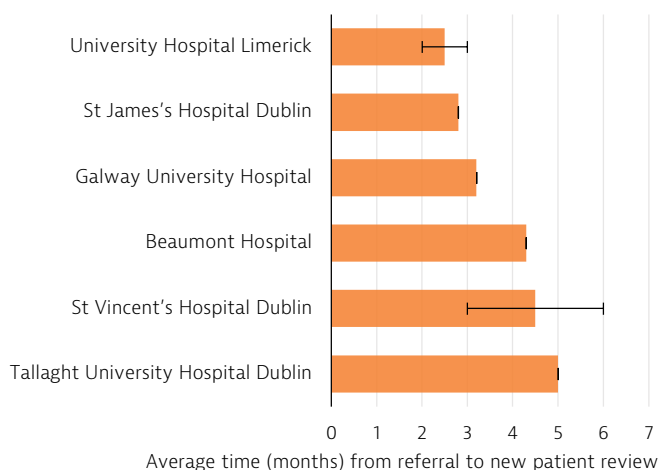
COVID-19 has led to a significant number of individuals experiencing a wide range of long-lasting and often debilitating symptoms following SARS-CoV-2 infection which are unexplained by an alternative diagnosis. This constellation of symptoms is known as long COVID. The lack of a consensus on the exact diagnostic criteria for long COVID make estimating its prevalence challenging. However, the most extensive observational cohort study with a control group conducted to date found that over 12 % of individuals who had contracted COVID-19 reported

experiencing symptoms compatible with a long COVID diagnosis at three months post-infection (Ballering, et al., 2022).

To meet the growing clinical demands of a rising population of long COVID patients in Ireland, in September 2021 the HSE implemented a comprehensive plan to create an interim model of care specifically catering to the unique requirements of these individuals. The model established a patient pathway focusing on symptom management at the primary care level, with more severe cases being referred to one of six specialised long COVID clinics set up across the country. However, significant difficulties in

recruiting suitably-qualified clinical staff to run the clinics led to delays in their operationalisation, which are reflected in long waiting lists for patients (Figure 24). As of March 2023, the majority of the specialised clinics began operations, but expertise shortages continue obstructing care capacity. To support demand forecasting and guide future modifications to the design of Ireland’s long COVID interim care model, the HSE launched an epidemiological survey in 2023 to obtain a more precise understanding of the exact prevalence of long COVID in Ireland.

**Figure 24. Long covid patients face significant wait times to access specialist clinics**



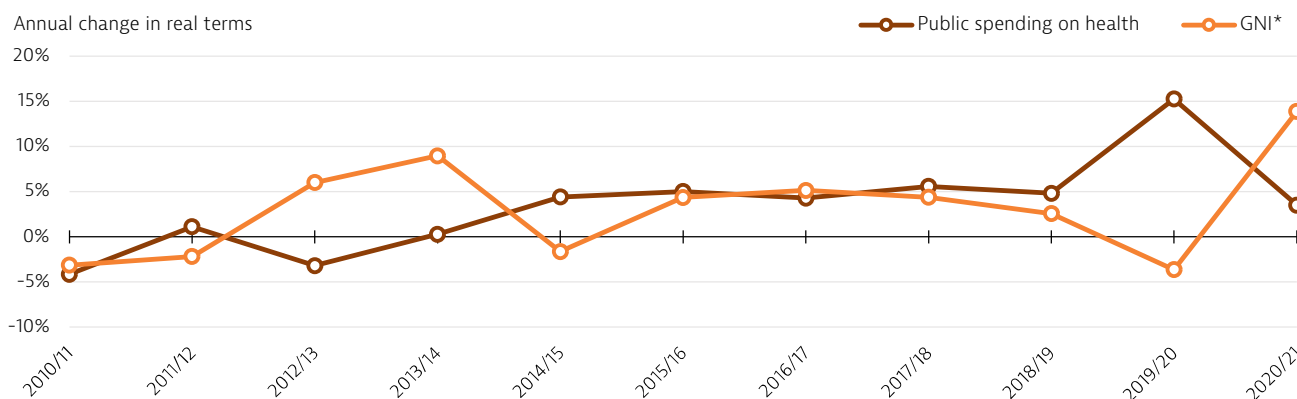
Source: Population Health Information Research Infrastructure (PHIRI) (2023)

