Ireland

Health Care & Long-Term Care Systems

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Ireland

Health care systems

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2.14. IRELAND

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

GDP per capita in PPS thousand is at €47.8 and far above EU average of €29.6 in 2015. Ireland has a population of 4.7 million inhabitants ([188]). It should be noted that in 2015 the GDP of Ireland grew by 25.1% from its 2014 level, which has a strong effect on some of the variables presented as a ratio of GDP in this country profile.

During the coming decades the population will steadily increase to 6 million inhabitants in 2070. Thus, Ireland is facing a considerable increase of its population by 29%, while the EU average population is estimated to increase by 2%.

Total and public expenditure on health as % of GDP

Total expenditure ([189]) on health as a percentage of GDP (8.2% in 2015) has fallen sharply from 2014, although this is due to the increase in GDP in that year rather than to an actual fall in health expenditure. It is below the EU average ([190]) of 10.2% in 2015. Public expenditure also fell from 7.1% of GDP in 2014 to 5.6% of GDP in 2015 versus the EU average of 8%. Looking at health care without long-term care ([191]) reveals a similar picture with public spending being below but slightly further from the EU average (4.2% vs 6.8% in 2015).

To provide more context one can look at these variables in per capita terms. Total current spending on health at 4115 PPS in Ireland is above the EU average of 3305 in 2015. Similarly, public current spending on health care is, at 2849 PPS, higher than the EU average of 2609 PPS in 2015.

([188]) This is according to Eurostat projections.

([189]) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + HC.R.1.

([190]) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year.

([191]) To derive this figure, the aggregate HC.3 is subtracted from total health spending.

Expenditure projections and fiscal sustainability

As a consequence of demographic changes, health care expenditure is projected to increase by 1.0 pps of GDP, above the average growth expected for the EU (0.9) ([192]), according to the Reference Scenario. When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 1.7 pps of GDP from now until 2070 (EU 1.6).

Ireland faces low fiscal sustainability risks in the short run and medium term, but risks are medium in the long term, risks, due to the significant projected increase in ageing costs including health care and long-term care ([193]).

Health status

Life expectancy at birth (83.4 years for women and 79.6 years for men in 2015) is close to the respective EU averages (83.3 and 77.9 years of life expectancy in 2015) ([194]). However, healthy life years, at 67.9 years for women and 66.6 years for men, were far above the EU averages of 63.3 and 62.6 in 2015. The infant mortality rate of 3.4 deaths per 1,000 live births is also slightly lower than the EU average of 3.6 deaths per 1,000 live births in 2015, having gradually fallen over most of the last decade (from 3.8%% in 2005), although it has been relatively flat since 2006.

As for the lifestyle of the Irish population, data from the 2017 Healthy Ireland survey has shown that 22% of the Irish population aged 15 and over are regular smokers. In contrast, Eurostat reports a proportion of 19% for 2015. The 2017 Healthy Ireland survey also shows that 23% of the Irish population aged 15 and over are obese (Eurostat report 18.9%) while the survey also shows a reduction in alcohol consumption from 12.7 litres per capita in 2003 to 11 litres in 2015, but still above the EU average of 10.0 in 2012.

([192]) The 2018 Ageing Report https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf .

([193]) Fiscal sustainability Report (2018), Institutional Paper 094, January 2019, European Commission.

([194]) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database. Data on life-styles is taken from OECD health data and Eurostat database.

System characteristics

Coverage

All persons ordinarily resident in the country are eligible, subject to certain charges, for all in-patient public hospital services in public wards including consultant services and out-patient public hospital services. Some groups are exempted from the charges (e.g. pregnant women, those suffering from certain medical conditions, medical card holders) and there is an annual cap of €800 for these charges.A medical card ensures free access to all general practitioner services, prescribed drugs ([195]), emergency, inpatient, outpatient, certain dental aural ophthalmic and maternity care. Currently, 33% of the population are eligible for a medical card. In addition, persons with an income up to 50% above the income threshold for a medical card are eligible to receive free general practitioner services under the GP visit card scheme, which equates to an additional 10.4% of the population. Since Summer 2015, all children under 6 years of age (1 July 2015) and all persons 70 years and older (4 August 2015) are eligible for free general practitioner services. From 1 September 2018, all recipients of a Carer's Allowance (full and half-rate) or Carer's Benefit will be eligible for free General Practitioner Services. The remainder of the population is not entitled to free GP services ([196]). Non-medical card holders are not covered for aural, ophthalmic and dental care and must also pay the first €134 each month towards prescribed pharmaceuticals; thereafter the public health system covers 100% of the cost.

Administrative organisation and revenue collection mechanism

In 2015, 69.3% of total health expenditure funding came from government sources (taxes at central level) and from the Health Contribution Levy (substituted by a new Universal Social Charge in 2011).

There has been an effort in recent years to reduce administrative costs and improve the general management of the sector. The Health Service Executive (HSE) was established under the Health Act 2004 as the single body with statutory responsibility for the management and delivery of health and personal social services in the Republic of Ireland. As outlined in the Health Act 2004 the objective of the Executive is to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public.

As regards the funding of the HSE and the Department of Health, the budget is determined by the Parliament (Oireachtas). Each year the Parliament votes public monies to fund the Department of Health and services provided by or on behalf of the HSE. Since the start of 2015 the HSE no longer has a separate Vote and its spending and funding are accounted for as part of the Health Vote. The HSE submits its National Service Plan for the Minister of Health's approval, setting out the type and volume of health and social care services to be provided by the HSE that year. The HSE is required to operate within the limits of its allocation, delivering the levels of service which are provided for in the Plan. During the course of the year, detailed information related to performance of the health service in relation to Access to and Integration of services, the Quality and Safety of those services, Finance, Governance and Compliance, and Workforce are provided to the Department of Health by way of monthly Performance Monitoring Reports against the Plan..

Role of private insurance and out of pocket co-payments

In recent years, private expenditure as a percentage of total health expenditure has increased (from a trough of 23.3% in 2003 to 30.7% in 2015) and is above the EU average (21.6% in 2015).

Note also that more than 40% of the private expenditure is voluntary community-rated health insurance ([197]) (which 45.8% of the population takes up) to help cover for a) cost-sharing (complementary insurance) when not eligible for a

([195]) A prescription charge of €2.50 per item in respect of items dispensed to medical card holders subject to a monthly cap of €25.00 per person or family.

([196]) As a result, Ireland scores a bit above 5 on the scope of basic coverage (the third lowest OECD value) and a bit below 5 out of 6 on the depth of coverage according to the OECD scoreboard.

