State of Health in the EU

IRELAND

Country Health Profile 2025

European Commission

OECD
BETTER POLICIES FOR BETTER LIVES

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

The Country Health Profiles 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 knowledge transfer. The 2025 edition of the Country Health Profiles includes a special section dedicated to pharmaceutical policy.

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 Observatory's 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, the Survey of Health, Ageing and Retirement in Europe (SHARE), the European Cancer Information System (ECIS), 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 2025, based on data that was accessible as of the first half of September 2025.

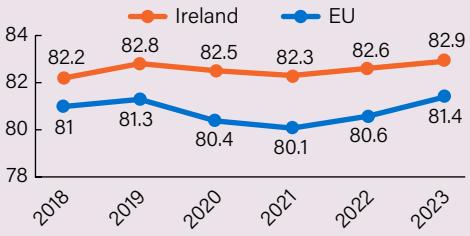
Demographic and socioeconomic context in IRELAND, 2024

Demographic factors	Ireland	EU
Population size	5 351 681	449 306 184
Share of population over age 65	16 %	22 %
Fertility rate 2023[1]	1.5	1.4
Socioeconomic factors		
GDP per capita (EUR PPP)[2]	83 681	39 675
At risk of poverty or social exclusion rate[3]	17.1 %	20.9 %

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. At risk of poverty or social exclusion (AROPE) is the percentage of people who are either at risk of poverty, severely materially and socially deprived, or living in a household with very low work intensity.

Source: Eurostat Database.

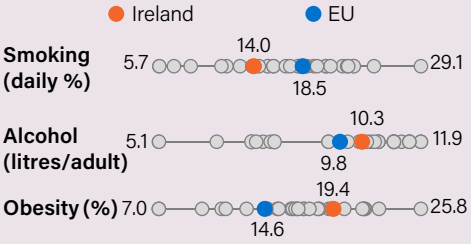
1 Highlights



Life expectancy at birth

Health Status

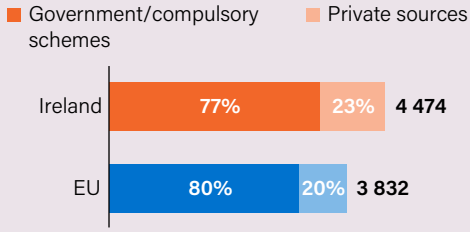
Ireland's life expectancy at birth rebounded to 82.9 years in 2023, matching its pre-pandemic level and exceeding the EU average by 1.5 years. Cancer (28 %) and cardiovascular diseases (28 %) accounted for over half of deaths in 2022, with preventable deaths concentrated in lung cancer, ischemic heart disease, chronic obstructive pulmonary disease and intentional self-harm. While 80 % of adults report being in good or very good health, a 22-percentage-point gap exists between the highest and lowest income groups.



Adults, 2022 (or nearest year)

Risk Factors

Daily smoking prevalence in Ireland fell from 19 % in 2015 to 14 % in 2022, well below the EU average of 19 %, reflecting the impact of sustained tobacco control policies. However, the trend in obesity prevalence has moved in the opposite direction. In 2022, 19 % of Irish adults were classified as obese, a five percentage-point increase since 2017 and notably above the EU average of 15 %.



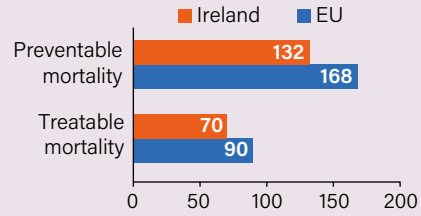
Health spending per capita (EUR PPP), 2023

The Health System

Despite lacking universal coverage, Ireland's health spending per capita is 17 % above the EU average, with almost one quarter privately funded through a mix of out-of-pocket payments and voluntary health insurance. Primary care (GP) coverage is expanding under *Sláintecare* reforms, which aim to achieve universal, equitable and integrated healthcare across the system. Over 45 % of the population have voluntary private health insurance.

Health System Performance

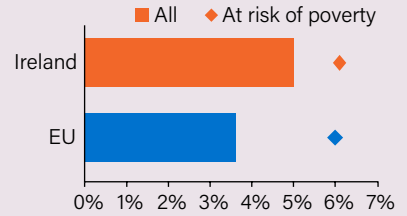
Effectiveness



Age-standardised rate per 100 000 population, 2022

Ireland's avoidable mortality rate is 21 % lower than the EU average, and 30-day survival after heart attacks and strokes exceeds EU levels. Breast and cervical cancer screening participation leads the EU by 15 to 20 percentage points, but avoidable COPD and asthma admissions remain double the EU average. Measles immunisation coverage fell to 90 % in 2022, below the WHO target.

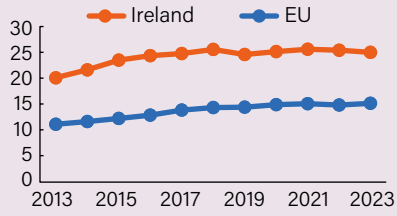
Accessibility



% reporting unmet medical care needs, 2024

Accessibility of primary care services remains a significant challenge, with 5 % of adults who had a need for medical care indicating their needs were unmet due to costs, distance, or waiting times. Waits for specialist access persist, as over 50 % of patients exceed 12 weeks for elective surgeries. Affordability is partially ensured through public schemes capping costs for low-income households.

Resilience



Medical graduates per 100 000 population

Ireland's workforce expansion exemplifies the challenge of building a resilient health system: between 2013 and 2023, the number of medical graduates per 1 000 population rose by 25 % and permanent senior doctor positions doubled between 2019 and 2021. However, ongoing retention difficulties undermine these gains, resulting in persistent shortages.

Spotlight: pharmaceuticals

Pharmaceutical spending in Ireland is 7 % below the EU average in 2023, reflecting effective cost-containment measures that have generated an estimated EUR 1.6 billion in savings since 2013. Yet the percentage of generic prescribing remains 7 percentage points below the EU average, while access to new medicines faces growing delays due to protracted Health Technology Assessment (HTA)/pricing processes and selective industry launches. Conversely, R&D investment surged to EUR 71 per capita, ranking third highest in the EU and signalling strong innovation commitment. Clinical trial activity outpaced the EU for much of the past decade, though recent reduction has aligned it with EU levels.

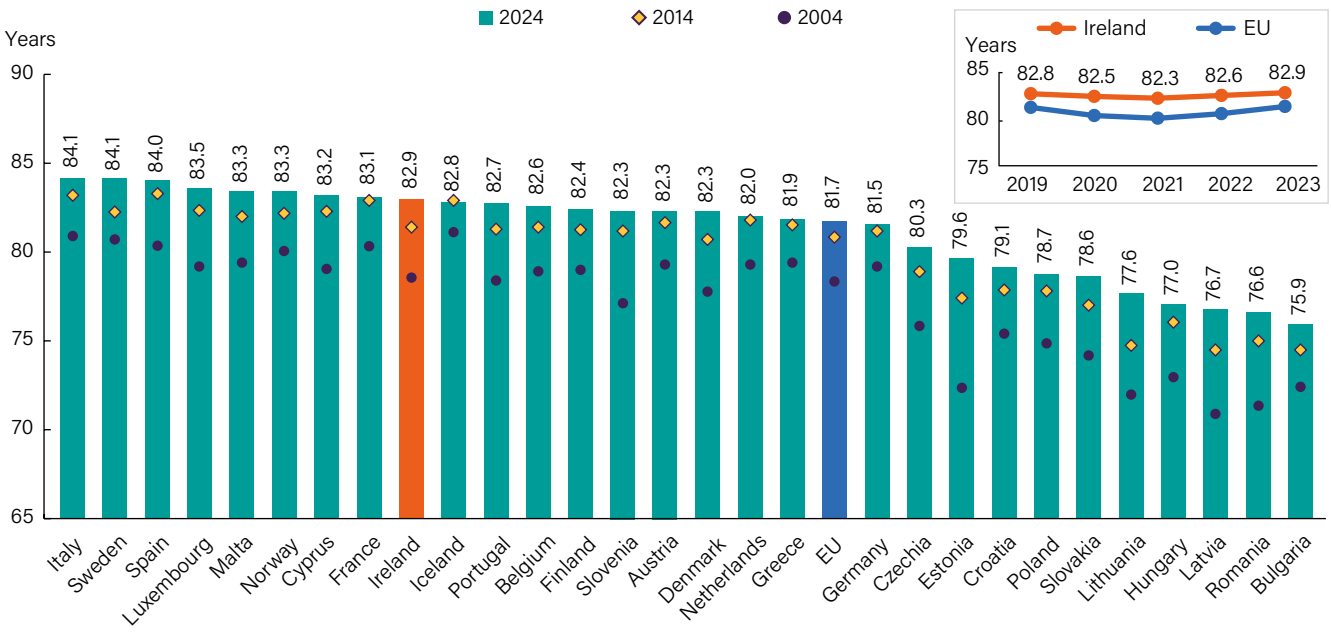
2 Health in Ireland

Ireland's life expectancy at birth rebounded to its pre-COVID high in 2023

In 2023, life expectancy at birth in Ireland was recorded at 82.9 years, surpassing the EU average by over one year and ranking as the eighth highest within the EU (Figure 1). This marks a slight increase from the pre-pandemic life expectancy of 82.8 years observed in 2019.

Consistent with trends in other European countries, men in Ireland generally have shorter life expectancies than women. However, the gender gap in life expectancy in Ireland is narrower than the EU average. In 2023, women in Ireland could expect to live, on average, three and a half years longer than men, with life expectancies of 84.6 years for women and 81.1 years for men compared to an EU average gap of 5.3 years.

Figure 1. Life expectancy in Ireland in 2023 was over one year higher than the EU average



Notes: The EU average is weighted. 2024 data for Ireland pertains to 2023.
Source: Eurostat (demo_mlexpec).

Cancer was the leading cause of death in Ireland in 2022

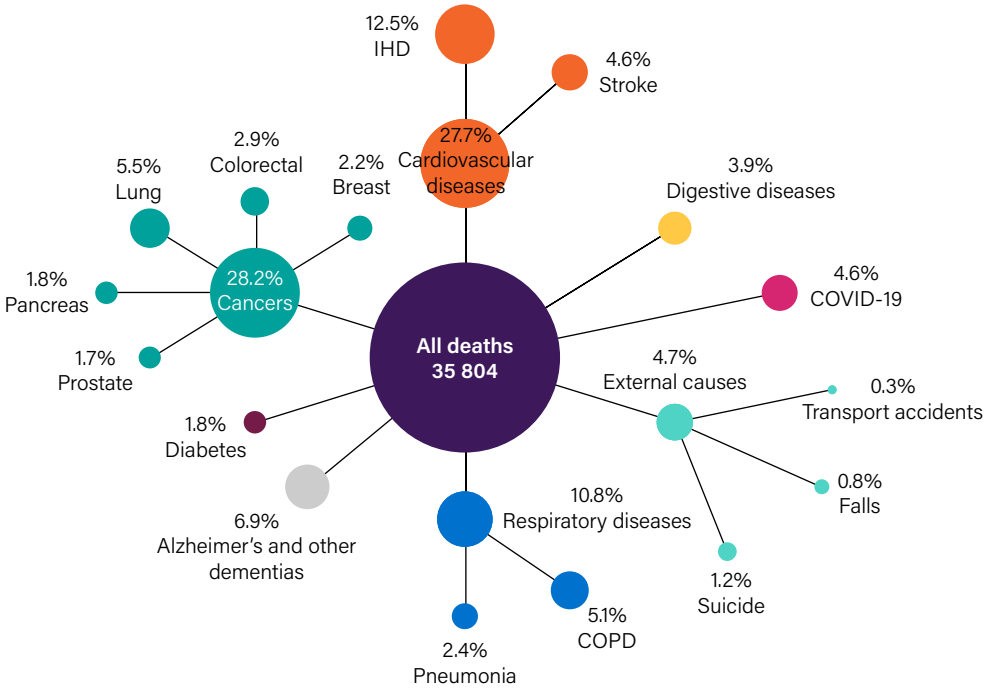
In 2022, cancer was the leading cause of death in Ireland, closely followed by cardiovascular diseases (CVDs), including ischaemic heart disease (IHD) and stroke. Together, these two causes accounted for 56 % of all deaths. Unlike most EU countries, where CVDs typically top the mortality rankings, cancer has consistently been the primary cause of death in Ireland in recent years. Other major contributors to mortality included respiratory diseases, dementia, external causes (such as suicides and accidents) and COVID-19 (Figure 2).

Between 2020 and 2022, Ireland's age-standardised mortality rate rose by 4 %, driven largely by a 9 % increase in CVD deaths and a 14 % increase in deaths from respiratory diseases. These increases likely reflect a rebound in mortality following temporary declines during the pandemic due to reduced viral transmission and fewer hospitalisations. Access to timely cardiac care also declined during this period: the proportion of ST-elevation myocardial infarction (STEMI) patients receiving primary percutaneous coronary intervention (PCI) fell from 84 % in 2020 to 74 % in 2022, before rising to 78 % in 2023, potentially contributing to the higher CVD mortality (National Office of Clinical Audit, 2024). In contrast, COVID-19 mortality declined by 19 % over the same period, supported by the successful rollout and uptake of vaccination programmes. Cancer mortality fell by 14 % between 2014 and 2022, reflecting improvements in early detection and treatment under Ireland's National Cancer Strategy 2017–2026.

Some 80 % of Irish adults report being in good health, but disparities across income groups are significant

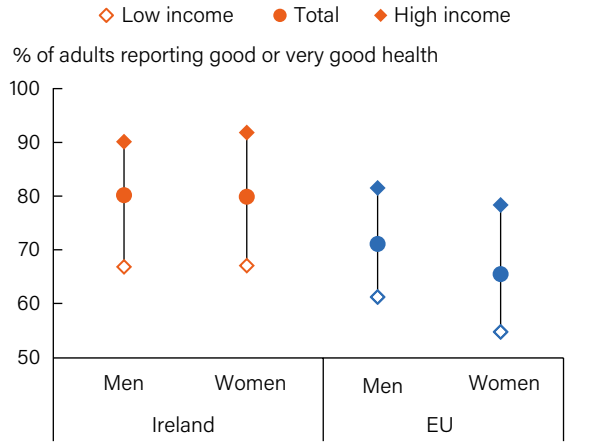
In 2024, 80 % of Irish adults self-reported being in at least good health – the highest proportion in the EU, owing in part to the Irish population's younger age profile compared to the EU average. While there is almost no gender gap in how men and women rate their health in Ireland, there is a substantial gap by income level as in other EU countries. Only 67 % of Irish women in the lowest income quintile reported being in good health compared to 91 % of those in the highest quintile. This income gap was similarly large among men (Figure 3).

Figure 2. Cancer accounted for over a quarter of all deaths in Ireland in 2022



Notes: IHD = ischaemic heart diseases; COPD = chronic obstructive pulmonary disease.
Source: Eurostat (hlth_cd_aro); Data refer to 2022.

Figure 3. Ireland's income gap in self-rated health aligns with the EU average



Note: Low income refers to adults in the bottom 20 % (lowest quintile) of the national equivalised disposable-income distribution, while high income refers to adults in the top 20 % (highest quintile).
Source: Eurostat based on EU-SILC (hlth_silc_10). Data refer to 2024.