**COVID-19 had a dramatic impact on the size and makeup of health spending in 2020**

Following a significant reduction in the wake of the 2008 financial crisis, Ireland’s government spending on health returned to growth in 2015. Between 2015 and 2019, the average growth in government health expenditure stood at nearly 5 % per year, which slightly outpaced the country’s growth in GNI\*. The pandemic temporarily disrupted this trend, causing publicly financed health expenditure to surge by over 15 % while GNI\* declined by 3.5 % (Figure 25). As the economy rebounded strongly in 2021, government health expenditure increased at a more moderate rate of 3.5 %, driven in large part by continued rises in COVID-19-related expenditure – including vaccines, tests and increased staff expenses.

The scale of the pandemic’s impact on Ireland’s healthcare system was also reflected in considerable changes to its financing mix. In the face of a near 10 % increase in total health expenditure in 2020 driven by public sources, private spending funded through PHI declined by 11 %, reflecting a marked reduction in non-urgent care that would have typically been the object of health insurance claims. Consequently, several PHI providers temporarily waived portions of their premiums and provided moderate rebates to customers. As volumes of non-COVID-19 care rebounded partially in 2021, health expenditure funded through PHI returned to its 2019 levels.

**Figure 25. The pandemic temporarily decoupled public health expenditure and economic output trajectories in 2020**



Sources: OECD Health Statistics 2023, Central Statistics Office (for GNI\*).

**Ireland’s Recovery and Resilience Plan will support digital health investments and key elements of the Sláintecare reform**

Through the implementation of its Recovery and Resilience Plan (RRP) – a key pillar of the EU’s

response to the COVID-19 crisis – Ireland plans to deploy a set of investments and reforms to improve the accessibility and efficiency of its healthcare system. Regarding investments, the RRP designates EUR 75 million for the implementation of an integrated financial management system

and the deployment of an e-pharmacy system in hospitals to streamline workflows and foster better integration between the health and social care sectors.

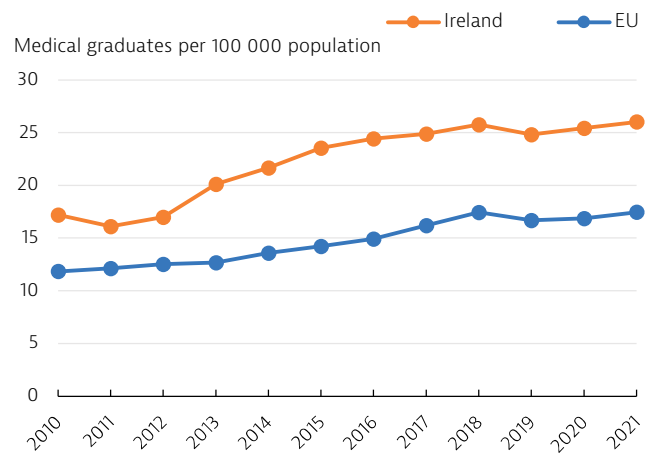
In parallel, Ireland is committed to a series of foundational reforms under its Sláintecare programme aiming for universal healthcare. A key element involves operationalising a new hospital consultant contract, which will gradually phase out the longstanding practice of physicians engaging in private practice within public hospitals. Following extensive negotiations between the Irish government and relevant professional associations, this public-only employment contract was introduced in March 2023. Other important RRP-backed reforms include the establishment of 96 Community Healthcare Networks with small primary care teams around the country, and the expansion of a chronic condition management programme aimed at reducing avoidable hospitalisations (see Section 5.1).