([197]) See for instance McDaid D, Wiley M, Maresso A and Mossialos E. Ireland: Health system review, Health Systems in Transition, 2009; 11(4): 1 – 268.

medical card, b) the services and goods excluded from the benefit basket (supplementary) and c) the same goods and services as the primary coverage (duplicative) ([198]). It would be important that this type of insurance does not discourage the recourse to the most cost-effective services (e.g. more primary care than specialist care or hospital care when the latter are unnecessary).

Out-of-pocket payments are about 15.2% of all health-expenditure and have decreased since their highest value of 18.2 in 2010.

Types of providers, referral systems and patient choice

The public health service is a mix of public and private provision. Primary care is delivered in public health centres and private premises of general practitioners (GPs). In recent years, Primary Care Centres have been developed within which both GPs and a range of primary care professionals employed by the HSE are housed. Outpatient specialist care is delivered in hospital outpatient departments. Approximately 85% of acute care beds are within the public hospital system. Persons may also decide to access services in the private hospital sector and in most such cases patients use private health insurance to meet the costs involved.

The number of licensed physicians per 100 000 inhabitants in Ireland is, at 288, below the EU average of 344 in 2015, below the 2010 peak of 308 (before which it had been steadily increasing). The number of general practitioners (GPs) per 100 000 inhabitants was 75 in 2015, below the EU average of 78.3. The number of nurses per 100 000 inhabitants (1240 in 2013) is far above the EU average of 825.

Medical card and GP Visit card holders are free to select any GP participating in the General Medical Services (GMS) Scheme but must continue to use this GP subject to applying to and getting approval from the Health Service Executive (HSE) for a change of GP under the GMS Scheme. The remainder of the population make their own arrangements to access primary care physicians but must pay the full private fee for this service. Access to specialist medical services in acute hospitals is available only on foot of a referral by a primary care physician. The delivery of specialist medical care and care utilisation is strongly centred on hospitals where most specialists work ([199]). Authorities have planned the greater use of ICT and a standard approach to the use of electronic health information, which can help in implementing more effective referral systems and care coordination and as a consequence improve effectiveness and efficiency of care (see below for more details).

In 2014 the number of acute care beds per 100 000 inhabitants was 243, compared to an EU average of 402. The number has decreased since 2003, but has been relatively flat since 2011.

Inpatient hospital discharges per 100 inhabitants in 2014 were, at 13.7, below the EU average of 16.2. There were 20,8 day case discharges per 100 inhabitants in 2014, far above the EU average of 16.4. As a result, the ratio of day cases to longer stays is amongst the highest in Europe.

Acute care bed occupancy rates in 2015 were 94.7%, far above the EU average of 76.8%. The rates have been increasing since a value of 85% in 2003.

Average length of stay has fallen slightly from a peak of 7,7 in 2008 to 6.4 days in 2015, below the EU average of 7.6.

It should be noted that hospital bed data for Ireland excludes private hospitals, and is therefore under-reported compared with other countries. This also applies to hospital discharge data and may contribute to explain the extremely high bed occupancy rates as well as the low levels of discharges.

There is a Common Basket of services of the public health system that has to be delivered to the whole population covered.

([198]) In addition, in 2002 the Government established the National Treatment Purchase Fund to pay for the treatment in the private hospital sector of patients deemed to have been waiting for too long for surgery in the public hospital system.

([199]) Indeed, according to the OECD, the level of choice has a score of a bit more than 4 out of 6, while gatekeeping scores 2 out of 6.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

GPs are paid on a capitation (per number of registered patients) basis plus a fee-per-item basis for specified services (e.g. immunisations) for medical card and GP visit card patients (i.e. 44% of the population as of April 2017) ([200])([201]). Heretofore, there has been limited room to use performance-related payments to encourage health promotion, chronic disease prevention or disease management actions. However, in 2015, a package of measures was introduced, including terms for the delivery of GP care without fees for all children under 6 years and the provision of GP care without fees to all persons aged 70 years and over. These represent the first phase in the delivery of a universal GP service. The new enhanced under-6 service involves age-based preventive checks focused on health and wellbeing and the prevention of disease and also covers an agreed cycle of care for children under 6 diagnosed with asthma.

A Diabetes Cycle of Care for adult Medical Card and GP Visit Card patients who have Type 2 Diabetes was also introduced in 2015.

Historically, specialists have been permitted to engage in private fee-for-service practice in conjunction with the receipt of salary as public hospital employees. This dual practice in conjunction with the presence of duplicative private insurance (private insurance that covers the same goods and services as the primary coverage) risked inducing specialists to devote an excessive proportion of their time to private practice, with consequent negative effects of the service for public patients. In an attempt to mitigate the problem, in 2008 authorities negotiated a new employment contract for specialists, granting that a proportion of consultants will not have any fees from private practice while those who engage in private practice are obliged to have a minimum of 80% public patients workload ([202]).

Public remuneration of doctors is determined by the central government and following the severe economic crisis national authorities have focused on controlling wages in the health sector.

Hospitals are paid or funded using a combination of prospective global budgets and activity-related/DRG payment. Efforts continue to improve cost transparency and efficiency in the sector.

The introduction of an activity-based funding mechanism is a key health reform initiative. In May 2015, the authorities published an action plan for 2015-2017 to implement activity-based funding in public hospitals. The actual transition from block-funding of hospital activities is a gradual process that commenced in January 2016 and will extend over several years, starting with inpatient and day-cases before widening to outpatient care. In the longer term, the programme will consider implementation of activity-based funding in other areas such as emergency, community and home care. Activity-based funding is meant to improve quality, transparency, data collection and the allocation of resources across hospitals. It is important to note that while the new funding model will encourage hospitals to use resources at their disposal more efficiently within their overall budgetary ceilings, activity-based funding does not seek to reduce current expenditure on acute hospital services. Implementation of the forthcoming stages could prove challenging in the absence of a complete system of patient identifiers and fully reformed financial management systems. A new Healthcare Pricing Office (HPO) was established on an administrative basis in January 2014 to set the national DRG ([203]) prices on which the activity-based funding system is based and to manage the HIPE ([204]) dataset.