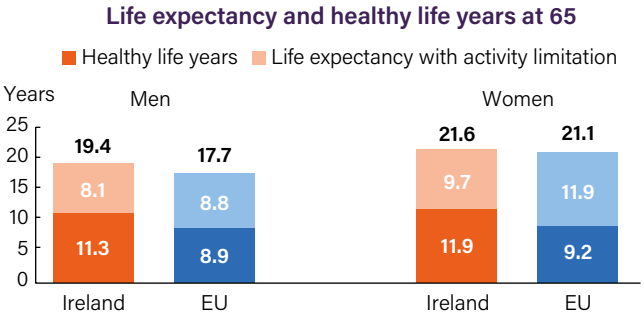
Irish people aged 65 can expect to live longer and healthier than the EU average

Ireland's demographic profile currently shows a slower rate of population ageing compared to the EU average. The proportion of individuals aged 65 and over increased from 11 % in 2000 to 16 % in 2024, remaining well below the 22 % EU average. However, future demographic projections anticipate a rapid acceleration, with this share projected to reach 25 % by 2050. In addition to this slower ageing trend, older adults in Ireland demonstrate favourable indicators for longevity and healthy ageing. In 2022, life expectancy at age 65 was 21.6 years for women and 19.4 years for men, both surpassing the corresponding EU averages. More significantly, Irish seniors enjoy more healthy life years after 65 compared to their European counterparts (Figure 4). While Irish women outlive men by over two years at age 65, the gender gap in healthy life years is considerably narrower, at only six months. This suggests that women's additional years are more likely to be accompanied by some degree of functional limitation, a pattern consistent with the EU average.

About 5 % of the population in Ireland are living with a cancer diagnosis

The European Cancer Information System (ECIS) estimates approximately 27 000 new cancer cases in Ireland in 2022, with over 215 000 individuals living with a cancer diagnosis in 2020 (Figure 5). Compared with the EU average, both the age-standardised incidence and prevalence rates of cancer in Ireland are 12 % higher than the EU. Cancer mortality has

Figure 4. Healthy life expectancy in Ireland at age 65 is higher than the EU average



Source: Eurostat for healthy life years (tespm120, tespm130). Data refer to 2022.

decreased substantially over the last decade accounting for 28 % of all deaths in 2022 down from 31 % in 2014 (OECD/ European Commission, 2025). Irish men have a 30 % higher cancer incidence rate than women. Among men, the most prevalent cancers are prostate, colorectal and lung cancer, while for women, breast, lung and colorectal cancer are the most common.

Figure 5. About one in twenty people were living with a cancer diagnosis in Ireland in 2020

26 884
New cases in 2022
Incidence rate (age-standardised), 642 per 100 000 population (572 in the EU)

215 089
Living with the condition in 2020
Prevalence rate (age-standardised), 5 343 per 100 000 population (4 767 in the EU)

Notes: These are estimates that may differ from national data. Cancer data includes all cancer sites except non-melanoma skin cancer.
Source: European Cancer Information System (estimates refer to 2022 for incidence data and 2020 for prevalence).

About 10 % of the population in Ireland live with a cardiovascular disease

Cardiovascular diseases (CVDs) represent the principal cause of morbidity and disability in Ireland, a trend consistent with patterns observed across the EU. According to estimates from Institute for Health Metrics and Evaluation (IHME), about 40 000 new cases of CVDs occur annually in Ireland and nearly 425 000 people were living with a CVD in 2021. This translates to an age-standardised CVD incidence rate of 979 cases per 100 000 population, which is 15 % lower than the EU average. Ireland's CVD prevalence rate was also 20 % below the EU average (Figure 6). In 2022, CVDs constituted 9 % of all hospital admissions. Consistent with trends across other EU countries, CVD incidence was 29 % higher and prevalence 14 % higher among men than women in Ireland in 2021. Ischaemic heart disease (coronary artery disease) is the most common CVD, accounting for an estimated 13 000 new cases annually in Ireland, representing one-third of all CVD diagnoses.

Figure 6. About one in ten people are living with a cardiovascular disease in Ireland

39 516
New cases in 2021
Incidence rate (age-standardised), 979 per 100 000 population (1 157 in the EU)

424 800
Living with the condition in 2021
Prevalence rate (age-standardised), 10 477 per 100 000 population (12 965 in the EU)

Source: IHME, Global Health Data Exchange (estimates refer to 2021).

3 Risk factors

Behavioural and environmental risk factors are major drivers of mortality in Ireland

According to estimates from IHME, about 8 000 deaths in Ireland in 2021 can be attributed to behavioural risk factors. These behavioural and environmental risk factors accounted for 26 % of all deaths in Ireland in 2021, slightly lower than the EU average share of 29 %. The main contributors were tobacco smoking (12 %), dietary risks (9 %), and alcohol consumption (3 %). Another 600 deaths can be attributed to air pollution in the form of fine particulate matter (PM2.5) and ozone exposure alone.

Tobacco smoking rates have declined to a low level among both adults and adolescents

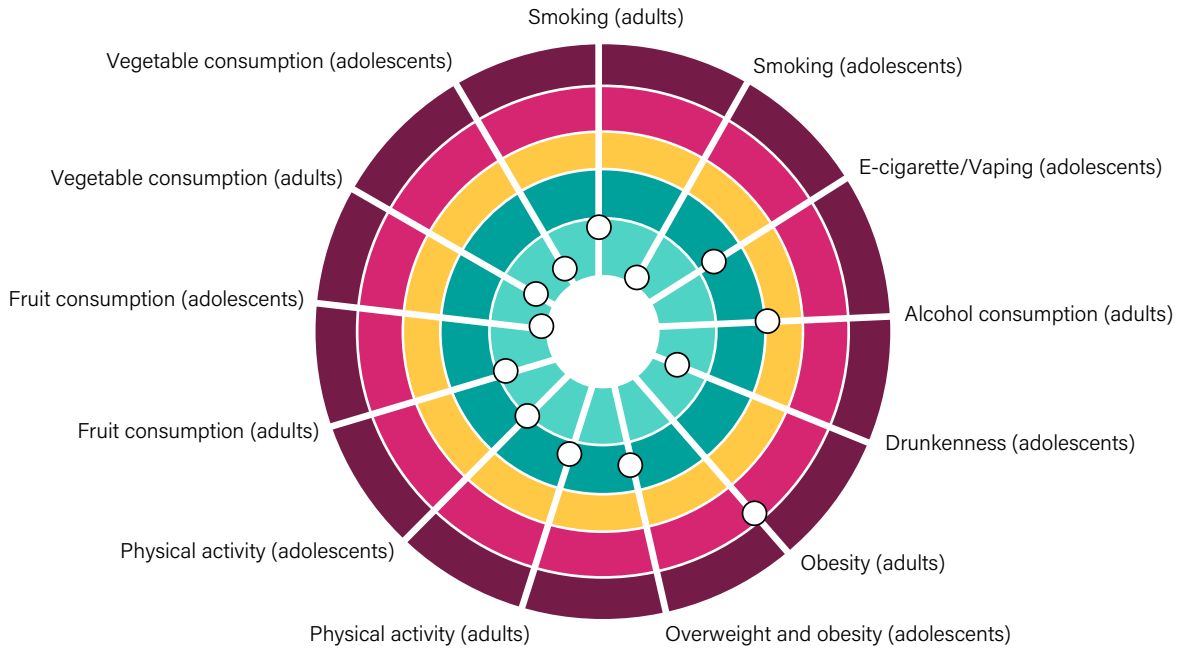
The prevalence of daily tobacco smokers in Ireland has declined by a quarter over the past decade, reflecting the government's resolve to de-normalise tobacco use within Irish society with the introduction of its Tobacco Free Strategy 2013-25. In 2024, 14 % of the Irish population reported smoking daily, a slight decline from 16 % in 2021 and substantially below the latest available EU average of 19 % (2022 data). Among adolescents, tobacco smoking is comparatively low and has also been declining over time: in 2022, the share of 15-year-olds who reported smoking over the past month was 7 %, far below the EU average of 17 %. However, the popularity of e-cigarettes among teenagers

has surged, with 18 % of 15-year-olds reporting its use over the last 30 days in 2022. This is of concern given e-cigarettes are a possible gateway to tobacco smoking. Public health policy to discourage smoking includes a complete ban on smoking in public places since 2004, a ban on advertising of tobacco products, plain packaging since 2018, and a taxation rate of 76.1 % on tobacco cigarette retail prices. Following the adoption of the 2025 Budget, an excise duty of EUR 0.50 per millilitre was introduced in mid-2025 on all e-liquids, regardless of nicotine content (Irish Tax and Customs, 2025).

Rising obesity among adults is a public health concern with inequalities by education level

In 2022, nearly one in five adults in Ireland, or 19 %, were obese, reflecting an increase from 15 % in 2017 and exceeding the EU average of 15 %. The prevalence of obesity was higher among males, at 22 %, compared to 17 % among females, a trend consistent with the broader EU average. Among adolescents, 20 % of 15-year-olds in Ireland were overweight or obese in 2022, slightly below the EU average of 21 % (Figure 7). The steady rise in overweight and obesity prevalence in Ireland's youth is evident, with rates increasing from 12 % in 2002 to 14 % in 2010, and reaching 19 % by 2014. Notably, adolescent boys in Ireland exhibited a lower prevalence of obesity at 21 %, compared to the EU average of 26 %; indicative of the higher engagement in daily moderate physical activity in 22 % of 15-year-old boys compared to 12 % of girls in Ireland.

Figure 7. Rising overweight and obesity are important public health issues in Ireland



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country reaches the white target area, indicating that all countries have room for improvement in all areas.
Sources: OECD calculations based on HBSC survey 2022 for adolescents' indicators; Eurostat based on EU-SILC and OECD Data Explorer for adults' indicators (2022 or nearest year).

Alcohol consumption among adults is now on par with the EU average

Adult alcohol consumption in Ireland has gradually declined over the past decade, falling from 10.6 litres per person in 2013 to 10.3 litres in 2022, approaching the EU average of 9.8. This downward trend extends to adolescent drinking patterns, with the proportion of 15-year-olds reporting frequent intoxication dropping from 16 % in 2014 to 13 % in 2022 – considerably below the EU average of 23 %. These improvements reflect the impact of Ireland's comprehensive Public Health (Alcohol) Act, introduced in 2018 with the explicit goal of reducing early drinking initiation. The legislation has proven instrumental in reshaping national alcohol policy through minimum unit pricing, structural separation of alcohol products in retail outlets to limit children's access, and advertising bans near schools, crèches and playgrounds. One of the Act's most ambitious provisions – mandatory health labelling requiring alcohol products to display calorie content, alcohol grams, and warnings about pregnancy risks, liver disease and cancer - has been delayed for implementation in July 2025 from 2026 to 2028 (Government of Ireland, 2023).

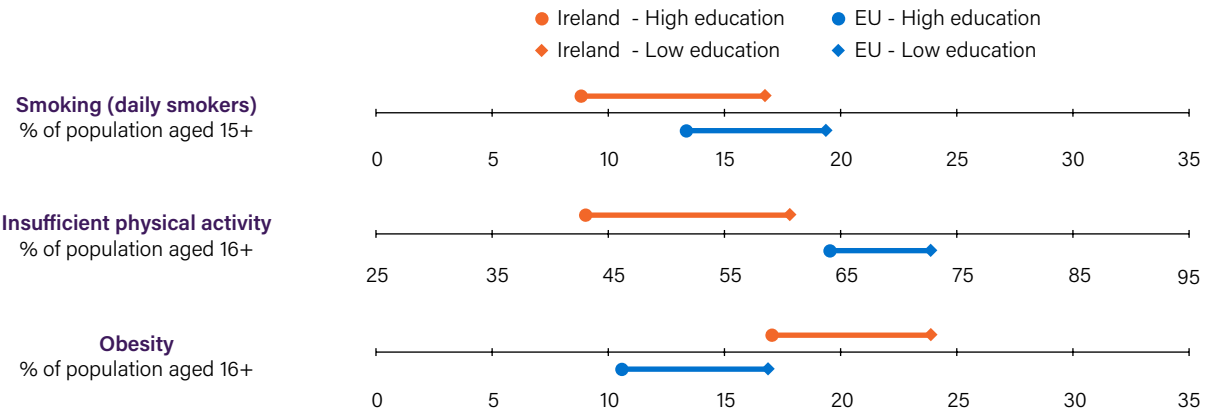
Irish adults and adolescents report eating fruit and vegetables more often than in other countries

In 2022, 65 % of adults in Ireland reported consuming fruit daily and 72 % reported daily vegetable intake – both above the EU average. However, as in most other countries, daily consumption among adolescents remains substantially lower. Only around 40 % of 15-year-olds in Ireland reported eating at least one portion of fruit or vegetables per day, though this still ranks above the EU average, reflecting relatively better dietary habits among Irish adolescents compared to their peers in most EU countries.

Behavioural risk factors are more frequent among people with lower education in Ireland

As in most EU countries, the prevalence of key behavioural risk factors in Ireland varies significantly by education level. In 2019, 17 % of adults with lower education levels reported smoking daily, nearly double the rate among those with higher education (9 %). A similar pattern is observed for obesity: in 2022, 24 % of adults with low education were obese, compared to 17 % among those with higher education according to EU-SILC data (Figure 8). These disparities highlight the continued need for targeted public health interventions to reduce inequalities in health behaviours driven by broader socio-economic and environmental determinants of health.

Figure 8. The gap in prevalence of smoking and obesity between people of lower and higher education in Ireland is wider than the EU average



Note: Low education is defined as the population with no more than lower secondary education (levels 0-2), whereas high education is the population with tertiary education (levels 5-8). Low physical activity is defined as people doing physical activity 3 times or less per week.
Source: Eurostat based on EHIS 2019 for smoking (hlth_ehis_sk1e) and EU-SILC 2022 for physical activity and obesity (ilc_hch07b, ilc_hch10).

4 The health system

Ireland has a national health service, but the voluntary and private sectors play a key role in healthcare delivery

Ireland's national health service is primarily financed through general taxation, which accounted for 77 % of total health expenditure in 2023. The Department of Health provides strategic leadership, policy direction and performance oversight, while the Health Service Executive (HSE) is responsible for managing and delivering publicly funded health and social care services. In many cases, the HSE both purchases and directly provides services through its network of hospitals and community health organisations. A purchaser–provider split also exists, as the HSE contracts services from general practitioners (GPs), dentists, pharmacists, allied health professionals, voluntary hospitals (section 38: HSE-contracted, state-funded, independently governed providers), community organisations (section 39 - HSE grant-aided bodies), private hospitals and homecare agencies. Private actors play a central role in service delivery, particularly in primary, acute and long-term care. In 2024, 46 % of the population held voluntary private health insurance, primarily to secure faster access to hospital services and to partially cover out-of-pocket (OOP) payments (see Section 5.2).

Recent decentralisation to six Health Regions aims to integrate healthcare and improve service delivery

Ireland's ongoing health system reforms are anchored in *Sláintecare*, a cross-government strategy to achieve universal, equitable and integrated healthcare. The establishment of six new HSE Health Regions, each with budgetary autonomy to assess, plan and deliver services based on local population needs, took place in 2024 (Schulmann, et al., 2024). Implementation continues in 2025 with the rollout of the 20 Integrated Healthcare Areas (IHA) which began in March in five of the six regions. These regions are expected to reduce organisational fragmentation, improve care coordination and facilitate a shift away from hospital-centric models toward strengthened primary and community-based care. By enhancing regional responsiveness and integration, *Sláintecare* aims to improve both accessibility and efficiency across the system.