### Ireland relies significantly on non-EU countries to meet its clinical staff recruitment needs

As highlighted in Section 4, the Irish healthcare system faces a scarcity of doctors, especially in certain specialisations. Despite consistently producing one of the highest numbers of medical graduates per capita in the EU over the past decade, Ireland's recruitment targets struggle to keep pace with the increasing size and care needs of its population due to supply-side constraints (Figure 26). The low domestic retention rate of medical graduates can be attributed to various factors, including the fact that nearly half of medical students are internationals with limited opportunities to complete their training in Ireland. Furthermore, there has been a notable increase in the migration of Irish medical graduates and junior doctors to other English-speaking countries, driven by the prospect of better working conditions and career opportunities. As a result, Ireland has become increasingly reliant on foreign-trained medical staff, primarily from Pakistan and Sudan (for doctors) as well as India and the United Kingdom (for nurses) to meet a significant part of its recruitment needs. In 2021, over 40 % of doctors and 46 % of nurses in Ireland were foreign-trained, among the highest rates in the EU. This paradoxical recruitment pattern highlights deficiencies in Ireland's past workforce planning efforts. In response, a number of initiatives have been launched, including the ongoing development of a Health and Social Care Workforce Planning Strategy, Action Plan and Planning Projection

Model supported by the European Commission through its Technical Support Instrument.

**Figure 26. Despite producing a large number of medical graduates, Ireland recruits a significant share of medical staff from non-EU countries**



Note: The EU average is unweighted.

Sources: OECD Health Statistics 2023; Eurostat Database.

### Antimicrobial resistance remains a serious threat to healthcare in Ireland

Antimicrobial resistance (AMR) is a major public health concern in the EU, with estimates of approximately 35 000 deaths due to antibiotic-resistant infections and healthcare costs of around EUR 1.1 billion per year (OECD/ECDC, 2019). Because antibiotic overprescription and overuse in humans are major contributors to the development of antibiotic-resistant bacteria, antibiotic consumption data are a useful tool to evaluate the risk of AMR and the efficacy of programmes to promote their appropriate use.

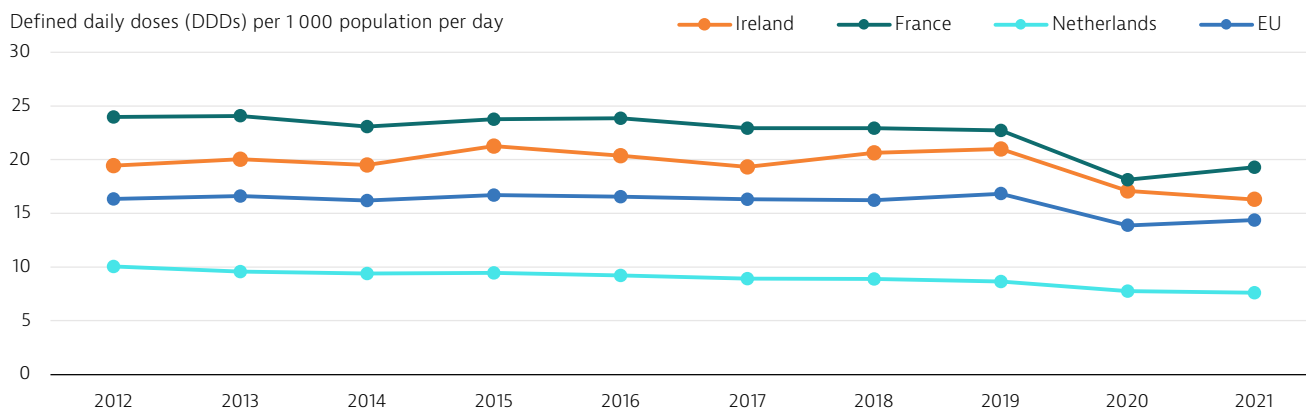
In contrast to the gradual decline in total antibiotic consumption observed across the EU in the five years preceding the pandemic, consumption in Ireland rose on average by 1.7 % per year, reaching a level 15 % above the EU average in 2019. As in most other EU countries, Ireland saw a marked reduction in antibiotic consumption during the first two years of the pandemic, as reduced transmission of all respiratory pathogens resulted in fewer prescriptions in the community. Community antibiotic consumption in Ireland declined by about 17 % in 2020, a decline in line with the EU average. In contrast to the EU average, Ireland registered a further 3 % decrease in 2021 as well (Figure 27).