The market for pharmaceutical products

The initial price of all reimbursable medicines is based on clinical performance, economic evaluation, the cost of existing medicines and international prices (currently based on the average manufacturing price in AT, BE, DK, ES, FI, FR,

([200]) The remaining 56% of the population must pay GPs on a private fee per visit basis.
([201]) The OECD score for remuneration incentives to raise the volume of care is 3 out of 6 for Ireland as a result of this mix of fee-for-service, salary and capitation systems.
([202]) Monitoring arrangements based upon measurement of activity and case-mix have been introduced.
([203]) Diagnosis-Related Groups (or DRGs) are a classification which groups hospital case types that are clinically similar and are expected to have a similar hospital resource usage.
([204]) HIPE (Hospital Inpatient Enquiry) is the principal source of national data on discharges from acute hospitals in Ireland.

GR, DE, IT, LU, NL, PT, SE and UK, in line with current agreement with industry). Discounts and rebates plus price freezes and cuts are measures to control expenditure directly. The authorities, through the Health Service Executive have established a Medicines Management Programme. A key focus of the programme is on cost-effective prescribing and the reduction in drug expenditure through more rational prescribing.

Public pharmaceutical spending as a proportion of public current health spending was.13.8% in 2015, above the EU average of 12.7%. It should be noted that, given the large increase of GDP in 2015 this probably underestimates the difference in pharmaceutical expenditure.

The ESRI report "Pharmaceutical Prices, Prescribing Practices and Usage of Generics in a Comparative Context" was published in 2013 and showed that prices for originator in-patent medicines and generic medicines were higher in Ireland compared to other EU Member States.

Several policies have been implemented to reduce the price of pharmaceuticals and details of the main policy initiatives are as follows:

- Agreement with Industry. The authorities have entered into a series of price reduction agreements with both the Irish Pharmaceutical Healthcare Association (IPHA) and the Association of Pharmaceutical Manufacturers in Ireland (APMI). Taking these Agreements together, it is estimated that cumulative savings in excess of €1.5 billion have been generated between 2006 and 2014. Successor agreements are expected to be introduced in 2016.

- Generic Substitution and Reference Pricing. The impact of this legislation has been positive in terms of increasing the level of generic penetration in the Irish market. A target for generic penetration of the off-patent market by volume of 70% by end 2016 has been exceeded. At the end of 2017, generics accounted for 74% of the total off-patent market by volume and 42% by value.

- Reference pricing. This involves setting a common reimbursement amount for designated interchangeable groups of medicines, has delivered savings in the region of €50 million in 2014 and a further €25 million in 2015.

Health and health-system information and reporting mechanisms/ Use of Health Technology Assessments and cost-benefit analysis

The Health Information and Quality Authority (Incorporating the Office of the Chief Inspector of Social Services) was established in mid-2007. It has a broad range of functions which include the setting and monitoring of service standards and health technology assessment. The Chief Inspector of Social Services currently registers regulates residential services for older people, regulates residential and residential respite services for children and adults with disabilities and inspects children's residential centres, special care units and foster care settings.

Future plans to develop HIQA's role include extending the Authority's remit for standard setting to private hospitals, overseeing a licensing system for public and private healthcare providers and to continue undertaking Health Technology Assessments in priority areas to support investment and disinvestment decisions.

The National Clinical Effectiveness Committee (NCEC) is a Ministerial committee established in 2010. It provides oversight for the National Framework for Clinical Effectiveness. Its terms of reference are to prioritise and quality assure to the level of international methodological standards a suite of National Clinical Guidelines and National Clinical Audit, prioritised, as significant for the Irish healthcare system. Each guideline has a full budget impact assessment and Health Technology Assessment if required.

A policy mandate for guideline implementation is provided through Ministerial endorsement.

Relevant Key Performance Indicators and audit are identified for each guideline to track and monitor implementation through the HSE Performance Assurance Reports, compliance with HIQAs *National Standards for Safer Better Healthcare.* It is intended that increased alignment with the clinical indemnity scheme and plans for licensing of hospitals will further strengthen the mandate for guideline implementation.

E-Health, Electronic Health Record

An *eHealth – Strategy for Ireland* was published in December 2013. eHealth Ireland and the role of the Chief Information Officer were established in 2014 and are responsible for implementing the eHealth strategy and driving eHealth initiatives. The development of a national Electronic Health Record (E.H.R.), along with the development of the Individual Health Identifier (I.H.I) are essential elements to ensure that patient data can be securely connected and shared within the health service, providing safer, better care to patients. The technical implementation of the IHI has commenced with a roll-out for the integration of the identifier into various ICT systems nationally on a phased basis across acute and primary health services. The national EHR Strategic Business Case published in 2016 sets out the rationale and investment required for the development of and implementation of a national E.H.R and work is ongoing in progressing the three core elements of the programme: (i) acute EHR, (ii) Community Operational Systems and (iii) a Shared Care Record supported by an integration capability to share data across the various health domains.

In addition to the I.H.I. and E.H.R. other national ICT systems are being introduced or standardised. The Maternal and New-born system (MN-CMS) continues to be deployed nationally on a phased basis while other systems such as the national laboratory system (MedLIS), the national oncology management system (MOCIS), eReferrals and ePrescribing continue to be progressed.

Recently legislated and/or planned policy reforms

Legislation was introduced in 2013 to provide for the charging of all private in-patients in public hospitals.

The Nursing Homes Support Scheme (NHSS), often referred to as the "Fair Deal" is a scheme of financial support for people who require long-term nursing home care. The statutory based scheme commenced on the 27th October 2009 with the enactment of the Nursing Homes Support Scheme Act 2009 and replaced the former Nursing Home Subvention scheme which had been in existence since 1993. The NHSS is operated by the HSE. This Scheme was reviewed and a report of the Review was published in 2015. Work is underway in implementing the recommendations contained in the Review.

In June 2016, the All-Party Committee on the Future of Healthcare was established with the goal of developing a consensus on the future direction of healthcare policy in Ireland. The Committee consulted with a broad range of stakeholders and published the Sláintecare Report in May 2017. The report presents a ten-year vision for a health service where the majority of care is delivered in the community, care is integrated across different services and access is based on need and not ability to pay. The report details key reforms needed to move towards that vision.

The Government gave approval for the Department of Health to advance key actions in the Sláintecare Report and to develop a full response to the report. Among these actions, was the establishment of an independent group to examine the effects of removing private practice from public hospitals. This group is expected to report by the end of 2018.

A new implementation and governance structure has been put in place to drive reform. A dedicated Sláintecare Programme Office has been established and a new Executive Director recruited. The Chair of the new Sláintecare Advisory Council was appointed in July 2018. The council will provide both Irish and international health expertise to support the work of the Sláintecare Programme Office.