Ireland combines universal hospital coverage with means-tested primary care entitlements

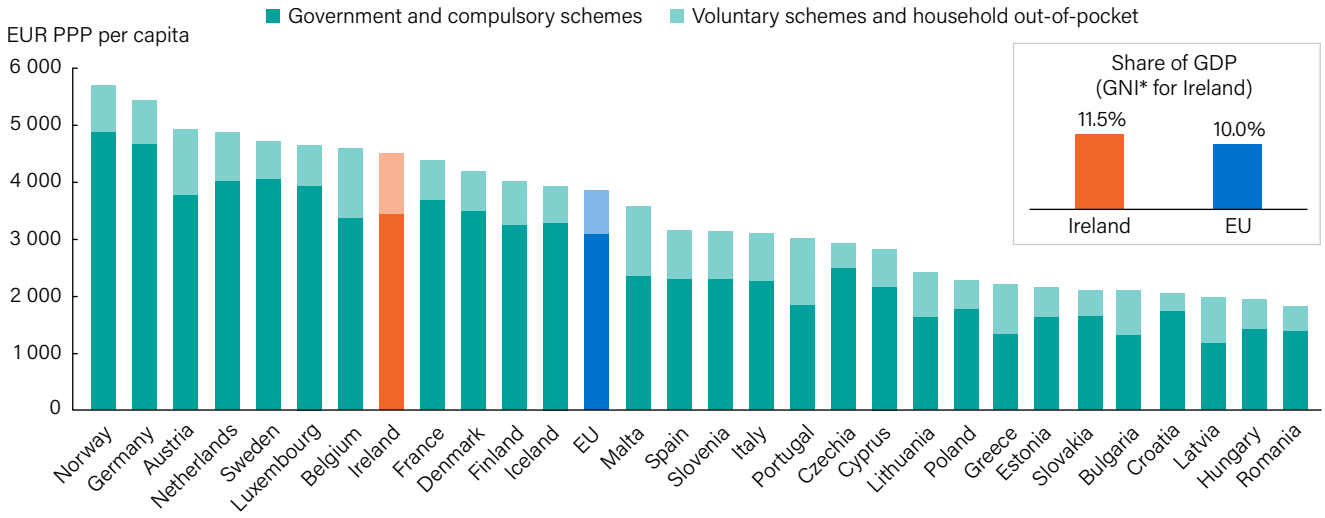
All residents in Ireland are entitled to either fully or partially publicly funded health services, with the extent of eligibility determined primarily by income and age (see Section 5.2). Approximately 29 % of the population held a General Medical

Scheme card in 2025, providing them comprehensive access to health services free of charge. Some 14 % of Irish people also qualified for a GP visit card that offers free GP care to a broader group, including all children aged under 8 and adults 70 years and over as well as those aged 8-69 years under certain income thresholds. GPs serve as gatekeepers to secondary care, operating primarily as private practitioners mostly reimbursed through public schemes with some income from OOP payments. Patients with private health insurance receive partial reimbursement for GP fees depending on their coverage. While medical cardholders receive free primary care, Ireland lacks universal primary care entitlement. Those without qualifying cards typically pay about EUR 55 - 75 per GP visit (see Section 5.2). Public hospital services achieved universal coverage in 2023 following the abolition of inpatient user charges. Despite this milestone, 46 % of the population maintained voluntary private health insurance in 2024 (Health Insurance Authority, 2024), primarily to circumvent persistent waiting times in the public hospital system and secure faster access to specialist services. The high uptake of private insurance reflects the practical limitations of Ireland's universal hospital coverage: while legally accessible to all, capacity constraints mean that timely access often requires private alternatives for both diagnosis and treatment.

Health expenditure has increased over the past decade, in particular since the COVID-19 pandemic

In 2023, Ireland's current health spending per capita reached EUR 4 474 (adjusted for purchasing power differences), nearly 17 % above the EU average of EUR 3 832. This trajectory reflects a marked recovery from the post financial-crisis period of fiscal consolidation: following a real-term decline of 2.2 % between 2012 and 2014, per capita health spending increased by 21 % up to 2019 and rose by a further 17 % between 2019 and 2023. However, Ireland's distinctive economic structure poses challenges for interpreting standard expenditure indicators. When expressed as a share of GDP, health spending in 2023 appears comparatively low at 6.6 %, well below the EU average of 10 %. This metric, however, is significantly distorted by the activities of multinational corporations, which inflate Ireland's GDP. An alternative measure developed by Ireland's Central Statistics Office - modified gross national income (GNI*) – offers a more reliable reflection of the domestic economy. Based on this indicator, current health expenditure accounted for 11.5 % of GNI* in 2023 (Figure 9).

Figure 9. Ireland's per capita health spending is higher than the EU average



Notes: 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. The EU average is weighted (calculated by OECD).
Sources: OECD Data Explorer (DF_SHA); Eurostat Database (demo_gind). Data refer to 2023.

Ireland's share of financing from private health insurance is triple the EU average

Ireland's healthcare financing reflects the system's mixed public-private character. Public sources covered 77 % of health spending in 2023, below the EU average of 80 %, with private financing accounting for the remaining 23 %, exceeding the European average of 20 %. This elevated private share stems primarily from Ireland's exceptionally high voluntary private health insurance uptake, which represented 12 % of total health expenditure in 2023, nearly triple the EU average of 5 %. Irish residents purchase private insurance coverage not for additional benefits, but to circumvent public system delays, securing faster access to care in private hospitals as well as coverage for primary care consultations. By contrast, out-of-pocket payments remained relatively modest at 11 % of expenditure, below the EU average of 16 %.

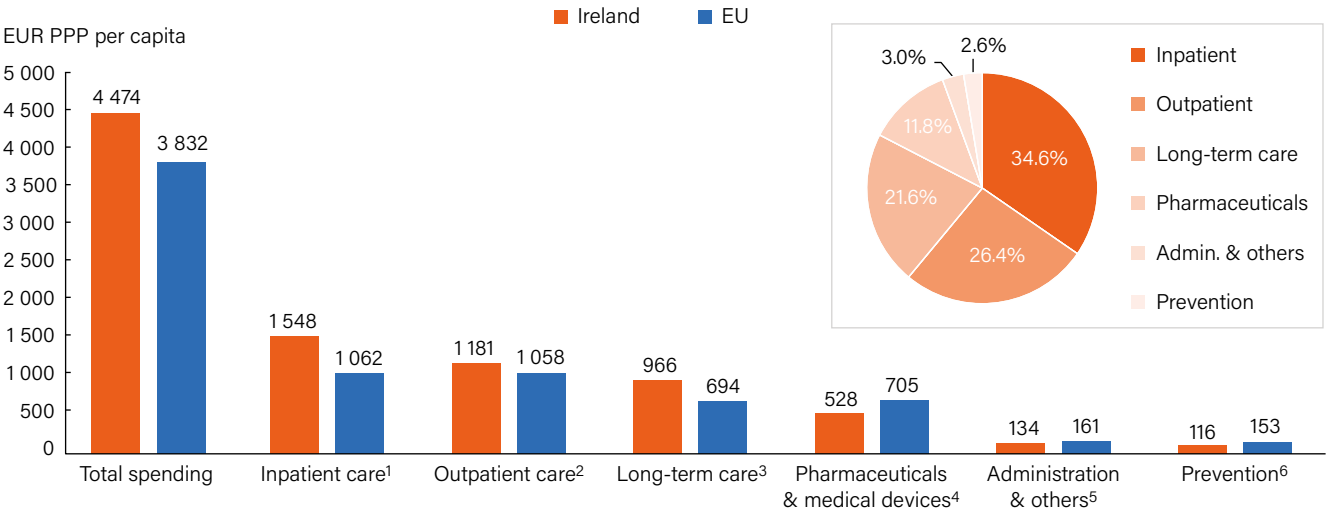
In 2025, the government allocated EUR 24.3 billion to the health sector, an increase of 6 % over the previous year, in recognition of persistent system pressures following the COVID-19 pandemic. An additional EUR 123 million from

the EU Recovery and Resilience Plan (RRP) 2021-2026[1] was earmarked for the healthcare budget in Ireland to expand hospital infrastructure, recruit health professionals, strengthen mental health services and modernise digital health systems (see Section 5.3).

Health spending on inpatient and long-term care in Ireland are comparatively high

Ireland's healthcare spending patterns reflect the system's hospital-centric model as well as recent policy shifts. Inpatient care commanded 35 % of health expenditure in 2023, above the EU average of 28 %, while long-term care absorbed another 22 %, above the EU average of 18 %. This inpatient-heavy allocation underscores the challenges facing *Sláintecare's* ambition to shift care demand toward strengthened primary and community settings, which requires complementary investments in staffing and infrastructure outside hospitals. Outpatient care represented 26 % of spending, broadly consistent with the EU average of 28 % (Figure 10). However, expenditure on pharmaceuticals and medical devices constituted a comparatively lower share of 12 %, significantly below the EU average of 18 %. This relatively low share reflects successful cost-containment efforts, including Framework Agreements on Medicine Pricing introduced in 2016 and 2021, health technology assessments (HTAs), increased pharmaceutical company rebates and enhanced medical device regulation, measures that have reduced the relative weight of pharmaceuticals and medical devices on Ireland's healthcare budget from 14 % in 2015 (see Section 5.3). Preventive care spending declined from 5 % in 2022 to 3 % in 2023, falling below the EU average of 4 % as pandemic-related expenditure on COVID-19 testing, tracing, vaccinations, and PPE normalised following the emergency response period (HSE, 2024).

Figure 10. Ireland allocates more than a third of its health spending to inpatient care



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 health system governance and administration and other spending. 6. Includes only spending for organised prevention programmes; The EU average is weighted (calculated by the OECD).
Sources: OECD Data Explorer (DF_SHA). Data refer to 2023.

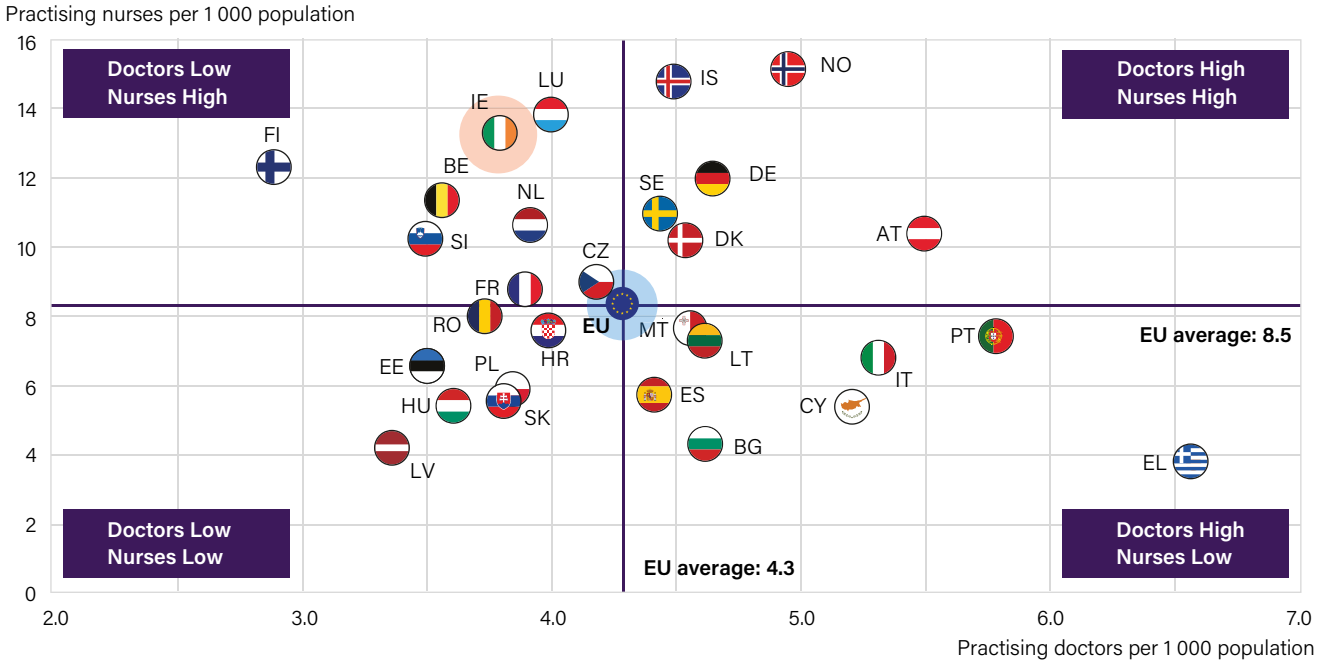
Despite strong nursing density and expanding GP capacity, Ireland's medical workforce struggles to match demographic pressures

In 2023, Ireland employed 13.7 nurses per 1 000 population, significantly above the EU average of 8.5, and the 2025 national budget includes additional allocations to further strengthen this core workforce component (Figure 11). The medical workforce has experienced remarkable expansion, growing 43 % between 2015 and 2024 from 14 666 to 20 961 practising doctors. However, this growth has struggled to keep pace with Ireland's exceptional demographic pressures: population growth averaged 1.5 % annually over this period, compared to just 0.16 % on average across the EU. As a result, Ireland's physician density of 3.8 per 1 000 population remains below the EU average of 4.3. Beyond density concerns, the composition of Ireland's medical workforce reveals potential vulnerabilities to long-term sustainability and service continuity: over 40 % of doctors in Ireland in 2024 were trained abroad, and the system remains comparatively dependent on junior and non-consultant hospital doctors relative to most other EU countries.

Looking to alleviate physician shortages, Ireland has made some medical tasks, such as prescribing for common conditions, available to qualified nurses (advanced nurse practitioners) and pharmacists. In parallel, a new public-only consultant contract has been introduced to support recruitment and retention of senior doctors and help bridge staffing gaps in public hospitals. This contract offers enhanced remuneration to hospital specialists who agree to work exclusively in the public sector, including during evenings and weekends. As of May 2025, 64 % of hospital-based consultants had taken up the new contract.

[1] Recovery and Resilience Fund data are based on the information available as of 20 September 2025; potential future amendments may affect these figures.

Figure 11. Ireland has a comparatively low number of doctors but a high number of nurses



Note: The EU average is unweighted. 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 practice, resulting in a large overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospital.
Source: OECD Data Explorer (DF_PHYS, DF_NURSE). Data refer to 2023 or nearest year.

Primary care presents a particularly complex picture. GPs constituted 26 % of practicing doctors in 2023, a higher share than the EU average of 19 %. GP density increased slightly from 0.82 per 1 000 population in 2019 to 0.85 in 2023 (Irish College of GPs, 2024)[2], keeping pace with the country's rapid 8 % demographic growth from 2019 to 2024. Yet despite this progress, 5 % of Ireland's population reported unmet primary care needs in 2024, exceeding the 3 % EU average. The HSE projects the need for an additional 1 660 GPs by 2028, driven by population ageing, which generates more complex healthcare needs, and planned expansions of free GP care coverage. Training capacity has responded accordingly, with GP training places expanding 35 % from 258 in 2022 to 350 in 2024. However, geographical disparities persist, with counties such as Meath, Monaghan and Kilkenny facing continued supply shortfalls that help explain why aggregate workforce growth has not alleviated access barriers (HSE - National Doctors Training & Planning, 2020).