Nonetheless, preliminary figures for 2022 indicate a return to pre-pandemic levels of total antibiotic consumption in Ireland, as during the fourth quarter of the year antibiotic usage

in the community reached 29.4 daily defined doses (DDD) per 1 000 inhabitants per day, the greatest consumption for any given quarter since surveillance began in Ireland (Health Protection Surveillance Centre, 2022). Planned investments

in digital health tools are expected to enable a more thorough investigation of the fluctuations and geographic variation in antibiotic prescription patterns across Ireland.

**Figure 27. COVID-19 caused a large but transient reduction in antibiotic consumption in Ireland**



Notes: The data only cover consumption in the community (outpatient).  
Source: ECDC ESAC-Net.

## 6 Spotlight on mental health

### The burden of mental ill health in Ireland is among the highest in the EU

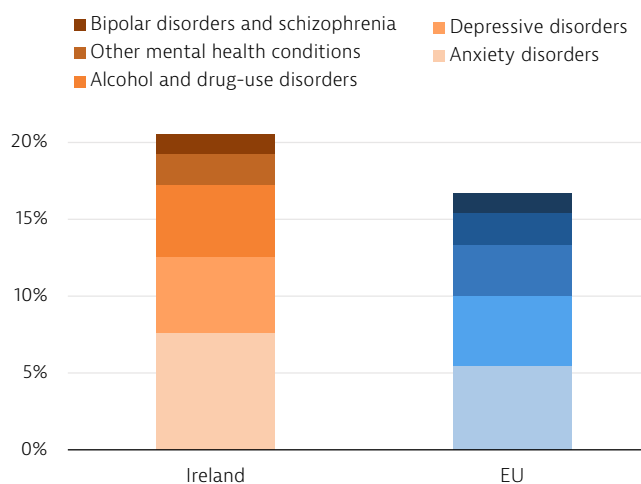
Just like in other countries, determining the exact proportion of the Irish population affected by a mental health disorder at any point in time is challenging due to methodological limitations specific to mental disorders, which often result in undercounting their true burden.

According to prevalence estimates from the Institute for Health Metrics and Evaluation (IHME), over one million individuals in Ireland had a mental health disorder in 2019, which accounted for 21 % of the population – an increase from 18.5 % in 2016 and a higher share than the EU average of 16.7 %. Among the various mental disorders, anxiety disorders were the most prevalent, affecting approximately 7.6 % of the population, followed by depressive disorders at 5 % and alcohol and drug-use disorders at 4.7 % (Figure 28).

The relatively high prevalence of mental health disorders in Ireland significantly affects its citizens' welfare and has a profound impact on the economy. Based on the estimates listed above, mental health disorders in Ireland resulted in the loss of approximately 141 500 years of productive life in 2019. Furthermore, in 2015 the total costs

linked to mental health issues in Ireland were estimated to be around 3.2 % of GDP, with most of these costs attributed to reduced participation and productivity in the labour market (OECD/EU, 2018).

**Figure 28. Anxiety and substance use disorders drive higher prevalence of mental health problems in Ireland**



Note: The EU average is unweighted.  
Source: IHME (data refer to 2019).

## Depression tends to be more prevalent among those on lower incomes and women

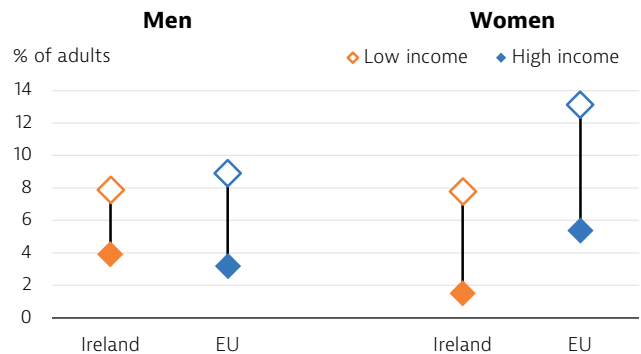
According to survey data from 2019, nearly 4 % of the Irish population reported experiencing depression, a lower proportion compared to the EU average of 7.2 %. As in all other EU countries, self-reported depression was more prevalent among Irish women, although the gender gap was significantly smaller than the one observed on average across the EU.