In August 2018, the Sláintecare Implementation Strategy was published following approval by government. This is the Government's ten-year strategy to reform Ireland's health and social care services. The strategy provides a framework for reform with four over-arching goals, and 10 strategic actions.

An Independent Review Group has been established to examine and enquire into the effects of the removal of private activity from public hospitals and examine potential benefits and potential adverse consequences, including any unintended consequences that may arise in the removal.

The Department of Health is committed to evolving the current health structures, in line with other reforms, in order to devolve decision-making and autonomy in line with demonstrated functionality, as outlined in the Sláintecare Implementation Strategy.

The Irish National Dementia Strategy was launched in December 2014. The Strategy aims to improve dementia care to allow people with dementia to live well for as long as possible and have services and supports delivered as well as possible. A National Dementia Office was established in the HSE in 2015 to drive the Strategy's implementation. A mid-term review of the Strategy (May 2018) noted that good progress has been made on implementing many of the Strategy's 35 priority and additional actions but that additional financial and staffing resources will be required in the areas of diagnosis, post-diagnostic supports, primary care, acute care, home care and housing if the Strategy is to be fully implemented.

The introduction of activity-based funding and a Healthcare Pricing Office described under "Price of healthcare services, purchasing, contracting and remuneration mechanisms" above will help to deliver greater efficiency and transparency in the delivery of services and therefore will enhance the fiscal sustainability of the health system.

The Department of Health conducts an annual data collection of the private hospital sector. This is an important step in closing current data gaps, and allows statistics for Ireland to be viewed in a more comparable way with other Member States.

The Department of Health launched a public consultation on a new Health Information Policy Framework in late 2017 with a view to finalising the policy in early 2019.

The National Development Plan provides €10.9 billion, over the ten year period, for a number of major capital investment projects and programmes along with significant reform initiatives for the health sector including new healthcare facilities that allow for implementation of new models of care, for the delivery of services in high quality modern facilities and expanded bed numbers and health services to build a better health service for the future consistent with the National Planning Framework.

The Health Service Capacity Review was published in January 2018. The Review forecasts future capacity requirements in acute hospitals, primary care and in services for older persons (residential and homecare services) for the period 2016 to 2031. The analysis took account of current levels of demand and capacity, demographic and non-demographic factors that will drive future demand, and the potential impact that key system reforms can have on capacity needs.

The analysis of the Capacity Review informed the investment commitments in the National Development Plan. Arising from the findings of the Capacity Review, the Government committed to funding an extra 2,600 acute hospital beds, 4,500 residential care beds and three new elective-only hospitals in major population centres. This commitment is part of a broader programme of reform in the health sector. Investment and reform will go hand in hand, in order to drive change in the delivery of health and social care services in Ireland ([205]).

Challenges

- To consider changes in payment procedures to physicians (e.g. through the use of mixed payment schemes) to encourage health promotion, disease prevention and disease management activities in primary care and make primary care more attractive; To implement measures to prevent chronic diseases and their complications.

- To continue to enhance primary care provision by increasing the numbers and spatial distribution of primary care professionals and ensuring an effective referral system from primary to specialist care and from specialist to

([205]) Project Ireland 2040 is the overarching policy and planning framework for the social, economic and cultural development of Ireland. It includes both the 20-year National Planning Framework and the detailed capital investment plan for the period 2018 to 2027, the National Development Plan. The Framework outlines the broad policy principles and priorities to plan for future population and economic growth in Ireland over the next 20 years. The principles of the Planning Framework will be underpinned by the National Development Plan, a ten-year, €116 billion capital investment programme.

primary care. This could improve access to care by different population groups and reduce unnecessary use of hospital care and therefore overall costs. A related challenge in streamlining patient care is the introduction of individual patient identifiers which is being addressed. These improvements could be complemented with incentives for patients, both financial and non-financial, to encourage the use of primary care versus specialist care.

- To reduce unnecessary use of specialist and hospital care and within hospitals, ensuring that care is provided in the most clinically appropriate and cost-effective way, for example by maximising the proportion of elective care provided on a day case basis, day-of-surgery admission and reducing inappropriate lengths of stay.

- To explore the means to improve the way private and public provision are better integrated in an overall provision framework and reconsider the current system of payment incentives which may be detrimental to public patients and the public sector.

- To consider additional measures regarding direct pharmaceutical expenditure control, product reimbursement on the basis of cost-effectiveness information and greater use of generics vs. branded medicines.

- To continue to enhance managerial accountability and decrease administrative costs while aligning incentives (payments, cost-sharing) with national public health goals and effectiveness and efficiency. The efforts in setting up activity-based costing should help improve quality, transparency, data collection and a reallocation of resources across hospitals, and in time the wider health care system.

- To improve data collection in some crucial areas such as resources and care utilisation. Better monitoring of activity in the sector, combined with greater use of health technology assessment could be used for planning purposes and for defining the extent of cost-sharing. The work to develop IHIs should be a key plank of future developments.

- To further enhance health promotion and disease prevention activities i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (diet, smoking, alcohol, obesity).

Table 2.14.1: **Statistical Annex - Ireland**

General context												**EU- latest national data**			
GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
GDP, in billion Euro, current prices	170	185	197	188	170	168	172	176	180	195	262	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	32.7	33.8	35.1	32.1	30.6	33.1	34.2	34.5	34.5	37.1	47.8	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	3.6	2.8	2.1	-6.0	-5.5	1.3	2.6	-0.2	1.4	8.0	24.8	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	-0.2	7.9	8.7	8.1	1.1	-2.4	4.1	2.6	2.6	-1.9	3.7	0.2	0.2	4.1

Expenditure on health*	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Total as % of GDP	8.0	7.8	8.2	9.5	10.9	10.9	10.4	10.8	10.9	10.4	8.2	10.2	10.1	10.1	10.2
Total current as % of GDP	6.7	7.0	7.2	7.6	7.5	7.8	9.1	10.5	10.4	9.9	7.8	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	1.4	0.8	1.0	1.9	3.4	3.1	1.3	0.3	0.5	0.5	0.4	0.9	0.6	0.2	0.3
Total per capita PPS	2,997	3,089	3,374	3,618	3,696	3,613	3,509	3,721	3,849	3,920	4,115	2,745	2,895	2,975	3,305
Public total as % of GDP	6.3	6.1	6.5	7.5	8.3	8.3	7.8	7.9	7.5	7.1	5.6	8.0	7.8	7.8	8.0
Public current as % of GDP	6.0	5.8	6.2	7.2	8.1	8.0	7.5	7.6	7.3	6.9	5.4	7.7	7.6	7.6	7.8
Public total per capita PPS	2,358	2,399	2,643	2,845	2,827	2,748	2,638	2,728	2,639	2,693	2,849	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.29	0.21	0.28	0.28	0.24	0.25	0.24	0.29	0.21	0.26	0.22	0.2	0.2	0.2	0.2
Public as % total expenditure on health	78.7	77.7	78.3	78.6	76.5	76.0	75.2	73.3	68.6	68.7	69.3	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	21.4	21.8	20.5	18.2	16.9	13.0	18.3	19.3	20.1	19.6	18.9	14.8	14.8	15.2	15.0
Proportion of the population covered by public or primary private health insurance	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	16.0	16.1	14.8	15.3	16.1	18.2	17.7	11.4	15.0	15.4	15.2	14.6	14.9	15.9	15.9