5 Performance of the health system

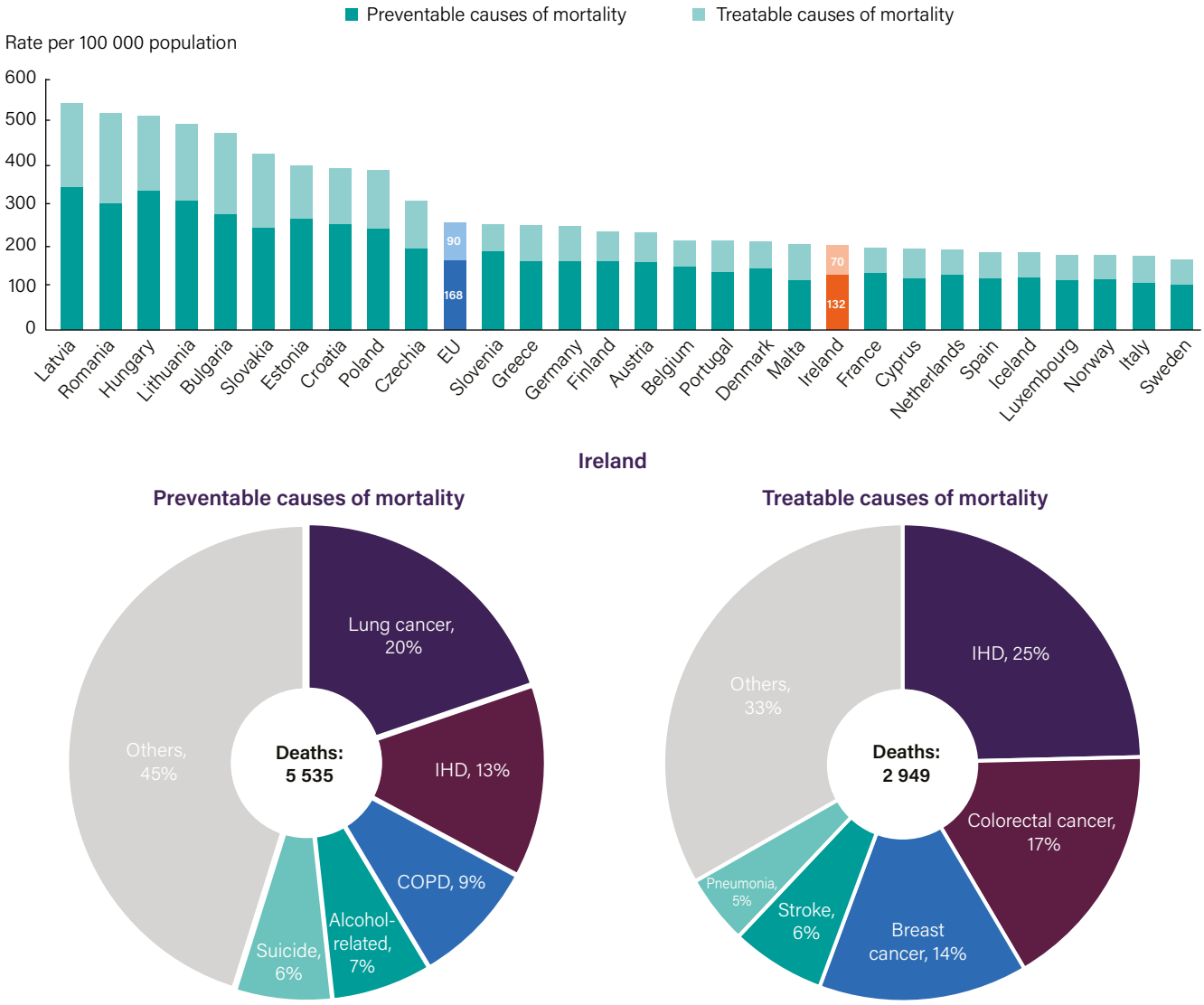
5.1 Effectiveness

Ireland's avoidable mortality rate has steadily declined and is among the lowest in the EU

In 2022, Ireland's age-standardised avoidable mortality rate stood at 203 per 100 000 population, a figure 21 % below the EU average of 258 per 100 000. Furthermore, the relative shares of preventable and treatable deaths in Ireland closely mirrored the EU average (Figure 12). Since 2012, both categories of avoidable mortality have demonstrated a downward trend at a pace consistent with the EU average, though this progress was temporarily reversed during the COVID-19 pandemic. Notably, between 2020 and 2022, Ireland experienced a more contained increase in preventable deaths than the EU average, reflecting high rates of compliance with non-pharmaceutical public health restrictions and a strong uptake of COVID-19 vaccination.

[2] Note: Due to a break in the data source for GP density after 2021, the national data for Ireland for the years 2022 and 2023 are sourced from the 2024 workforce report of the Irish College of General Practitioners.

Figure 12. Avoidable mortality rates in Ireland are significantly lower than the EU average



Note: Preventable mortality is defined as deaths that can be mainly avoided through public health and primary prevention interventions. Treatable 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 for some diseases (e.g. IHD, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting. IHD refers to ischaemic heart diseases; COPD refers to chronic obstructive pulmonary disease.
Source: Eurostat (hlth_cd_apr) (data refer to 2022).

Treatable mortality rate from stroke in Ireland is half the EU average rate, indicating high quality emergency and hospital stroke care

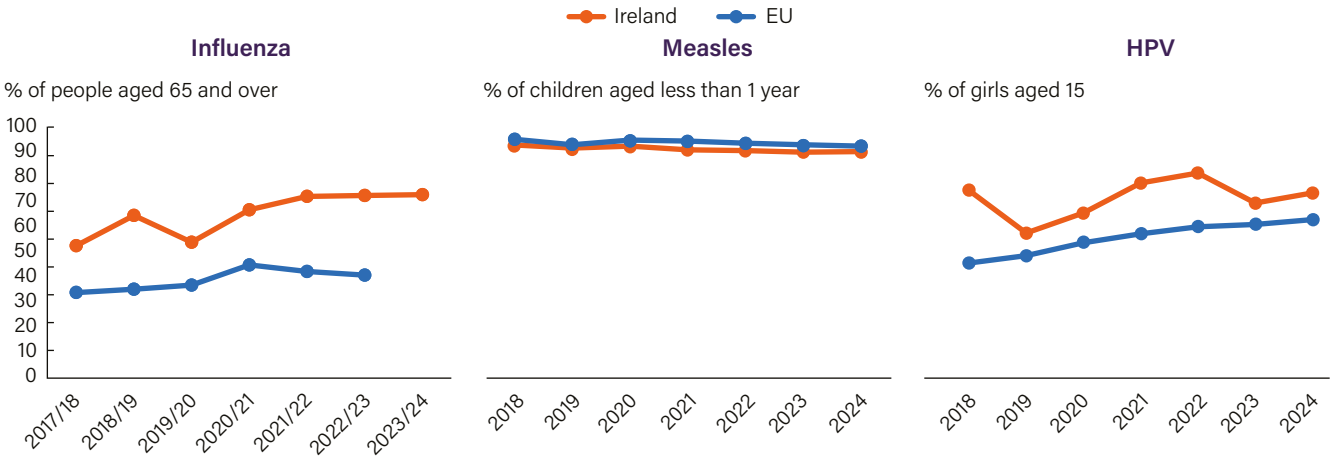
Ischaemic heart disease, colorectal cancer, breast cancer and stroke collectively account for nearly 60 % of treatable deaths in Ireland. Notably, Ireland's treatable mortality rate for stroke (4.5 per 100 000) is approximately half the EU average of 9.2 per 100 000, while rates for the other three leading conditions align closely with their respective EU averages. As CVD alone underlies almost one-third of treatable deaths, the Healthy Ireland Framework has prompted a suite of population-level interventions aimed at tackling key risk factors (Perry & Gallagher, 2023). Furthermore, the Enhanced Community Care programme has introduced integrated care models for older adults and patients with conditions such as type 2 diabetes, COPD, asthma or CVD (HSE, 2025). This initiative aims to shift the balance away from hospital-based care by strengthening prevention, chronic disease management and community support for those with multi-morbidity. To reduce cancer-related mortality, Ireland has operated national cancer screening programmes for breast cancer since 2000, for cervical cancer since 2008, and for colorectal cancer since 2013.

Ireland has high immunisation coverage rates for HPV and influenza, but measles immunisation has declined since 2018

Ireland's vaccination landscape reflects the residual effects of the COVID-19 pandemic across various programmes and population groups. Seasonal influenza immunisation among individuals aged 65 and older initially surged during the pandemic, climbing from below 60 % in 2019 to peak at over 76 % during the 2023-2024 season, one of the highest rates reported in the EU (Figure 13). Healthcare worker

influenza vaccination on the contrary has registered a decline, falling from over 70 % in 2020/2021 to just 32 % in the 2024/2025 season. This dramatic reduction may reflect broader "vaccination fatigue" among healthcare professionals, who showed heightened uptake during the acute crisis but have since fallen below pre-pandemic levels as the immediate threat receded. In contrast, school-based HPV vaccination has maintained steady progress, with uptake among adolescent girls increasing from 58 % in 2019 to 74 % in 2024, remaining above the EU average of 64 %. While only marginally below the EU average, measles vaccination trends are concerning, with coverage declining gradually from 92.3 % in 2018 to 89.7 % in 2024. This erosion likely reflects a combination of vaccine hesitancy and access barriers among unvaccinated populations.

Figure 13. Influenza and HPV vaccination uptake remain consistently above the EU average, but uptake has recently declined for measles



Notes: The EU average is weighted for influenza (calculated by Eurostat) and unweighted for measles and HPV.
Sources: Eurostat (hlth_ps_immu) and WHO/UNICEF Joint Reporting Form on Immunization (JRF).

Ireland's participation in breast and cervical cancer screening excels, but colorectal participation lags below targets

Ireland operates centrally organised, publicly funded national cancer screening programmes for breast, cervical and colorectal cancers. Participation in breast and cervical cancer screening is notably high, exceeding the EU average by 15 to 20 percentage points in 2023. In contrast, colorectal cancer screening has shown more gradual progress, with participation rates rising to 48 % in 2023, on par with the EU average but still below the national *BowelScreen* programme target of 50 % (HSE, 2025) (Figure 14). To address suboptimal participation in colorectal screening, the BowelScreen programme provides direct home delivery of screening kits to eligible individuals. Quality assurance indicators point to strong clinical performance: the adenoma detection rate reached 59 %, surpassing the programme's minimum threshold of 45 %, and the post-colonoscopy colorectal cancer rate stood at 4.3 %, within the acceptable range of 2.5 % to 8.5 %. However, access to follow-up care remains an area for improvement: in 2023, only 75 % of participants received a colonoscopy appointment within the four-week target, below the programme's standard of 90 % (HSE, 2025). In 2024, EU4Health programme (2021-2027) funds financed pilot screening programmes for lung (SOLACE), prostate (PRAISE-U) and gastric (TOGAS) cancers.

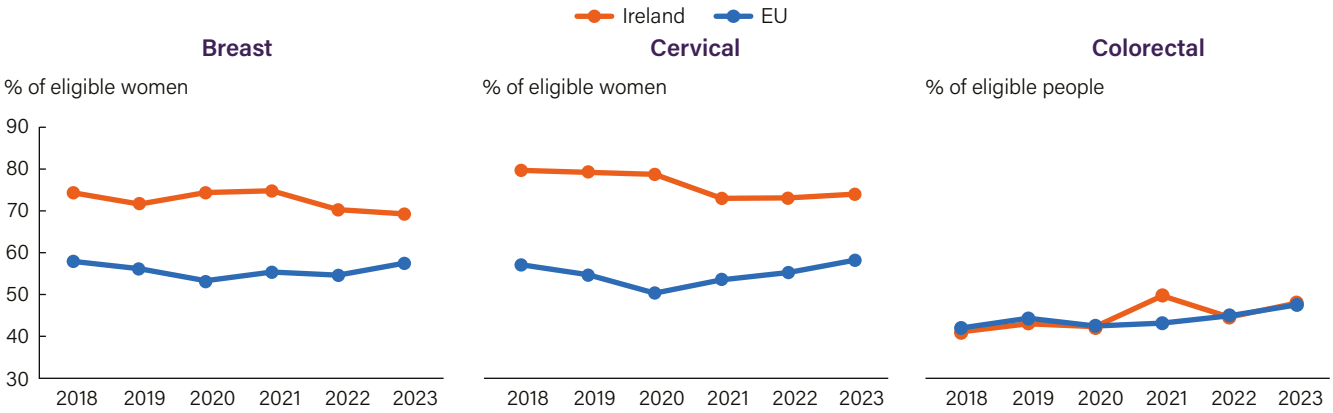
Cancer survival rates in Ireland have improved across all cancer types in the last decade

Ireland has made gains in cancer survival for all main cancer types over the last decade from 2013 to 2022. The 5-year survival for colorectal cancer increased by 3 percentage points to reach 66 % in 2019-2022, while lung cancer survival increased by 7 percentage points to reach 25 % in 2019-2022 (National Cancer Registry Ireland, 2025). Among women, breast cancer survival increased by 4 percentage points to 88 % in 2019-2022, while cervical cancer survival increased by 4 percentage points to reach 65 % in 2019-2022 (National Cancer Registry Ireland, 2025). These systematic improvements reflect Ireland's efforts to enhance cancer care quality through its *National Cancer Control Programme* (NCCP), with the centralisation of services in eight designated high-volume cancer centres having contributed to better outcomes (OECD/European Commission, 2025).

Avoidable hospitalisations have declined, yet admissions for COPD and asthma remain almost twice the EU average

Avoidable hospital admissions reveal significant variation in Ireland's primary care effectiveness across different chronic conditions. While admission rates for diabetes are in line with and those for congestive heart failure are 39 % lower than the EU average, admissions for COPD and asthma are nearly double the EU average in 2023 (Figure 15).

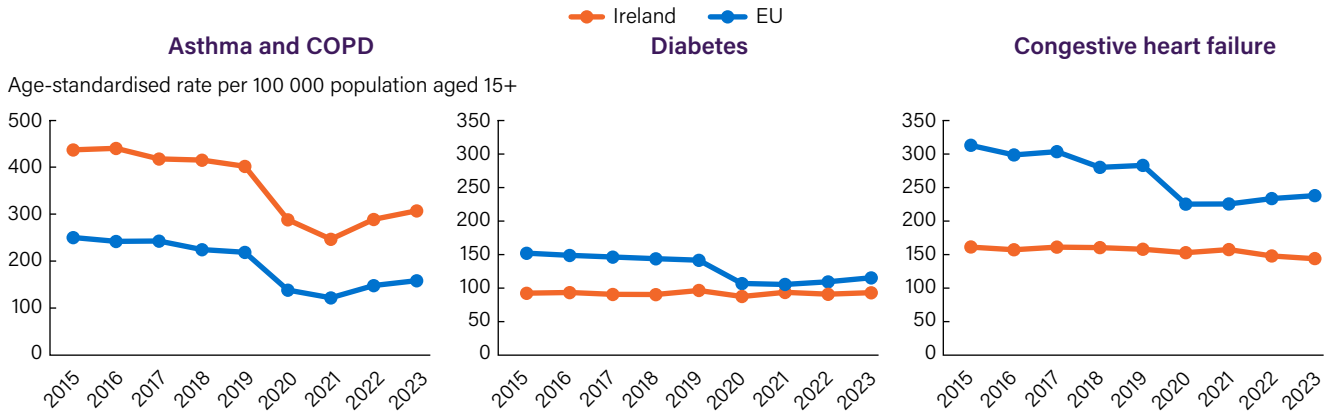
Figure 14. Participation rates in breast and cervical cancer screening in Ireland are above the EU average



Notes: All data refer to programme data. Colorectal programme data are based on national programmes that may vary in terms of age group and frequency. The EU average is unweighted.
Sources: OECD Data Explorer (DF_KEY_INDIC) and Eurostat database (hlth_ps_prev).

In response to these prevalent chronic comorbidities, Ireland has progressively introduced Enhanced Community Care (ECC) models. These integrated primary and community-based programmes target key conditions systematically: type II diabetes (launched in 2018), followed by COPD and asthma (both in 2020) and congestive heart failure (2021). The ECC approach emphasises prevention, patient self-management and multidisciplinary support, with the explicit objective of reducing avoidable admissions through more proactive community-based care (HSE, 2025).

Figure 15. Admissions for asthma and COPD in Ireland are more than double the EU average



Note: Admission rates are not adjusted for differences in disease prevalence across countries.
Source: OECD Data Explorer (DF_HCQO).