While in the EU higher income levels were consistently associated with a lower prevalence of depression, in Ireland the relationship between income levels and depression was not linear, with Irish men in the top 20 % income bracket reporting a significantly higher prevalence of depression (3.9 %) than those in the fourth income quintile (0.8 %). Despite this nuanced pattern, a clear link between income and depression prevalence remains evident. Individuals in the lowest income quintile in Ireland were nearly three times more likely to report suffering from depression than those in the highest quintile – a ratio comparable to the EU average (Figure 29).

## Ireland has witnessed a nearly 12 % decline in its suicide rate over the past decade

Suicide is significant public health problem in the EU, including in Ireland, where it accounted for 1.4 % of all deaths in 2020. The factors contributing to suicide are complex, but extensive research and clinical practice have established that mental health problems play a substantial role as risk factors for suicide. As in other EU countries, suicide rates in Ireland are characterised by a marked gender split, with a higher incidence among men.

## Figure 29. Differences in depression prevalence by income and gender are relatively less pronounced in Ireland compared to the EU average



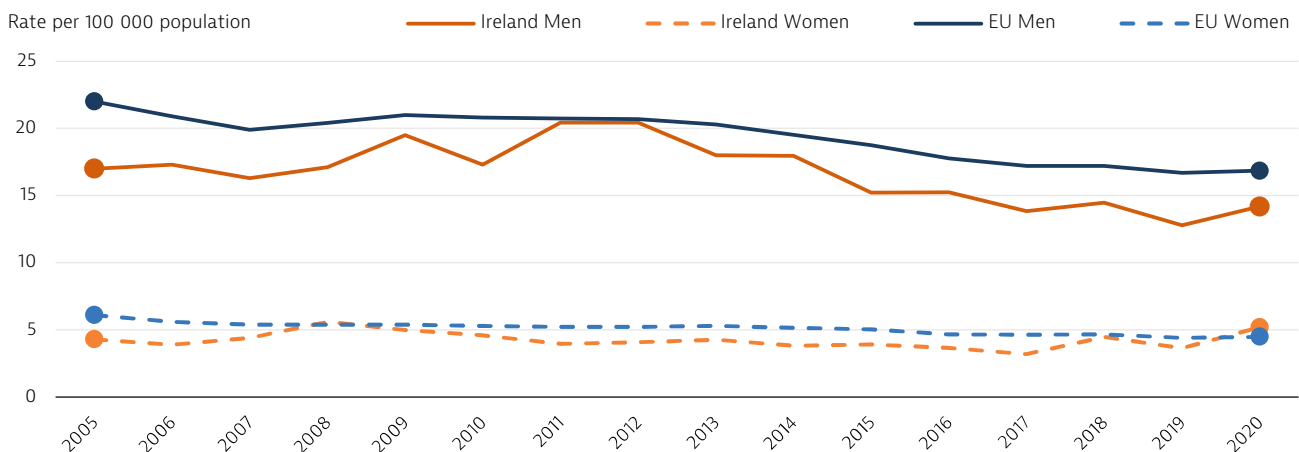
Note: High income refers to people in the top income quintile (20 % of the population with the highest income), whereas low income refers to people in the bottom income quintile (20 % of the population with the lowest income).

Source: Eurostat Database (based on EHIS 2019).

Between 2016 and 2020, the average suicide rate among Irish women was less than a third of that among men.

Albeit at a slower pace compared to most other EU countries, over the past decade Ireland's suicide rate declined in line with the trend observed across the EU. In 2020, Ireland's suicide rate stood at 9.6 per 100 000 inhabitants, which was about 6.1 % lower than the EU average. This reduction was driven by a decrease in men's suicide rate, while the rate among women increased slightly, reaching its highest level of the decade in 2020 (Figure 30). The decline in suicide rates since 2015 can be attributed at least partly to the implementation of Ireland's National Strategy to Reduce Suicide, Connecting for Life (2015-24), which outlines a comprehensive approach to suicide prevention.