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Population, current (millions)	4.1	4.2	4.3	4.5	4.5	4.5	4.6	4.6	4.6	4.6	4.7	502.1	503.0	505.2	508.5
Life expectancy at birth for females	81.3	81.7	82.1	82.4	82.7	83.1	83.0	83.1	83.1	83.5	83.4	82.6	83.1	83.3	83.3
Life expectancy at birth for males	76.7	76.9	77.3	77.9	77.8	78.5	78.6	78.7	79.0	79.3	79.6	76.6	77.3	77.7	77.9
Healthy life years at birth females	64.0	64.9	65.6	65.1	65.2	66.9	68.3	68.5	68.0	67.5	67.9	62.0	62.1	61.5	63.3
Healthy life years at birth males	62.9	63.2	62.9	63.5	63.9	65.9	66.1	65.9	65.8	66.3	66.6	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	59	57	53	55	50	48	126	122	117	112	111	64	138	131	127
Infant mortality rate per 1 000 live births	3.8	3.9	3.2	3.4	3.3	3.6	3.5	3.5	3.5	3.3	3.4	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics												**EU- latest national data**			
Composition of total current expenditure as % of GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	2.5	2.4	1.9	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	0.7	0.7	0.5	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	2.1	1.9	1.5	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	1.2	1.2	1.3	1.5	1.6	1.6	1.4	1.4	1.5	1.4	1.0	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	0.0	0.0	0.1	0.3	0.3	0.4	0.4
Prevention and public health services	:	:	:	:	:	:	:	:	0.3	0.3	0.2	0.3	0.2	0.3	0.3
Health administration and health insurance	:	:	:	:	:	:	:	:	0.3	0.4	0.2	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	1.7	1.6	1.3	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	0.4	0.4	0.3	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	1.4	1.3	1.0	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	0.8	0.9	0.9	1.1	1.2	1.2	1.1	1.1	1.1	1.0	0.8	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	0.0	0.0	0.0	0.1	0.1	0.2	0.2
Prevention and public health services	0.2	0.2	0.2	0.2	0.2	:	:	:	0.2	0.2	0.1	0.2	0.2	0.2	0.3
Health administration and health insurance	:	:	:	:	:	:	:	:	0.1	0.1	0.1	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

Table 2.14.2: **Statistical Annex - continued – Ireland**

Composition of total as % of total current health expenditure	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU- latest national data 2009	2011	2013	2015
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	23.5%	23.8%	24.2%	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	6.7%	6.8%	6.7%	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	20.0%	19.3%	19.6%	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	17.7%	17.6%	17.7%	19.0%	21.2%	20.0%	15.7%	13.5%	14.5%	14.0%	13.0%	13.1%	12.8%	14.7%	14.6%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	0.4%	0.4%	1.2%	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	:	:	:	:	:	:	:	:	2.8%	2.7%	2.7%	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	:	:	:	:	:	:	:	:	3.1%	3.5%	2.8%	4.5%	4.3%	3.9%	3.8%
Composition of public as % of public current health expenditure															
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	22.8%	23.6%	23.6%	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	5.9%	6.1%	6.1%	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	19.6%	18.8%	19.2%	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	13.8%	15.3%	15.1%	15.1%	15.0%	15.1%	14.8%	14.5%	14.7%	14.1%	13.8%	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	0.4%	0.3%	0.4%	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	3.3%	3.4%	3.2%	2.8%	2.5%	:	:	:	2.5%	2.3%	2.4%	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	:	:	:	:	:	:	:	:	1.2%	1.2%	1.1%	4.1%	4.0%	3.6%	3.4%

Expenditure drivers (technology, life style)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU- latest national data 2009	2011	2013	2015
MRI units per 100 000 inhabitants	:	0.80	0.85	0.90	1.19	1.24	1.31	1.24	1.33	1.34	1.41	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	1.1	1.3	1.4	1.5	1.5	1.6	1.6	1.7	1.8	1.7	1.8	2.1	1.9	2.1	2.3
PET scanners per 100 000 inhabitants	:	:	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.2	0.2
Proportion of the population that is obese	:	:	15.0	:	:	:	:	:	:	18.2	18.0	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	:	:	29.0	27.0	:	:	:	:	:	12.7	19.0	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	13.3	13.4	13.6	12.7	11.4	11.9	11.7	11.5	10.5	10.8	:	10.4	10.3	10.1	10.2

Providers	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Practising physicians per 100 000 inhabitants	:	272	280	290	301	308	267	271	269	281	288	324	330	338	344
Practising nurses per 100 000 inhabitants	1236	1274	1296	1288	1274	1294	1261	1260	1240	:	:	837	835	825	833
General practitioners per 100 000 inhabitants	51	51	53	53	55	56	72	72	73	78	75	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402

Outputs	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Doctors consultations per capita	:	:	3.3	:	:	3.8	:	:	:	:	5.7	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	14	14	14	14	13	13	13	14	14	14	:	17	16	16	16
Day cases discharges per 100 000 inhabitants	10,667	15,542	16,500	17,425	18,404	18,998	19,311	20,016	20,270	20,809	:	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	86.0	87.0	87.1	88.8	89.2	91.4	91.9	92.6	93.8	93.3	94.7	77.1	76.4	76.5	76.8
Hospital average length of stay	6.5	6.3	7.4	7.7	6.7	6.6	6.4	6.2	6.0	6.0	6.4	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	44.0	53.2	54.6	56.3	58.1	59.3	60.0	59.4	60.0	60.3	:	28.0	29.1	30.9	32.3

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in pps. Ireland	EU
AWG reference scenario	4.1	4.3	4.4	4.6	4.8	4.9	5.0	5.1	5.1	5.2	5.2	5.1	1.0	0.9
AWG risk scenario	4.1	4.4	4.6	4.9	5.2	5.4	5.5	5.6	5.7	5.8	5.8	5.8	1.7	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in % Ireland	EU
Population projections until 2070 (millions)	4.7	4.9	5.0	5.1	5.3	5.4	5.5	5.7	5.8	5.9	6.0	6.0	29.4	2.0

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

Ireland

Long-term care systems

3.14. IRELAND

General context: Expenditure, fiscal sustainability and demographic trends

GDP per capita in PPS thousand is at €47,800 and far above EU average of €29,600 in 2015. Ireland has a population of 4.7 million inhabitants ([512]). It should be noted that in 2015 the GDP of Ireland grew by 25.1% from its 2014 level, which has a strong effect on some of the variables presented as a ratio of GDP in this country profile ([513]).