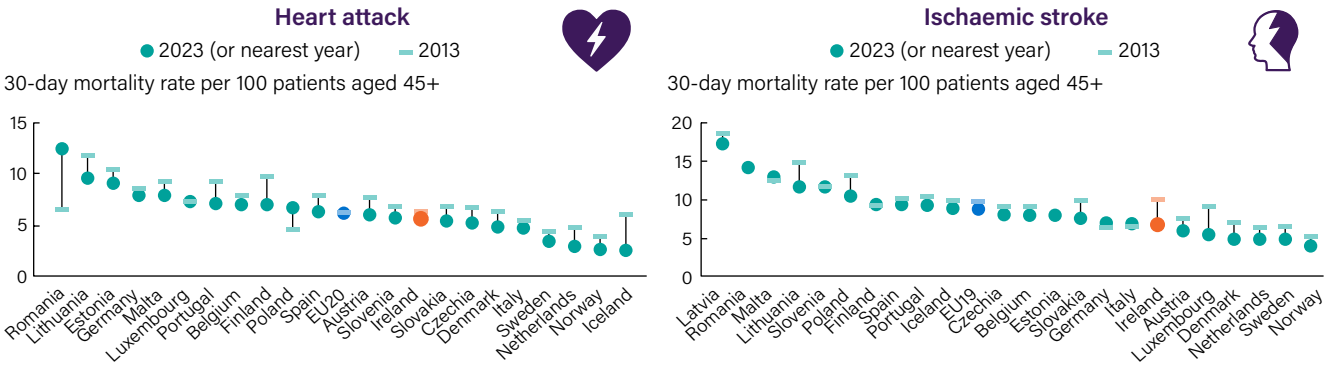
Despite pandemic-related pressures, Ireland performs well on 30-day mortality following AMI and stroke

In 2023, Ireland's 30-day case fatality rate following hospitalisation for acute myocardial infarction (AMI) was 5.6 deaths per 100 admissions, 9 % lower than the EU average of 6.1. Between 2013 and 2023, Ireland recorded a 32 % reduction in 30-day mortality following ischaemic stroke, the second largest decline in the EU (Figure 16). While the AMI fatality rate increased from 4.9 in 2019 to 5.6 in 2023, likely reflecting COVID-19-related disruptions to emergency and cardiovascular care, stroke-related 30-day mortality remained stable at 6.8 deaths per 100 admissions. Both rates remain below their respective EU averages, underscoring Ireland's strong overall performance in managing acute cardiovascular events and the relative resilience of stroke care during the pandemic.

Ireland's treatable stroke mortality is the seventh lowest in the EU, reflecting better access to timely stroke care and effective early intervention (see Section 5.2). In 2023, 11 % of stroke cases received thrombolysis (target 12 %), 11 % received thrombectomy and the median door-to-needle time was 53 minutes, beating the <60-minute goal. Other benchmarks also improved: 70 % of patients were admitted to a dedicated stroke unit (target 90 %) and 77 % underwent a swallow screen (target 90 %) (National Office of Clinical Audit, 2025). The need for additional acute stroke unit capacity is being addressed through implementation of the National Stroke Strategy.

Care for AMI was similarly close to target: 93 % of patients received reperfusion (target 95 %), 78 % received primary PCI (target 90 %) and 86 % were discharged with recommended secondary-prevention medicines (target 90 %), while referrals to cardiac rehabilitation met the 90 % target at 91 % (National

Figure 16. Ireland has cut its 30-day stroke mortality rate by one-third over the past decade



Note: Figures based on admission data standardised to age-sex structure of hospitalisations for heart attack and ischaemic stroke.
Source: OECD Data Explorer (DF_HCQO)c

Office of Clinical Audit, 2024), although patient uptake (52 %) remains a challenge. In 2023, Ireland began implementing an integrated care model for cardiac rehabilitation, a cost-effective, evidence-based programme aimed at reducing morbidity, hospitalisations and mortality in cardiovascular patients (HSE, 2023).

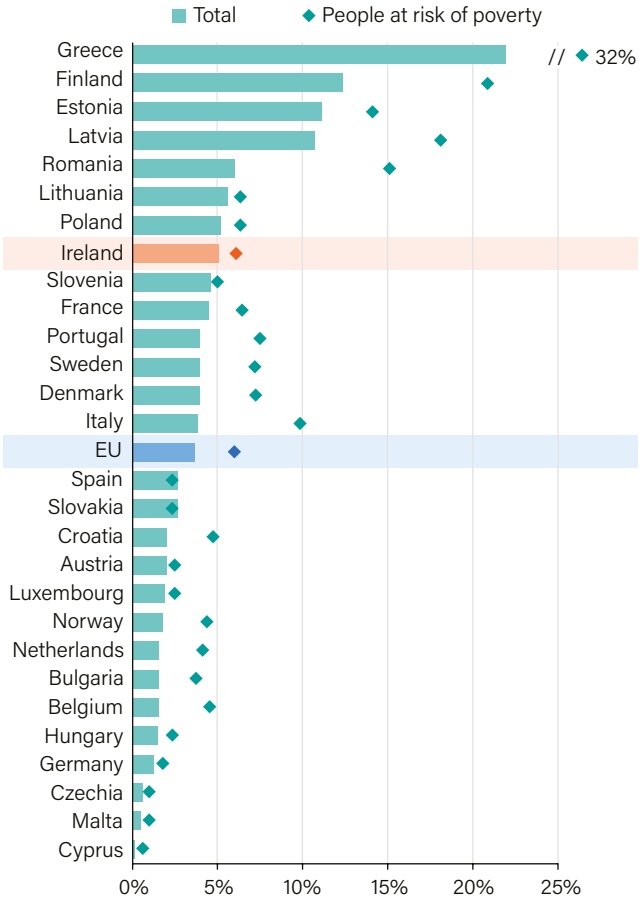
5.2 Accessibility

Unmet medical needs in Ireland are above the EU average, driven by high fees and constrained access to primary care

In 2024, 5 % of Irish adults with a need for medical care reported their needs were unmet due to cost, travel distance, or waiting times, a share above the EU average of 3.6 % (Figure 17). This result points to persistent structural barriers in the Irish healthcare system, notably long waiting times for public services, limited access to primary care appointments and financial constraints for individuals without Medical or GP visit cards. Over half of the population (57 %) lacks either of these entitlements and must pay out-of-pocket for GP and allied health professionals' consultations, with fees ranging from EUR 55 - 75 per visit, among the highest in the EU (Health Insurance Authority, 2025).

Unmet needs are particularly pronounced in primary care: according to the Eurofound survey, 5 % of adults in Ireland reported unmet needs for primary care in 2024, well above the EU average of 3 %, while 6 % reported unmet needs for mental healthcare, slightly below the EU average of 7 % (Figure 18). In the case of primary care, this disparity reflects a combination of high out-of-pocket costs and limited access, especially for those not covered by means-tested or age-based entitlements. Geographic disparities also contribute to access barriers: despite a substantial increase in GP numbers in recent years, the distribution remains uneven, with a two-fold difference in GP density across counties. As a result, residents in rural areas or disadvantaged urban areas face persistent supply shortfalls that limit timely access to essential GP services.

Figure 17. Reported unmet medical needs in Ireland are above the EU average

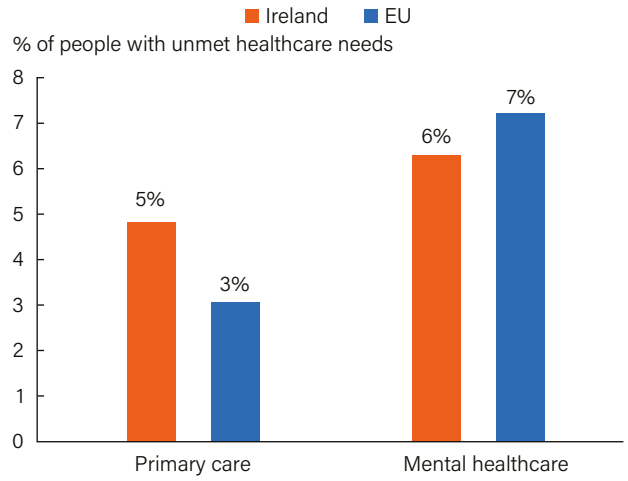


Notes: The EU average is weighted. Data refer only to individuals who reported having medical care needs. People at risk of poverty are defined as those with an equivalised disposable income below 60 % of the national median disposable income.
Source: Eurostat database (hlth_silc_08b). Data refer to 2024.

Public coverage rates by specific care service differ significantly from the EU average

Ireland's healthcare financing rates by service reveal a pattern of public coverage that diverges from the EU average. In 2023, public funds covered just 78 % of Ireland's hospital care expenditure, significantly below the EU average of 91 %. This disparity likely reflects high usage of private hospital

Figure 18. Unmet need for primary care in the general population in Ireland is higher than the EU average



Note: Primary care includes access to a GP/family doctor or a health centre. The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.
Source: Eurofound's "Living and working in the EU" e-survey (2025) (data refer to 2024).

care by those who have private healthcare insurance or can afford out-of-pocket payments (Figure 19). Conversely, public funding covers 79 % of retail pharmaceutical expenditure in Ireland, substantially exceeding the EU average of 59 %. This higher coverage stems from comprehensive HSE medication reimbursement schemes, including the Drugs Payment Scheme, Long-Term Illness Scheme, and General Medical Services cards, which provide free or capped medication costs for eligible populations.

Primary care access remains Ireland's most persistent coverage challenge. While overall primary care coverage aligns broadly with EU averages, over 50 % of the population, those not eligible for means-tested or age-related public healthcare coverage, still incurs out-of-pocket fees, positioning Ireland as an outlier against the broader EU-wide trend toward universal primary care coverage (HSE, 2025). Two recent policy initiatives in 2023 signal movement toward expanded public coverage. One reform eliminated inpatient hospital charges, a second extended free primary care to children up to eight years of age, with government commitments to expand this coverage to age twelve (The Lancet Regional Health – Europe, 2025). Moreover, several newly introduced services are now free at the point of use, including contraception for individuals aged 17-35, fertility treatments, specialist menopause clinics and free Hormone Replacement Therapy (Government of Ireland, 2025). The Department of Health has also initiated a long-term review of Ireland's current eligibility and entitlement policies, with a focus on services delivered at primary and community care level.

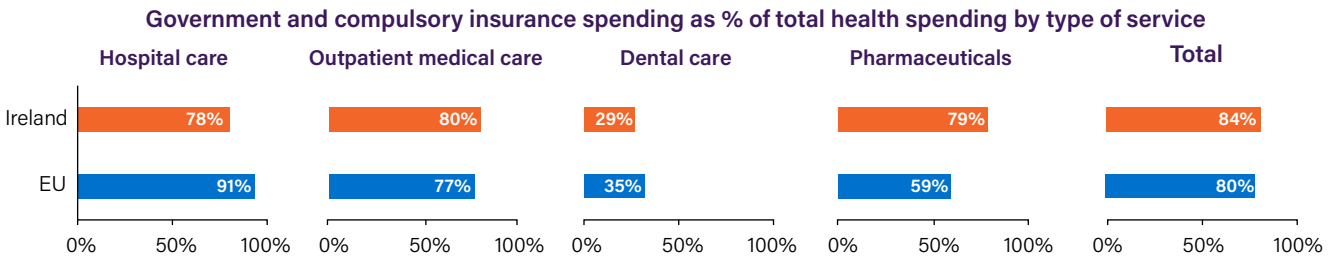
Purchase of voluntary health insurance is substantial, but it plays a limited role in health financing

In 2023, voluntary private health insurance accounted for 12 % of Ireland's current health expenditure, the largest share in the EU (Figure 20).

This prominence stems not from comprehensive coverage, but from widespread uptake driven by system bottlenecks: adoption extends to 46 % of the population, with data indicating that 28 % of older adults who already qualify for publicly funded healthcare also purchase a private health insurance policy (Kenny, Scarlett, & O'Mahoney, 2022). Irish voluntary private health insurance functions primarily as supplementary coverage, aimed at bypassing access barriers rather than providing full coverage. Insurance policies typically offer faster access to hospital specialists and private beds, along with partial reimbursement for services with limited public coverage, such as dental care and routine GP visits. However, many high-cost services remain outside the scope of VHI, meaning that despite high uptake across the population, premium revenues cover only a modest share of total health expenditure.

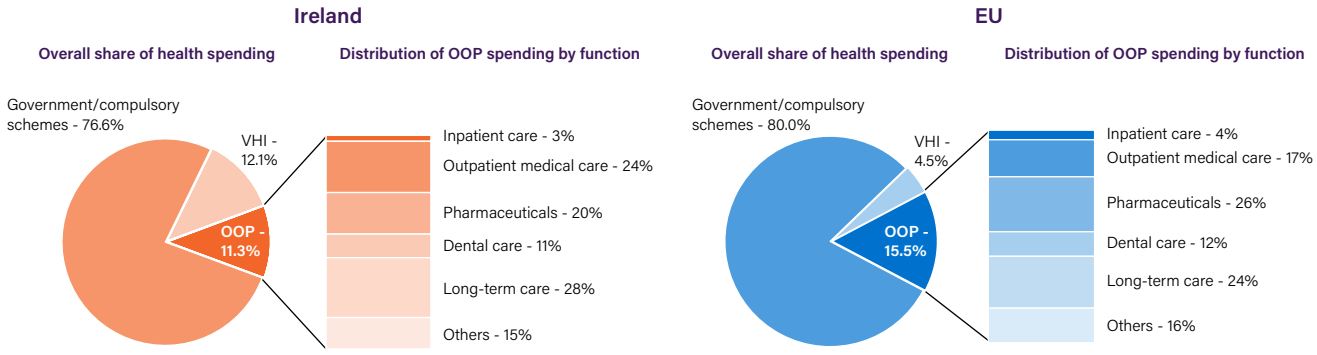
As a result, OOP payments remain a sizeable source of funding, accounting for 11 % of total health spending, though still below the EU average of 16 %. The composition of Irish OOP payments also reflects the unique structure of the health system: nearly 30 % is directed toward long-term care and 20 % to pharmaceuticals, the latter below the EU average of 26 %. The sizeable gap between the proportion of people insured (46 %) and the share of spending VHI actually funds (12 %) underscores both value-for-money concerns and the persistence of long waiting times in the public system, which continue to drive demand for private insurance coverage.

Figure 19. Ireland's public coverage for inpatient care is the second lowest in the EU, while it is the third highest for retail pharmaceuticals



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 as well as medical non-durables. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA). The data pertain to 2023.

Figure 20. Ireland's public health system covers less of total health spending than the EU average



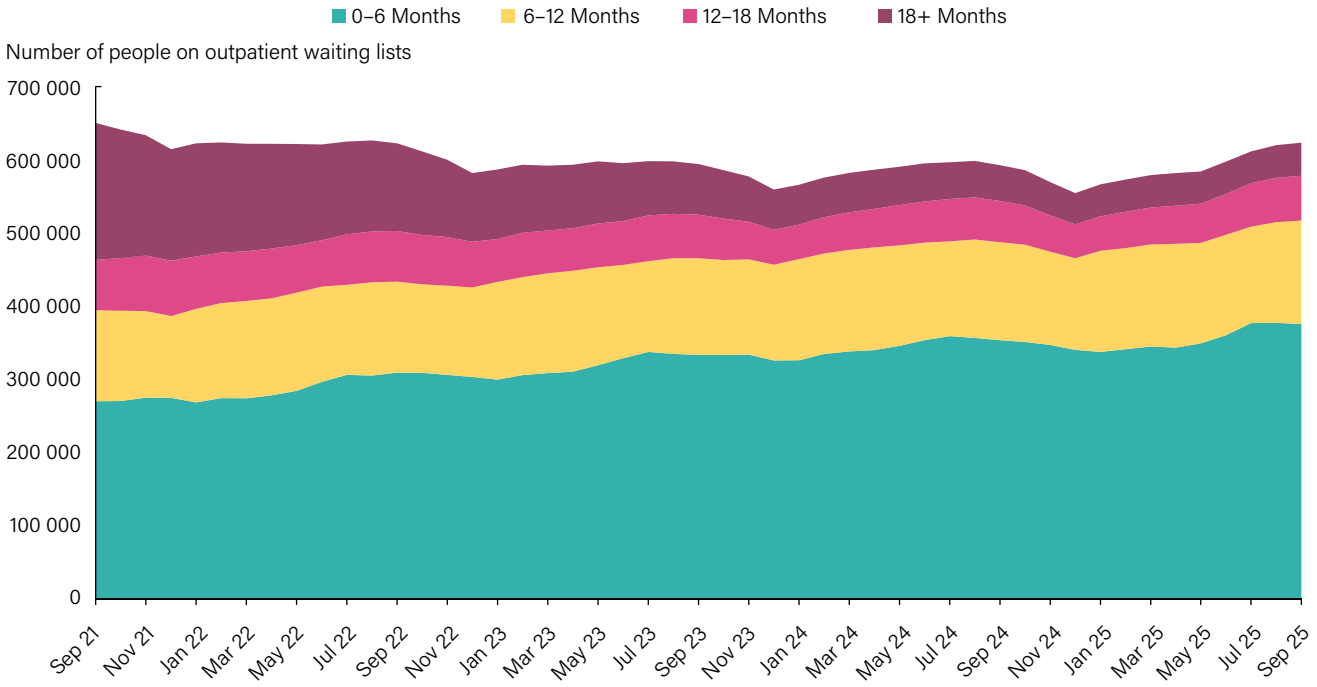
Note: VHI also includes other voluntary prepayment schemes. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023.