## Figure 30. Over the past decade, suicide rates among Irish men have fallen in tandem with the EU-wide trend and reached a level below the EU average

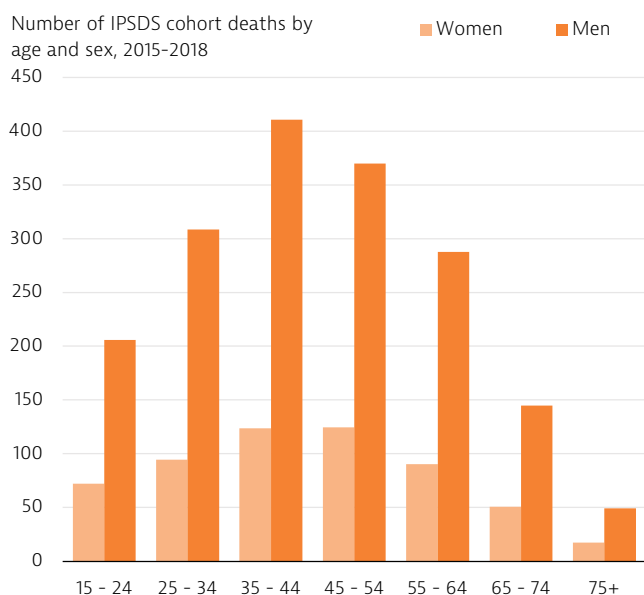


Source: Eurostat Database.



As part of its efforts to improve suicide-related data, in 2022 the HSE carried out an examination of coronial files spanning 2015-18. The aim was to identify probable suicides using a broader definition than the one typically used for official mortality statistics in Ireland. The study findings suggest a potential underestimation of up to 10 % compared to officially reported figures. The highest number of deaths by probable suicide in the study's cohort occurred between the ages of 35 and 44 for both sexes (Figure 31). Two thirds of individuals had a history of mental health conditions, with mood disorders such as depression being the most commonly observed. Moreover, just over half were known to have sought medical assistance prior to their death (HSE, 2022b).

**Figure 31. Adults aged 35-64 accounted for 60 % of probable suicides in Ireland in 2015-18**



Source: HSE (2022b).

### The surge in demand for mental health services is placing a burden on primary care, resulting in prolonged waiting times for specialist care

GPs serve as the initial point of contact for the vast majority of individuals seeking mental health services in Ireland. Moreover, several non-profit mental health organisations provide access to a range of community-based, non-clinical mental health support services. The planning, organisation and delivery of public specialist mental health services in Ireland is managed by the HSE, which operates multidisciplinary outpatient mental health clinics across the country. In recent years, a shortage of GPs has led to an overreliance on specialist care, which in turn led to excessive waiting lists. To address this issue, the Irish

government has formulated a plan to scale up the supply of primary care and improve continuity of care across the spectrum of mental health services in the coming years.

Mental health services in Ireland follow general health coverage rules, with full coverage provided to about 30 % of the population who hold a medical card (see Section 5.2). However, some specialist services are subsidised by providers for non-cardholders. Against the backdrop of these provisions, meeting the growing demand for mental health services in Ireland has become increasingly difficult due to limited capacity and significant regional disparities in service availability. Waiting lists have grown considerably, particularly for child and adolescent mental health services (CAMHS), which experienced a substantial surge in demand following the onset of the COVID-19 pandemic. Between the end of 2020 and February 2023, the waiting list for CAMHS services exceeded 4 300 children, representing an increase of over 60 % compared to the end of 2020 (Oireachtas, 2023c). In response, Ireland's 2023 Waiting List Action Plan allocated an additional EUR 6 million specifically for CAMHS, which are projected to reduce the waiting list by 2 500 children (Department of Health, 2023).

### Ireland has developed an ambitious strategy to strengthen its mental healthcare services

At the onset of the COVID-19 crisis, Ireland released *Sharing the Vision*, a revised mental health strategy which extends until 2030. The strategy, which consists of 100 recommendations derived from a comprehensive consultation process, seeks to increase the availability of mental health services at all levels while emphasising prevention and prioritising the mental well-being of young people through a community-based approach.