During the coming decades the population will steadily increase to 6 million inhabitants in 2070. Thus, Ireland is facing a considerable increase of its population by 29%, while the EU average population is estimated to increase by 2%.

Health status

Life expectancy at birth for both women and men was, in 2015, respectively 83.4 years and 79.6 years and is slightly above the EU average (83.3 and 77.9 years respectively). However, the healthy life years at birth for both sexes are 67.9 years (women) and 66.6 years (men) significantly above the EU-average (63.3 and 62.6 respectively). At the same time, the percentage of the Irish population having a long-standing illness or health problem is lower than in the Union as a whole (26.8% and 34.2% respectively in 2015). The percentage of the population indicating a self-perceived severe limitation in its daily activities has decreased since 2005, and is significantly lower than the EU-average (5.4% against 8.1%).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 0.25 million residents living with strong limitations due to health problems in 2016, an increase of 88% is envisaged until 2070 to slightly more than 0.46 million. That is a far steeper increase than in the EU as a whole (25%). Also as a share of the population, the dependents are becoming a bigger group, from 5.3% to 7.7%, an increase of 46% (EU: 21%).

([512]) This is according to Eurostat projections.

([513]) Real GDP based on 2017 National Income and Expenditure Accounts. Nominal growth in 2015 was 34.4%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 1.9 pps of GDP by 2070 ([514]). The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 3.4 pps of GDP by 2070. Ireland faces low fiscal sustainability risks in the short run and medium term, but risks are medium in the long term, risks, due to the significant projected increase in ageing costs including health care and long-term care ([515]).

System Characteristics ([516])

The National Positive Ageing Strategy (NPAS) was published in 2013. It is the first policy document focused on the care of older people since the publication of "The Years Ahead" in 1998. It represents the over-arching blueprint for age related policy and service delivery across Government and society in the years ahead (Department of Health, 2013).

A Framework for Improved Health and Wellbeing 2013-2025 (Department of Health, 2013) is a reform within Ireland's ongoing health reform programme that is of key importance to the implementation of the NPAS.

The Nursing Homes Support Scheme (NHSS), introduced in 2009, had the aim of ensuring consistency in the funding of nursing home care by the State and individuals. Its aim was to ‘make long term nursing home care accessible, affordable and anxiety free’ (Department of Health and Children, 2009). It replaced the previous Nursing

([514]) The 2018 Ageing Report https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf.

([515]) Fiscal sustainability Report (2018), Institutional Paper 094, January 2019, European Commission.

([516]) This section draws on OECD (2011b) and ASISP (2014).

Home Subvention Scheme which hugely subsidised care for some recipients, but meant a great number of recipients having to pay for the majority of the extremely high care costs.

In line with government policy, home support services are provided to assist older people to live as independently as possible in their own homes and communities. In addition to the mainstream Home Help (HH) service, enhanced home care is provided through Home Care Packages (HCP), introduced in 2005 and, since 2014, Intensive Home Care Packages for people with complex care needs In 2018, the funding streams for HH and standard HCPs were combined and a single Home Support Service came into operation, streamlining the application process and facilitating service users to move to changed levels of service as their assessed needs change. The target for this year is to provide 17.09 HSS hours to 50,500 people. This compares with 16.34 hours (HH & HCPs) to 50,000 people in 2017. In addition, 235 Intensive HCPs will provide 360,000 hours to people with complex needs.

The provision of short-stay residential beds is a key component of the integrated model of care planned for the delivery of services to older people. Short stay beds are allocated across 'step up/step down' care**,** intermediate care, rehab and respite care depending on current demands. In 2018, approximately 2,000 short-stay residential care beds will be provided. In addition, to facilitate discharge from acute hospitals, there is a targeted provision of approximately 850 transitional care beds at any one time.

Services are provided on the basis of assessed health-care need and there is no means-testing. Other services include day care which provides about 28,000 places per week in 299 centres, and meals-on-wheels provided by 345 centres.

In contrast to most other EU countries, the public expenditure long-term care takes exclusively the shape of in-kind benefits, with no role for cash benefits, beyond those provided to carers.

Administrative organisation

Long-term care is funded and delivered as part of the health services in Ireland under the auspices of the HSE. The responsible minister is the Minister of State with responsibility for Mental Health and Older People at the Department of Health. The Minister for State for Older People is also responsible for the coordination of policy beyond the Department of Health.

The Health Service Executive (HSE) of Ireland is responsible for providing and/or supervising a wide range of residential, community and home services designed to support people to live at home.

Types of care

In Ireland, long-term care can be taken to include both home care and residential care. This gives a four-fold classification of long-term care: older people/people (under 65) with disabilities, residential care/domiciliary care.

Several schemes/benefits provide support for people who require long-term care.

The Nursing Homes Support Scheme provides financial support towards the cost of long-term nursing home care. A care needs assessment is carried out by an appropriate healthcare professional to identify whether an applicant to the Scheme requires long-term care

Home care is an increasingly important component of the supports offered to older people. These services are critical to support older people to stay in their own homes and communities, and maintain their independence for as long as possible. They also facilitate the discharge of older people from hospital when the acute phase of their care has been completed.

Home Support Services are provided on the basis of assessed health-care need carried out by health care professionals and there is no means-testing. People are cared for at home under a wide variety of arrangements, both formal and informal. The HSE provides services both directly and through service agreements with private and voluntary sector providers.

Home Support Services provide personal and/or essential domestic care to dependent people to support them to live at home. In particular, they

are aimed at older people living in the community who are in acute hospitals and are at risk of admission to long-term residential care.