Outpatient waiting lists have gradually declined since 2021, but long waits remain concentrated in specific specialties

Between September 2021 and September 2025, the total number of people on outpatient waiting lists in Ireland declined by just over 4 %. This moderate reduction primarily reflects a marked fall in the number of patients waiting over one year, and a sharp decline among those waiting more than 18 months - largely attributable to catch-up measures targeting backlogs accumulated during the COVID-19 pandemic. These gains align with the multi-annual *Waiting List Action Plan* (WLAP), launched in late 2021, which prioritised long-waiters and set a national target of ensuring that 90 % of outpatients wait less than 12 months by the end of 2025. However, the distribution of waiting times has shifted: the number of patients waiting between six and twelve months has risen steadily, particularly in the past six months, pointing to growing pressure in the medium-term queue (Figure 21).

Among high-volume specialties, long waits remain concentrated in dermatology, ophthalmology, neurology and endocrinology, where at least one in five patients has been waiting over a year. Since January 2025, this share has worsened in dermatology (rising from 21 % to 25 %), improved in ophthalmology (from 27 % to 23 %) and remained broadly stable in neurology and endocrinology. Persistent challenges in these areas partly reflect workforce shortages in the public healthcare system concentrated in these specialties (see Section 4). By contrast, performance has been stronger in cardiology and gastroenterology. The share of patients waiting over a year in cardiology has declined to 13 %, while the 90 % target has already been achieved in gastroenterology, where only 9 % of patients remain on the list beyond 12 months.

Figure 21. Ireland has cut long outpatient waits since 2021, but rising medium-term queues signal mounting pressure



Note: Data refer to the total number of people on outpatient waiting lists, combining adult and child cases.
Source: National Treatment Purchase Fund (NTPF) Open Data Waiting List Reports (https://www.ntpf.ie/waiting-list-data/open-data/).

5.3 Resilience

Health system resilience – the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks and structural changes – has become central to policy agendas. Key priorities include easing pressures on service delivery, strengthening health infrastructure and workforce capacity, adapting crisis preparedness strategies, supporting digital innovation and safeguarding long-term sustainability.

Ireland has enhanced public health infrastructure and emergency preparedness over recent years

In recent years, Ireland has significantly strengthened its public health capacity, particularly in surveillance, laboratory diagnostics and emergency preparedness. The public health workforce has doubled from approximately 250 full-time equivalents (FTEs) in 2019 to around 500 FTEs in 2024, including 63 FTEs dedicated to the Health Protection Surveillance Centre, and the National Virus Reference Laboratory. This capacity building reflects both strategic planning and pandemic-driven acceleration. The 2020 pandemic workforce plan provided the framework for adding over 240 new posts across multiple disciplines, encompassing public health doctors, nurses, medical scientists and support staff. Moreover, key reforms addressed longstanding structural gaps, most notably the 2021 agreement establishing the role of consultant in public health medicine. By mid-2024, 79 consultants were in post, creating senior clinical leadership previously absent from Ireland's public health architecture. Structural reforms have also reorganised services into six regional units, supported by national programmes for surveillance, immunisation and health security. Ireland's readiness is monitored through the Health System Performance Assessment (HSPA) framework, launched in 2021 (Box 1), and in 2025 a new electronic outbreak and incident management system (OCIMS) is being deployed to further digitise infectious disease control.

Constrained bed supply sustains high occupancy and heightens seasonal pressure on Irish hospitals

Ireland's acute care system operates under persistent capacity pressures. With just 2.9 hospital beds per 1 000 population in 2023, Ireland falls significantly below the EU average of 5.1, creating a structural mismatch between supply and demand that manifests in consistently high occupancy rates (Figure 22). Prior to the COVID-19 pandemic, curative care bed occupancy hovered around 90 %, and apart from 2020, when pandemic-related disruption temporarily reduced occupancy to 76 %, rates have routinely exceeded 80 %, well above the EU average of 68 % in 2023.

This combination of limited capacity and intensive utilisation creates a system with little operational flexibility year-round; however, hospitals remain particularly vulnerable to predictable seasonal pressures, generating recurrent winter overcrowding and necessitating postponements of elective activity that compound existing access challenges. The COVID-19 pandemic highlighted the vulnerability of this configuration: with minimal surge capacity, hospitals relied on stringent public health measures imposed between 2020 and 2022 and increasing intensive care bed capacity to avoid system collapse. While these measures preserved acute care functionality, they also underscored the strategic importance of expanding baseline capacity to absorb routine fluctuations in demand to safeguard access and quality of care.

These capacity constraints have contributed to persistent access barriers for elective procedures, with waiting times for cataract, hip and knee surgeries demonstrating no substantial improvement since 2019. In 2024, just over half of patients waited longer than the 12-week benchmark set under the Sláintecare reform before receiving treatment (Figure 23). These delays have created market incentives for households to purchase voluntary private health insurance to secure faster access to care in private facilities. As a result, access to timely treatment is often influenced by ability to pay privately for insurance coverage or out of pocket for private care.

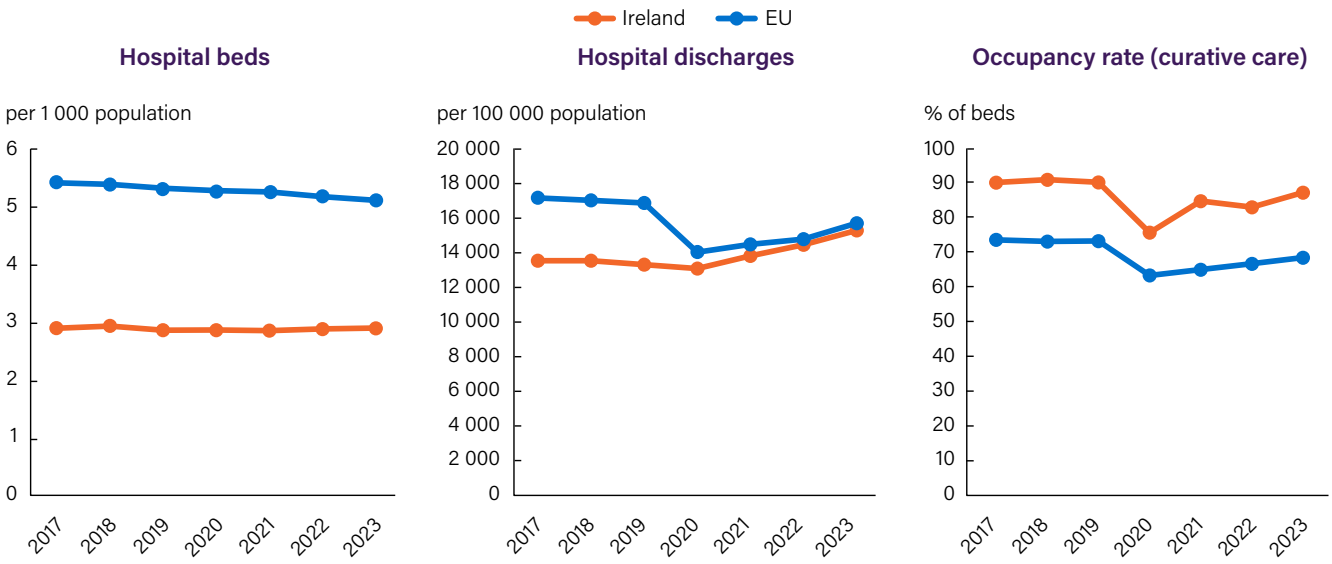
To address these pressures, the Irish Government has progressively expanded investment in acute bed capacity; between 2020 and 2024, a total of 1 218 additional inpatient beds were commissioned. Looking ahead, the Acute Hospital Bed Capacity Expansion Plan foresees the delivery of 2 997 new beds and the replacement of 355 existing beds by 2031 to improve access and reduce occupancy rates. Independently of government policy, the private sector has

Box 1. Ireland's Health System Performance Assessment: building resilience through data-driven governance

In June 2023, Ireland launched its comprehensive Health System Performance Assessment (HSPA) framework under the Sláintecare reform agenda. Developed in the frame of a Structural Reform Support Programme funded project of the European Union between 2019 and 2023, this framework represents a significant evolution, shifting focus from traditional activity-based metrics to a comprehensive measurement of outcomes, access, quality, and equity across 268 indicators spanning five strategic dimensions. The accompanying public digital platform published in 2023 provides data on indicators encompassing: staff absenteeism, support mechanisms and staff satisfaction, with plans to incorporate surge capacity data. Crucially, the framework embeds early-warning metrics designed to proactively identify system stress points, thereby moving beyond reactive management towards building sustained resilience.

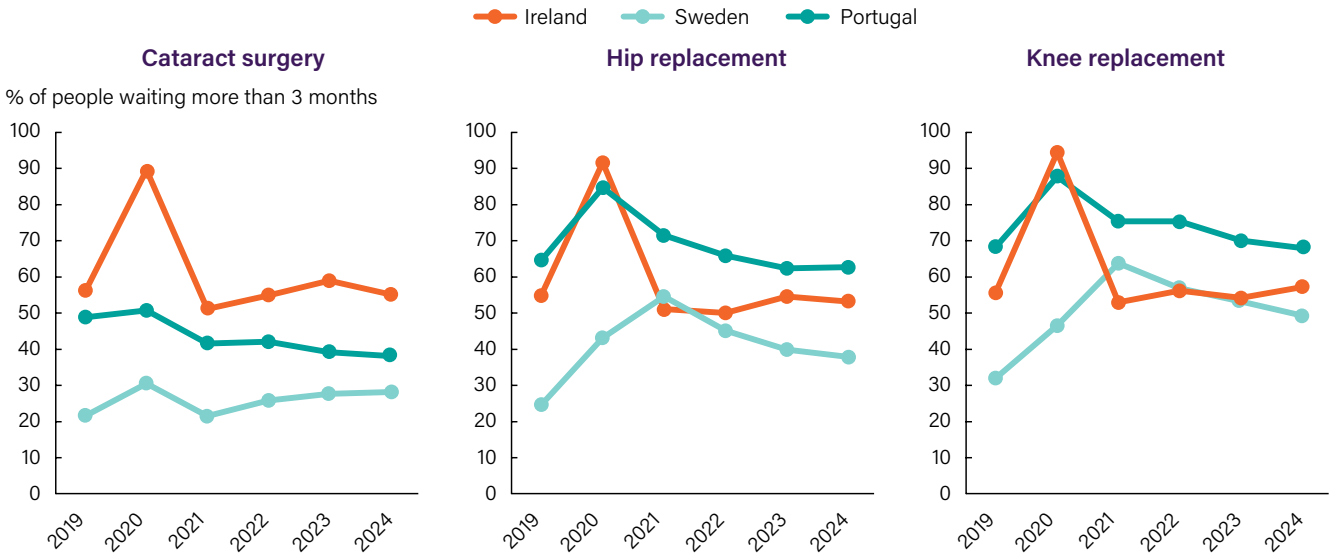
Jointly led by the Department of Health and the Health Service Executive, the HSPA has already improved visibility of performance disparities across regions, such as shortages of general practitioners in rural areas, while enabling systematic tracking of reform implementation.

Figure 22. Ireland's hospital bed capacity is about half the EU average, with significantly higher occupancy rates



Note: The EU average is weighted for hospital beds and hospital discharges.
Source: Eurostat (hlth_rs_bds1) and OECD Data Explorer (DF_KEY_INDIC).

Figure 23. Over 50 % of patients in Ireland wait more than three months for elective surgeries



Source: OECD Data Explorer (DF_WAITING).

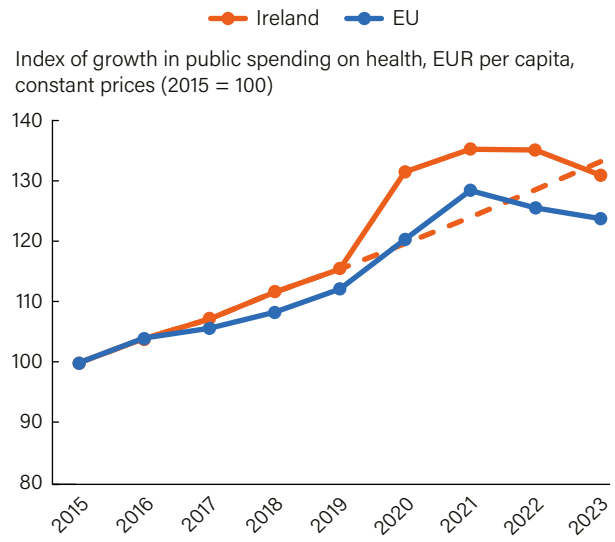
also invested to increase capacity of private hospitals in recent years.

Public healthcare spending growth moderated after 2021, but it continues at a relatively elevated pace

Between 2015 and 2019, Ireland's public health spending per capita increased by an average of 3.7 % per year in real terms, exceeding the EU average annual growth rate of 2.9 %. The COVID-19 emergency dramatically accelerated this spending trajectory through extraordinary fiscal mobilisation. Public expenditure per capita on health surged by almost 14 % in 2020 alone – nearly double the average increase of 7 % observed across the EU – lifting Ireland's public spending per capita on healthcare to a level 35 % above its 2015 baseline by 2021 (Figure 24). While essential to the pandemic response, this rapid expansion raised concerns over fiscal sustainability. In response, the government introduced targeted cost-containment measures in 2022, including a recruitment freeze and operational efficiency initiatives. These interventions stabilised health spending, resulting in no real-term growth in 2022 and a slight reduction in 2023, effectively bringing the expenditure trajectory back in line with the pre-pandemic trend from 2015-2019.

This budgetary adjustment occurred against the backdrop of unprecedented fiscal weight for health within overall government spending. In 2023, healthcare accounted for 23 % of Ireland's total government expenditure, the highest share in the EU, where the average stands at around 15 %. This concentration of public resources reflects both the political priority placed on health by the Irish government and the

Figure 24. After an extraordinary expansion, government expenditure on health returned to its pre-pandemic trajectory



Notes: The EU average is weighted, calculated by the OECD. The dashed line represents the projected trend based on pre-pandemic (2015-2019) data.
Source: OECD Data Explorer (DF_SHA).

pressing need to improve system efficiency to ensure the long-term financial sustainability of the Sláintecare reform agenda.

EU investments advance Ireland's digital transformation and accelerate Sláintecare

Ireland has earmarked EUR 123 million – 11 % of its Recovery and Resilience Plan (RRP) – for health projects to be completed by 2026. Funding is chiefly directed at digital health infrastructure to support *Sláintecare's* reform and the Digital for Care 2030 (eHealth Ireland, 2024) and the HSE's digital health roadmap (HSE, 2024). Priority deliverables include nationwide deployment of interoperable ePharmacy solutions, establishment of shared data platforms, and the (achieved) roll-out of Community Health Networks that plan and deliver primary care while scaling up participation in chronic disease management programmes.

Complementing the RRP envelope, Irish beneficiaries received nearly EUR 25 million under *EU4Health* work programmes (2021-25) through joint actions and direct grants, allocated mainly to cancer initiatives (39 %), further digitalisation (22 %) and crisis preparedness (19 %). Collectively, these EU-financed investments aim to enhance system interoperability, strengthen preventive services and accelerate the delivery of *Sláintecare*'s universal access goals.