To ensure the strategy's effective execution, a series of three-year Implementation Plans were formulated, overseen by an implementation and monitoring committee, which provides quarterly progress reports to the Department of Health. The first Implementation Plan has shown some progress across various domains, including digital mental health, acute bed capacity and youth mental health. As of July 2023, the milestones set in these areas are on track for completion by 2024. Recognising the importance of supporting this mental health agenda, Ireland's 2023 Budget has allocated a substantial sum of EUR 1.2 billion to mental health services.

# 7 Key findings

- Life expectancy at birth in Ireland was higher than the EU average in 2021, at 82.4 years, reflecting major gains attained in the two decades preceding the COVID-19 pandemic, and comparatively low mortality from all causes (including COVID-19) during the pandemic years. In 2020, cancer emerged as the leading cause of death, accounting for more than 29 % of all deaths. This reflects higher incidence of cancer in Ireland than in other EU countries, where circulatory diseases are the most common cause of death.
- Behavioural risk factors contributed to more than one third of all deaths in Ireland in 2019. The adult smoking rate had been decreasing until 2019, but has since stabilised at a level below the EU average. While obesity rates remain high, indications of improved dietary habits and increased physical activity in recent years indicate potential future declines. Excessive alcohol use among adults is a concern, with rates of alcohol consumption and heavy drinking declining but still above the EU averages.
- Health spending per capita in Ireland increased by over 12 % in real terms between 2019 and 2021, driven in large part by increased public financing aimed at expanding care capacity to address the COVID-19 emergency. Ireland's health expenditure per capita was close to the EU average in 2021, with private sources accounting for over 22 % of spending – above the EU average of 19 %.
- Public hospitals in Ireland continue to face capacity constraints due to increasing demand and an insufficient supply of acute care beds. While substantial funding was allocated to expand inpatient capacity, recruitment challenges and construction inflation have slowed their operationalisation. Against the backdrop of continued efforts to expand acute care capacity, projections still indicate a deficit of over 900 hospital beds in 2023 – a comparable amount to the additional number of beds deployed since the beginning of the pandemic.
- Significant investments have been made to expand the health workforce since the pandemic began, primarily in acute care. However, there are concerning shortages of general practitioners, which pose a risk to the practical implementation of the shift towards a more efficient, primary care-focused system – a crucial aspect of the Sláintecare reform, which aims to achieve universal healthcare.
- Ireland outperforms most EU countries in preventing mortality from preventable and treatable causes. Ireland's comparatively low COVID-19 mortality can be attributed in part to the successful rollout of its COVID-19 immunisation programme, which in parallel saw an increase in uptake of flu vaccination. Alongside initiatives to enhance accessibility of primary care to improve chronic condition management, Ireland is implementing measures to address the backlog in cancer screening caused by COVID-19 restrictions.
- In line with its goal to establish a universal healthcare system, Ireland has made significant strides to expand eligibility to free services. While inpatient charges in public hospitals have been abolished, limited capacity hinders the accessibility of free hospital care, as backlogs accumulated throughout the pandemic aggravated already extensive waiting lists. To address the inequalities arising from the tiered design of its healthcare system, Ireland is implementing various measures to alleviate waiting lists in public hospitals and a new public-only consultant contract.
- The burden of mental ill health in Ireland is high, with over 1 million individuals estimated to have a mental health disorder in 2019. Ireland's Strategy to Reduce Suicide has contributed to declining suicide rates over the past decade. In recent years, the surge in demand for mental health services has led to prolonged waiting times for specialist mental healthcare – particularly for adolescent services. To address this challenge, Ireland revised its strategy to strengthen mental healthcare services, and allocated a record budget of EUR 1.2 billion to mental health services in 2023.

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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		

# State of Health in the EU

## Country Health Profile 2023

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2023 edition of the Country Health Profiles provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

For more information, please refer to: [ec.europa.eu/health/state](https://ec.europa.eu/health/state)

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