Eligibility criteria

Applicants to the Nursing Homes Support Scheme must undergo care needs and financial assessments to determine a) whether long-term nursing home care is the most appropriate option (Care Needs Assessment) and b) what they can afford to contribute towards their cost of care. Anyone who is assessed as requiring long-term nursing home care can avail of the scheme, regardless of age. However, nursing home care must be appropriate to meet the individual's care needs. The legislation underpinning the Nursing Homes Support Scheme requires each private nursing home to negotiate and agree a price for long-term residential care services with the National Treatment Purchase Fund (NTPF), should they wish to be an approved nursing home for the purposes of the Scheme. This is a necessary feature of the scheme due to the commitment by the State to meet the full balance of the cost of care over and above a person's contribution.

To access Carer's Benefit, Carer's Allowance, Constant Attendance Allowance and Carer's Support Grant, the applicant must submit information from the care recipient's doctor as to the degree of care required. This is reviewed by a Department of Social Protection medical assessor and the benefits are provided by the Department of Social Protection.

Co-payments, out of the pocket expenses and private insurance

Under the NHSS scheme people make a contribution of up to 80% of their assessable income and a maximum of 7.5% of the value of any assets towards the cost of care and the State will pay the balance. In the case of a couple, the applicant's means are assessed as 50% of the couple's combined income and assets. The first €36,000 of assets, or €72,000 for a couple, is not counted in the financial assessment. Where assets include land and property in the State, the 7.5% contribution based on such assets may be deferred and collected from the person's estate. This is an optional Nursing Home Loan element of the scheme. An individual's principal residence is only included in the financial assessment for the first three years of their time in care. This is known as 'the three-year cap'

Government policy is to support older people to live in dignity and independence in their own homes and communities for as long as possible. This is achieved through a range of community based services such as mainstream Home Support Services, Meals-on-Wheels and Respite or Day Care. Intensive HCPs, for those with high dependency levels were introduced in 2014.

Role of the private sector

Public, voluntary and private for profit providers provide long-term care in Ireland. In the past most long-term care was either provided by public or publicly funded care providers (often run by Catholic and Protestant churches) or informally typically by family members (Wren, 2009). The last few years have seen a sharp increase in private providers of home care. There is no official register of private and not-for-profit home care companies, but it is estimated that currently there are in excess of 130 such providers (including franchises). This reflects a decline in informal care and a significant increase in the HSE budget allocation to home care services.

Formal/informal caregiving

Overall Government policy in Ireland is to maintain and support older people at home and in their communities. The Department of Social Protection operates a number of income support schemes for people who stay at home to care for elderly persons or persons with disabilities.

Carer's Allowance: Carer's Allowance is a means-tested payment for carers who look after certain people in need of care and attention on a full-time basis. Those in receipt of another social welfare payment and providing someone with full time care and attention may qualify for a reduced rate of carer's allowance in addition to the original payment.

Care Sharing: From 14 March 2005, two carers who are providing care on a part-time basis in an established pattern can be accommodated on the carer's allowance scheme.

Carer's Benefit: Carer's Benefit is a payment for people who have made social insurance contributions and who have recently left the workforce and are looking after somebody in need of full-time care and attention. Carer's benefit may be claimed for a total of 2 years for each person being cared for. Carers Leave (unpaid) may be applied for by those seeking to obtain leave to care from their place of work.

Carer's Support Grant: The Carer's Support Grant is an annual payment for full-time carers who look after certain people in need of full-time care and attention. The payment is made regardless of the carer's means but is subject to certain conditions.

The HSE provides respite care to give carers a break from caring. Respite is provided based on need and within available resources.

Prevention and rehabilitation policies/ measures

The National Positive Ageing Strategy was published in April 2013. This Strategy provides the blueprint for a whole of Government and whole of society approach to planning for an ageing society. The Strategy provides a vision for an age-friendly society and includes four National Goals and underpinning objectives to provide direction on the issues that need to be addressed to promote positive ageing.

The Department of Health has framed a new approach to improve engagement between stakeholders and relevant Departments and Agencies. The inaugural Positive Ageing Stakeholder Forum was held in March 2017, and was attended by civic society organisations who are representative of the needs and views of older people in Ireland. On foot of the success of and interest in the Stakeholder Forum, a second Forum is due to be held in late 2018.

The Cabinet Committee on Social Policy oversees the implementation of the Strategy. As part of the NPAS implementation process, a Healthy and Positive Ageing Initiative has been established to provide evidence of the factors contributing to healthy ageing, including at local level and ultimately inform policy responses to population ageing in Ireland. The first national Positive Ageing Indicators report was published in 2016 and highlights many of the positive and negative aspects of growing old in Ireland. A second national Positive Ageing Indicators report is due for publication in late 2018.

The National Carers Strategy was published in July 2012 and sets the strategic direction for policies, services and supports provided by Government Departments and agencies for carers. It sets out a vision to work towards an ambitious set of National Goals and Objectives to guide policy development and service delivery, to ensure that carers feel valued and supported to manage their caring responsibilities with confidence and are empowered to have a life of their own outside of caring.

Recently legislated and/or planned policy reforms

Recently legislated and planned reforms

The Nursing Homes Support Scheme (NHSS), often referred to as the "Fair Deal" is a scheme of financial support for people who require long-term nursing home care. The statutory based scheme commenced on the 27th October 2009 with the enactment of the Nursing Homes Support Scheme Act 2009 and replaced the scheme of Nursing Home Subvention, which had been in existence since 1993. The NHSS is operated by the HSE. When the Scheme commenced in 2009, a commitment was made that it would be reviewed after three years. The Report of the Review was published in July 2015.

The Government is committed to promoting care in the community so that people can continue to live in their own homes for as long as possible. To support this, the Department of Health is currently engaged in the development of a new, stand-alone statutory scheme and a system of regulation for home-care services.

The new home-care scheme will introduce clear rules in relation to the services for which individuals are eligible and in relation to service-allocation. It will therefore be an important step in ensuring that the system operates in a consistent and fair manner and will help to improve access to home-care services on an affordable and sustainable basis. The introduction of a system of

regulation for home-care will help to ensure public confidence in the services provided.

Policy reforms under preparation/adoption

It is estimated that there are currently 55,000 people with dementia in Ireland. This number is expected to treble to approximately 157,000 by 2046. Given the increasing numbers of people with dementia, the Government published Ireland's first National Dementia Strategy in December 2014.

The Irish National Dementia Strategy aims to improve dementia care to allow people with dementia to live well for as long as possible and have services and supports delivered as well as possible. A National Dementia Office was established in the HSE in 2015 to drive the Strategy's implementation. A mid-term review of the Strategy (May 2018) noted that good progress has been made on implementing many of the Strategy's 35 priority and additional actions but that additional financial and staffing resources will be required in the areas of diagnosis, post-diagnostic supports, primary care, acute care, home care and housing if the Strategy is to be fully implemented.