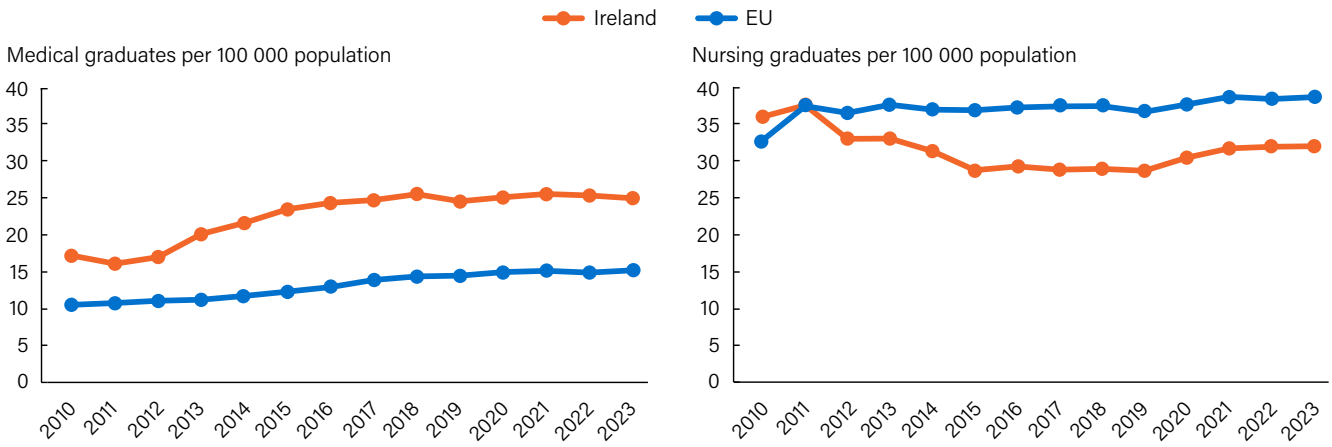
Ireland's large medical training output is offset by persistent emigration of health workers

Ireland has developed impressive medical education training capacity, recording the EU's fifth-highest rate of medical graduates in 2023 at 25 per 100 000 population – a 24 % increase since 2013 (Figure 24). However, only about half (54 %) of students admitted to a medical school in 2023/24 were Irish, with the remaining being foreign students most of which leave after graduating. Moreover, many Irish-trained doctors pursue postgraduate training or more favourable working conditions abroad, particularly in other English-speaking countries. As a result, physician density remains below the EU average and unable to respond to increasing healthcare demand (see Section 4).

Retention challenges prove most acute among specialist doctors, where the gap between training investment and workforce outcomes is most pronounced. Despite ambitious expansion under Sláintecare's consultant-led care model, with new annual permanent consultant positions more than doubling from 212 in 2019 to 520 in 2021, only 37 % of doctors who completed specialty training in 2023 accepted positions in Ireland (HSE - National Doctors Training & Planning, 2024).

The nursing workforce presents further challenges, with graduate output stagnating at 32 per 100 000 population in 2023, below the EU average of 39 (Figure 25). This limited training output has been compounded by policy decisions

Figure 25. The number of medical graduates trained in Ireland is among the highest in the EU



Note: The EU average is weighted (calculated by the OECD). Data include graduates from all nursing programmes, not limited to those meeting the EU Directive for general nurses.
Source: OECD Data Explorer (DF_GRAD)

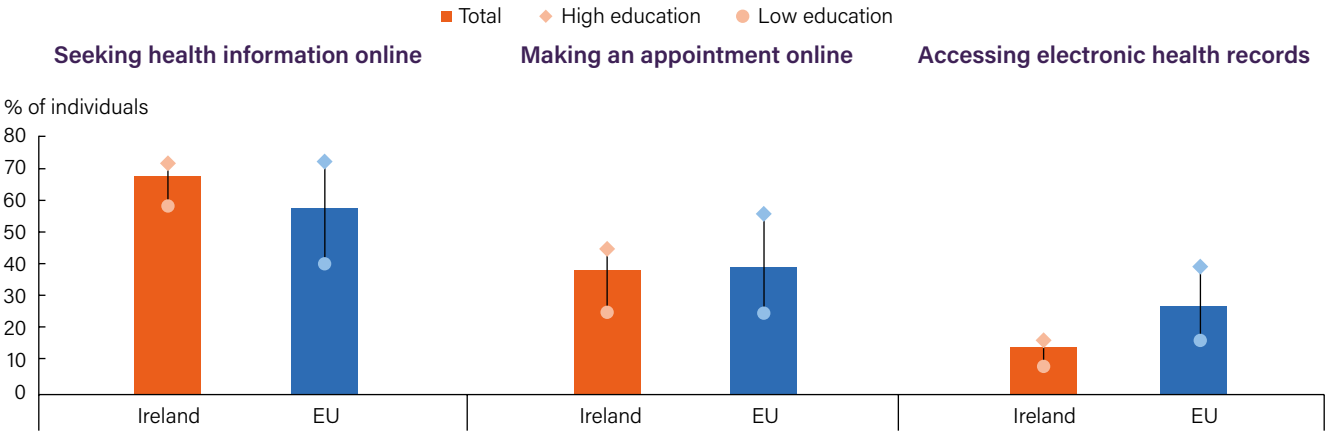
that further constrained capacity. In particular, the HSE's recruitment freeze in 2022 exacerbated existing retention challenges and accelerated outward migration. Although targeted international recruitment efforts, focused on South-East Asian countries and expatriate Irish nurses, have been introduced, their impact on resolving systemic capacity gaps remains limited. These trends suggest that sustainable workforce development will likely require a bigger focus on addressing the structural drivers of emigration and low retention, particularly working conditions, and career advancement opportunities.

Greater investment in digital health tools is still unmatched by comparable growth in patient and provider engagement

Ireland's digital health trajectory illustrates both the potential and limitations of infrastructure investment without corresponding systemic integration. Prior to the pandemic, spending on digital health infrastructure was 29 % below the EU average. Pandemic-era investments more than doubled capital spending to EUR 3 million per 100 000 population in 2022, supporting the rollout of teleconsultations and digital appointment systems. While in 2023, investment flows declined to EUR 1.8 million per 100 000 population below the EU average of EUR 2.3 million, digital service utilisation rates have not demonstrated commensurate gains.

In 2024, only 15 % of adults accessed their health records online, about half the EU average - a constraint imposed by the predominance of inaccessible paper-based records. Online consultation booking also remains low, even among highly educated individuals (Figure 26). Nonetheless, 38 % of adults booked appointments online in 2024, nearing the EU average, suggesting that barriers lie more in system design and digital access rather than in users' digital literacy. By contrast, mental health is an outlier: Ireland offers a broad range of digital supports, and the interactive My Mental Health Plan recorded a 70 % engagement rate between January and September 2025 (Health Service Executive, 2025). Digital cognitive behavioural therapy programmes for depression, anxiety and sleep difficulties have also been available since April 2021.

Figure 26. Ireland underutilises the internet to make appointments and access health records



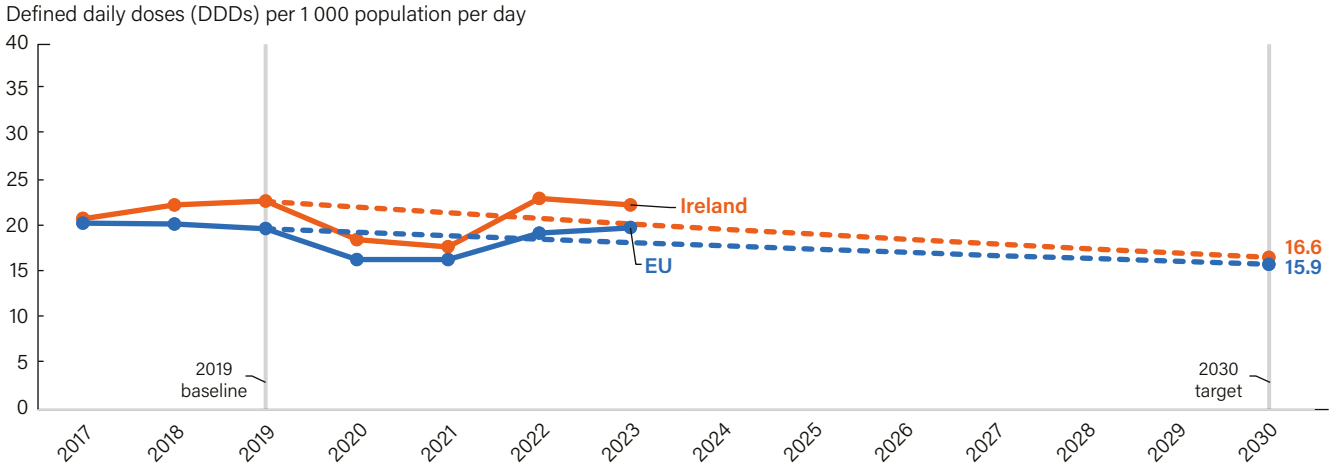
Source: Eurostat database (isoc_ci_ac_i). Data pertain to 2024.
Note: Low education is defined as the population with no more than lower secondary education (ISCED levels 0-2), whereas high education is the population with tertiary education (ISCED levels 5-8).

A major barrier is the lack of interoperability across Ireland's fragmented healthcare IT landscape. Multiple, non-integrated software systems are used across public hospitals, private facilities and primary care, limiting the utility of digital tools. Unlocking the full value of digital investments will require accelerating the rollout of interoperable electronic health records and unified access points across care settings. To address these gaps, Ireland published its Digital Health Framework 2024-2030, outlining a national strategy for digital transformation of the health system (HSE, 2024). As of 2024, implemented actions include the rollout of the HSE patient app (with certain functions such as medication lists, digital health cards and vaccination records), procurement of technology to host a national Shared Care Patient Record and a national electronic prescribing system, and investment in preparation for Electronic Health Records including increasing interoperability of existing systems.

Ireland's antimicrobial use exceeds the EU average, but stewardship efforts effectively curb the misuse of reserve antimicrobials

Antimicrobial resistance (AMR) remains a critical public health challenge that requires urgent action to reduce inappropriate antibiotic use. The EU Council's 2030 targets that were adopted in 2023 reflect this priority, mandating substantial reductions in antibiotic consumption by 2030. Ireland faces difficulties in meeting these targets: antibiotic consumption in 2023 was 22.4 DDD per 1 000 population approximately 13 % above the EU average of 19.9 (Figure 27). To achieve its proportional contribution to the 2030 objective, Ireland must implement strategies that deliver a 27 % reduction in antimicrobial consumption by 2030 from 2023 levels.

Figure 27. Ireland must curb antibiotic use by 27 % to meet its 2030 target



Note: The EU average is weighted. The chart shows antibiotic consumption in hospital and the community. The dashed line illustrates the policy target pathway to meet the 2030 reduction targets.
Source: ECDC ESAC-Net.

Ireland's strategic response is set out in its *Second One Health National Action Plan on Antimicrobial Resistance (2021–2025)*, which establishes a framework for coordinated interventions across the human and animal health sectors (Department of Health, 2021). Despite high consumption levels, Ireland has achieved notable success in antimicrobial stewardship. Resistance in invasive bacterial isolates fell from 25 % in 2016–17 to 14 % in 2022-2023, the fifth-lowest rate in the EU. In addition, 75 % of antibiotic prescriptions in Ireland fall within the WHO-recommended 'Access' category, significantly exceeding the 65 % benchmark and ranking Ireland third-best among EU countries. Sustained progress toward the 2030 target will depend not only on maintaining strong stewardship practices but also on expanding demand-side interventions. These include audit-and-feedback programmes in primary care, expanded public-awareness campaigns, the deployment of rapid diagnostics and financial incentives rewarding guideline adherence.

6 Spotlight on pharmaceuticals

Ireland manages pharmaceutical spending through strategic pricing policies and ceilings on patient copayments

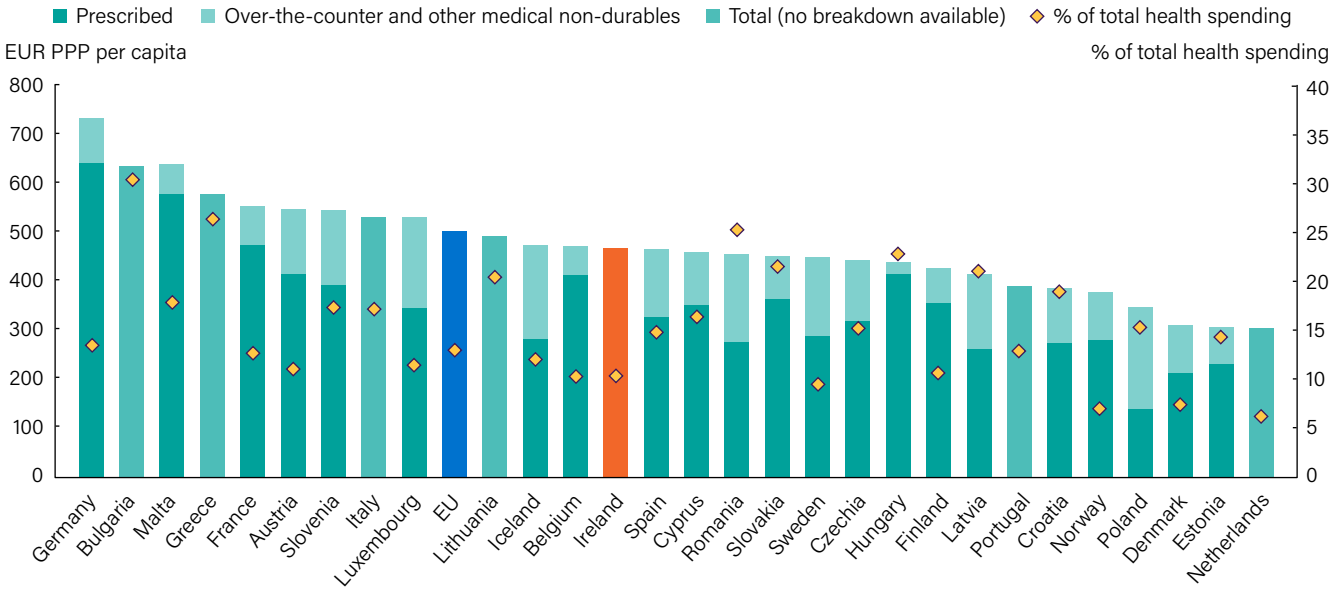
Ireland's pharmaceutical spending patterns indicate relatively controlled expenditure levels within the broader European context. Retail pharmaceutical expenditure amounted to EUR 474 per capita in 2024, 7 % below the EU average of EUR 510 per capita; this expenditure absorbed 11 % of Ireland's total health expenditure, compared with 13 % on average across the EU (Figure 28).

This comparatively moderate expenditure burden reflects cost-containment measures designed to moderate and balance patient and system-level costs. Notably, the Drug Payments Scheme establishes a monthly expenditure ceiling of EUR 80 per household for pharmaceuticals, with public funding covering costs above this threshold (see Section 5.2).

Pricing policy frameworks include negotiated manufacturer arrangements and generic substitution mechanisms. Ireland's pricing Framework Agreement negotiated with the pharmaceutical industry secured a 9 % rebate on exclusive patented medicines, with renegotiation scheduled for 2025. International reference pricing, together with statutory generic substitution by pharmacists for medicines on the national List of Interchangeable Medicines (over 160 active substances or combinations), has contributed to reducing the average cost per medication dispensed on the General Medical Services scheme (from EUR 21 in 2012 to EUR 16 in 2018) (Primary Care Reimbursement Service, 2021).

Hospital medications accounted for 30 % of total pharmaceutical spending – close to the EU average of 33 %, indicating that lower retail outlays are not simply a shift to inpatient use. High-cost, specialist medicines are managed under the High Tech Arrangement: products are purchased centrally by the HSE and supplied through community pharmacies. For some medicines, Managed Access Protocols require prescribers to apply for reimbursement for individual patients against defined criteria. To improve value from biological medicines, the HSE's 'best value biological' initiative designates a preferred biologic where biosimilars are available, provides prescribing and cost guidance, and offers a gain-share incentive to support initiation and switching. Taken together, these measures support expenditure control as utilisation rises.

Figure 28. Ireland spends a relatively small share of its health spending on retail pharmaceuticals



Note: This figure represents pharmaceutical expenditures dispensed through retail pharmacies for outpatient use only. It excludes medications administered in hospitals, clinics or physician offices.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023, except for Norway (2022).

Extensive public coverage limits household medicine costs

Ireland's combination of the General Medical Services scheme, which provides medicines to lower-income individuals with a small prescription charge, and the Drugs Payment Scheme, which caps monthly household outlays at EUR 80, results in a protective pharmaceutical financing framework for Irish households.

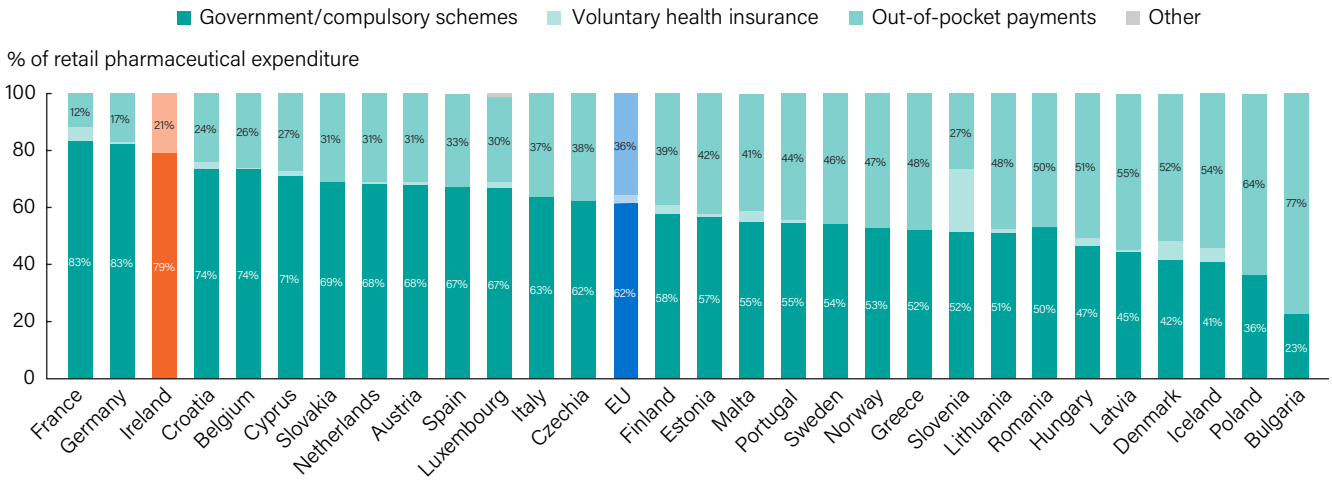
In 2023, these mechanisms, together with private health insurance top-ups, left households responsible for only 21 % of retail medicine expenditure, the third-lowest share in the EU and well below the EU average of 36 % (Figure 29).

Government budgets financed 79 % of retail spending, reducing the risk of catastrophic spending on medicines[3] and underpinning broad affordability across income groups.

The availability of medicines in Ireland is constrained by lengthening timelines for reimbursement approval and inclusion of new medicines

Ireland employs a sequential, two-stage assessment process for pharmaceutical reimbursement. The National Centre for Pharmacoeconomics (NCPE) first conducts HTAs using incremental cost-per-QALY thresholds and budget impact

Figure 29. Ireland has the third-highest share of publicly financed pharmaceutical spending



Note: The EU average is unweighted.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023, except for Norway and Malta (2022).

[3] Catastrophic spending on medicines occurs when household out-of-pocket payments for pharmaceutical products exceed 40 % of a household's non-subsistence spending (total expenditure minus normative costs for food, housing and utilities).

analyses, followed by pricing negotiations through the HSE's Corporate Pharmaceutical Unit. While this sequential structure aims to ensure value for money, it accounts for roughly two-thirds of total decision timelines and has contributed to Ireland's declining position in European rankings on timely access to new medicines.

Assessment timelines have extended significantly in recent years: according to the 2024 EFPIA Patients W.A.I.T. Indicator, the average time from EU marketing authorisation to patient access for centrally authorised medicines in Ireland reached 645 days in 2024, almost two months longer than the EU average and representing a 120-day increase from 2023 levels (Newton et al., 2025). This timeline translates into stark availability disparities: by mid-2024, only 31 % of medicines approved by the European Commission between 2020 and 2023 were accessible to Irish patients, contrasting sharply with over 90 % availability in Germany. Oncology therapeutics face particularly pronounced delays, with Irish patients experiencing on average 644 days and having access to only 25 % of new cancer therapies approved since 2020.

These delays reflect both structural and operational challenges. Rigid cost-effectiveness thresholds and pricing constraints may systematically exclude therapies offering modest but clinically relevant benefits, while therapies with a high-cost relative to potential comparators, a high budget impact, or with clinical efficacy and/or value for money queries undergo a lengthy HTA (National Centre for Pharmacoeconomics, 2025). Industry practices, such as incomplete dossier submissions and selective market launches, also contribute to access delays, accounting for an estimated one-third of total lag time.

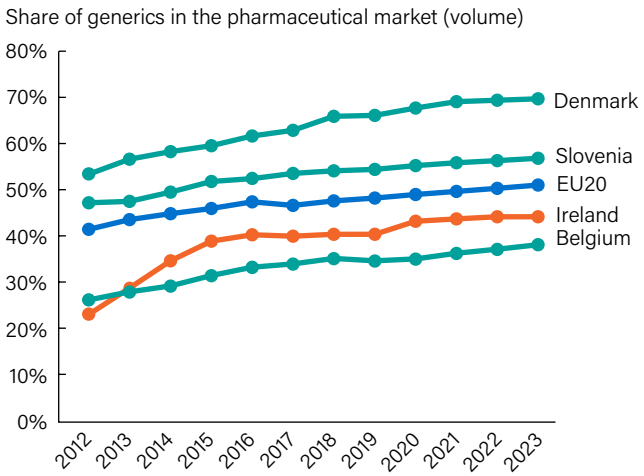
The 2023 Mazars Report provided an independent assessment that identified systemic governance weaknesses, including delays for rare disease therapies, inconsistent timelines and inadequate resourcing. Some recommendations have been implemented. Further progress can be supported by Ireland's participation in BeNeLuxA (shared HTAs and joint price negotiations), the new EU HTA Regulation (from January 2025) and the scheduled 2025 renegotiation of the Framework Agreement. These offer complementary opportunities to address structural impediments and align Ireland more closely with European standards for pharmaceutical access.

Ireland can still realise substantial savings through wider adoption of generic medicines

Generic medicines offer therapeutically equivalent alternatives to originator products following patent expiry and represent a key instrument for controlling pharmaceutical expenditure. In Ireland, pharmacy-level substitution is permitted through the Health Products Regulatory Authority's (HPRA) List of Interchangeable Medicines. Pharmacists routinely dispense generics when prescribers use international non-proprietary names (INN), although INN prescribing remains voluntary rather than mandatory.

Ireland has made notable progress in promoting generic use over the past decade: the share of prescriptions dispensed as generics rose from 29 % in 2013 to 44 % in 2023, placing Ireland ahead of countries such as Belgium and Austria. However, this growth has plateaued since 2020, and generic penetration remains below the EU average of 51 % and significantly behind peer countries such as Denmark and Slovenia (Figure 30). Ireland's policies on generic and biosimilar uptake have delivered considerable economic benefits. Between 2013 and 2021, targeted measures generated an estimated EUR 1.6 billion in cumulative savings (Medicines for Ireland, 2021). Notable examples include the shift to generic antiretroviral therapies, which supported the rollout of universal HIV prevention and care programmes, and the substitution of originator statins, which reduced annual public spending from EUR 160 million to EUR 36 million. These documented savings underscore the considerable fiscal headroom that expanded generic adoption could unlock across additional therapeutic areas.

Figure 30. The market share of generics in Ireland has increased by 50 % over the past decade



Note: The EU average is weighted.
Source: OECD Data Explorer (DF_GEN_MRKT).

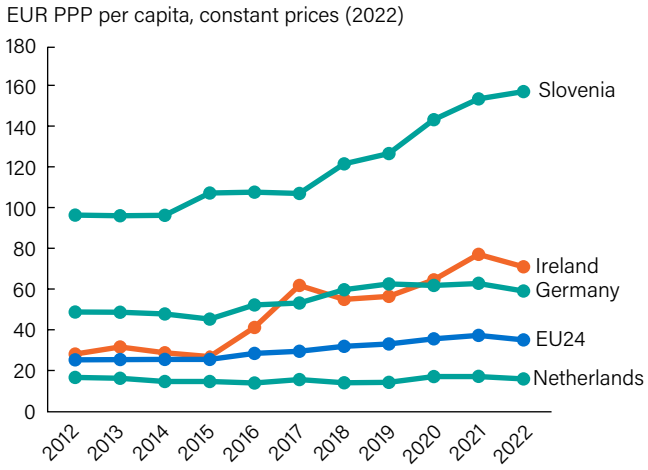
The plateau in uptake rates since 2020 suggests that Ireland may have captured the most accessible gains under current policy frameworks, indicating that further progress toward EU-leading performance levels may require more comprehensive structural reforms, potentially including mandatory INN prescribing or enhanced financial incentives for pharmacies dispensing medicines.

Ireland's strong pharmaceutical R&D investment contrasts with limitations in clinical trial recruitment

Ireland has emerged as a key hub for pharmaceutical research and development (R&D), marked by sustained growth in business investment and innovation outputs over the past decade. Business expenditure on pharmaceutical R&D rose 2.5-fold from EUR 27 per capita in 2015 to EUR 71 in 2022, more than twice the EU average of EUR 35 and the fourth-highest level in the EU (Figure 31). This expansion reflects a deliberate policy architecture aimed at attracting pharmaceutical innovation, combining a competitive 12.5 % corporate tax rate with targeted incentives such as a 25 % R&D tax credit and the *Knowledge Development Box*, which

lowers the effective tax rate on qualifying IP-derived profits to 6.25 %. These investments have translated into measurable innovation gains. International pharmaceutical patent filings originating from Ireland rose from 56 in 2015 (3 % of the EU total) to over 100 in both 2020 and 2021, during which Ireland accounted for roughly 6 % of EU filings. While filings moderated to 82 in 2022, this still represents substantial growth over the baseline. On a per capita basis, Ireland ranked second in the EU in 2022, with 16 pharmaceutical patent applications per million population, trailing only Denmark.

Figure 31. Ireland's per capita business pharmaceutical R&D spending is twice the EU average



Note: The EU average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_ANBERDi4).

Clinical trial activity has followed a similar trend. From 2010 to 2014, Ireland consistently registered three to four more trials per million population than the EU average. Trial intensity peaked at 26.7 per million population in both 2017, driven by robust sponsor engagement and favourable regulatory conditions. However, activity has declined since 2022, with trial density falling to 15.9 per million population in 2024, below the EU average of 18.3. This moderation reflects structural constraints linked to Ireland's small population, which limits patient recruitment for early-phase trials requiring strict inclusion criteria. Consequently, Ireland's trial portfolio is skewed toward later-stage studies, with early-phase trials (Phases I and II) comprising an average of around 30 % over the past decade, below the EU average of over 40 %. To address these constraints, a National Clinical Trials Oversight Group was established in 2024 to develop recommendations that increase trial activity, improve system efficiency and expand patient access.

Within this landscape, Ireland continues to maintain its position as the leading pharmaceutical manufacturer in the EU. In 2023, pharmaceutical output amounted to nearly EUR 68 billion, accounting for 21 % of total EU pharmaceutical production. Ireland's pharmaceutical manufacturing strength, combined with Ireland's status as an English-speaking country providing Single Market access post-Brexit, preserves distinct structural advantages for attracting talent and ensuring market accessibility that extend beyond immediate clinical research capacity constraints.

7 Key findings

- Ireland's life expectancy reached 82.9 years in 2023, ranking 8th in the EU and exceeding the EU average by one and a half years. Cancer is the leading cause of death (28 %), closely followed by cardiovascular diseases (28 %). Despite Ireland's relatively young demographic profile, with 16 % of the population aged 65 and over compared to the EU average of 22 %, approximately 15 % of the population experiences either cardiovascular disease or cancer. Cardiovascular disease incidence remains 15 % below the EU average, whilst cancer incidence exceeds it by 12 %.
- Behavioural and environmental risk factors account for 26 % of deaths in Ireland, slightly below the EU average of 29 %, with tobacco consumption representing the principal contributor. Ireland demonstrates strong tobacco control success, with daily smoking declining to 14 % in 2024, well below the EU average of 19 %, though e-cigarette use among 15-year-olds has surged to 18 %. Adult obesity prevalence of 19 % is of concern and remained above the EU average in 2022. Health inequalities are significant, with obesity 7 percentage points more prevalent among adults with lower education levels.
- Per capita health spending reached EUR 4 474 in 2023, 17 % above the EU average. Ireland's system combines universal hospital coverage with means-tested primary care, leading 46 % of the population to maintain voluntary private health insurance to circumvent public system delays. Acute care capacity is constrained: hospital bed density is 43 % below the EU average, and Ireland records the EU's highest bed occupancy rate. These pressures contribute to long waiting times, with nearly two-thirds of patients waiting more than 12 weeks for elective surgery.
- Ireland's health system demonstrates strong performance across key quality indicators: avoidable mortality is 21 % below the EU average. Treatable stroke mortality ranks among the EU's lowest and acute myocardial infarction mortality is 10 % lower than the EU. Screening participation excels for breast and cervical cancers, while colorectal screening lags at 48 %. Despite overall progress, gaps remain in chronic disease management, with hospitalisations for COPD and asthma at nearly double the EU average despite the implementation of ad-hoc integrated care programmes.
- Over half of Ireland's population lacks medical or GP visit entitlements and incurs costs of EUR 55-75 per primary care consultation. Public funding patterns diverge markedly from the EU average, with only 78 % of hospital care being publicly funded while pharmaceutical coverage exceeds the EU average at 79 %. Geographic disparities exacerbate access challenges, with two-fold variations in GP density across counties resulting in workforce shortages in rural areas.
- *Sláintecare* reforms are progressing, with decentralisation into six Health Regions in 2024 and gradual efforts to expand universal coverage. While workforce capacity is increasing, retention challenges persist, as evidenced by only 37 % of specialist doctors accepting posts in Ireland in 2023. Ireland's antimicrobial consumption is 13 % above the EU average, requiring a 27 % reduction to meet 2030 targets.
- Ireland maintains controlled retail pharmaceutical expenditure at EUR 474 per capita, 7 % below the EU average, achieved through strategic pricing frameworks including manufacturer rebates and monthly household spending caps. However, medicine access faces significant delays: new therapies require 645 days from EU marketing authorisation to patient access, with only 31 % of medicines approved centrally accessible to Irish patients. Generic medicine uptake has plateaued at 44 % since 2020, below the EU average of 51 %. Ireland excels in pharmaceutical R&D investment, double the EU average, and has the second-highest patent filing rate per capita, while maintaining its position as the EU's leading pharmaceutical manufacturer with 21 % of total production.

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Country abbreviations

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

State of Health in the EU
Country Health Profiles 2025

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 2025 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;
- an account of the pharmaceutical sector and policies within the country.

Complementing the key findings of the Country Health Profiles is the *Synthesis Report*.

For more information, please refer to: https://health.ec.europa.eu/state-health-eu_en

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BETTER POLICIES FOR BETTER LIVES

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