Possible future policy changes

The Review of the Nursing Homes Support Scheme included a general examination of the Scheme, as well as the balance between residential care and care in the community, and a number of key issues have been identified for more detailed consideration across Departments and Agencies. To this end, an Interdepartmental/Agency Working Group has been established to oversee the implementation of certain recommendations contained in the Review. On foot of recommendations within the Review, it has been undertaken to amend the scheme, affording farms and small businesses similar consideration, in certain circumstances, as principle private residences with regards the 'three-year cap'. This is in progress. As the Scheme is statutory based, the implementation of recommendations arising from the Review may require amendments to the Nursing Homes Support Scheme Act 2009.

Challenges

Ireland has taken significant steps to provide its population with good quality care and to provide care in the community. The main challenges of the system appear to be:

- **Improving the governance framework:** To set the public and private financing mix and organise formal workforce supply; To face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; To use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation.

- **Improving financing arrangements:** To consider better pooling across generations, e.g. by levying LTC premia on those aged 40 years and over or by requiring also retirees to contribute premia to social LTC insurance, based on their pension; To explore the potential of private LTC insurance as a supplementary financing tool; To determine the extent of user cost-sharing on LTC benefits.

- **Encouraging home care**: To develop alternatives to institutional care by e.g. developing new legislative frameworks encouraging home care and regulation controlling admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage home care; To monitor and evaluate alternative services, including incentives for use of alternative settings.

- **Ensuring availability of formal carers:** To determine current and future needs for qualified human resources and facilities for long-term care; To seek options to increase the productivity of LTC workers.

- **Supporting family carers:** To establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not

encouraged to withdraw from the labour market for caring reasons.

- **To facilitate appropriate utilisation across health and long-term care:** To arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for LTC; To create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system; To steer LTC users towards appropriate settings.

- **Improving value for money:** To encourage competition across LTC providers to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; To invest in ICT as an important source of information, care management and coordination.

- **Prevention:** To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 3.14.1: **Statistical Annex - Ireland**

GENERAL CONTEXT

GDP and Population	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
GDP, in billion euro, current prices	170	185	197	188	170	168	172	176	180	195	262	12,451	13,213	13,559	14,447
GDP per capita, PPS	32.7	33.8	35.1	32.1	30.6	33.1	34.2	34.5	34.5	37.1	47.8	26.8	28.1	28.0	29.6
Population, in millions	4.1	4.2	4.3	4.5	4.5	4.5	4.6	4.6	4.6	4.6	4.7	502	503	505	509
Public expenditure on long-term care (health)															
As % of GDP	:	:	:	:	:	:	:	:	1.8	1.7	1.4	1.1	1.2	1.2	1.2
Per capita PPS	:	:	:	:	:	:	:	:	574.9	582.9	624.0	264.1	283.2	352.1	373.6
As % of total government expenditure	:	:	:	:	:	:	:	:	4.5	4.6	4.7	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
Health status															
Life expectancy at birth for females	81.3	81.7	82.1	82.4	82.7	83.1	83.0	83.1	83.1	83.5	83.4	82.6	83.1	83.3	83.3
Life expectancy at birth for males	76.7	76.9	77.3	77.9	77.8	78.5	78.6	78.7	79.0	79.3	79.6	76.6	77.3	77.7	77.9
Healthy life years at birth for females	64.0	64.9	65.6	65.1	65.2	66.9	68.3	68.5	68.0	67.5	67.9	62.0	62.1	61.5	63.3
Healthy life years at birth for males	62.9	63.2	62.9	63.5	63.9	65.9	66.1	65.9	65.8	66.3	66.6	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	25.4	24.9	24.5	26.2	28.3	26.5	26.7	27.7	27.1	26.8	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	6.1	5.9	5.5	5.4	5.2	4.9	4.9	5.6	5.8	5.4	8.3	8.3	8.7	8.1

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
Number of people receiving care in an institution, in thousands	:	:	22	22	22	22	23	23	27	28	28	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	51	52	53	54	55	56	65	66	67	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	1.7	1.7	1.7	1.7	1.7	1.7	2.0	2.0	2.0	2.0	2.2	2.2	2.2
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients															
Providers															
Number of informal carers, in thousands	:	161	:	:	:	:	187	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	21	26	25	24	25	24	24	24	25	:	:	:	:

Source: EUROSTAT, OECD and WHO.

Table 3.14.2: **Statistical Annex - continued - Ireland**

PROJECTIONS

Population	**2016**	**2020**	**2030**	**2040**	**2050**	**2060**	**2070**	**MS Change 2016-2070**	**EU Change 2016-2070**
Population projection in millions	4.7	4.9	5.2	5.4	5.7	5.9	6.0	29%	2%
Dependency									
Number of dependents in millions	0.25	0.26	0.31	0.36	0.40	0.44	0.46	88%	25%
Share of dependents, in %	5.3	5.4	6.1	6.7	7.1	7.5	7.7	46%	21%
Projected public expenditure on LTC as % of GDP									
AWG reference scenario	1.3	1.4	1.7	2.1	2.7	3.1	3.3	145%	73%
AWG risk scenario	1.3	1.4	1.9	2.6	3.4	4.3	4.8	255%	170%
Coverage									
Number of people receiving care in an institution	35,036	38,024	49,307	63,982	80,168	97,649	109,458	212%	72%
Number of people receiving care at home	69,231	75,509	97,136	121,738	147,391	172,235	184,783	167%	86%
Number of people receiving cash benefits	0	0	0	0	0	0	0	:	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	2.2	2.3	2.8	3.4	4.0	4.6	4.9	119%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	42.3	43.0	46.5	51.4	56.3	61.1	63.6	50%	33%
Composition of public expenditure and unit costs									
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	0%	5%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	:	-27%
Public spending on institutional care (% of tot. publ. spending LTC in-kind)	59.3	59.3	59.6	60.3	61.0	61.8	62.7	6%	0%
Public spending on home care (% of tot. publ. spending LTC in-kind)	40.7	40.7	40.4	39.7	39.0	38.2	37.3	-8%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	106.2	103.3	105.9	108.2	115.1	116.6	113.5	7%	10%
Unit costs of home care per recipient, as % of GDP per capita	36.9	35.7	36.5	37.5	40.1	40.8	40.0	8%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	:	:	:	:	:	:	:	:	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).