European Commission

Ireland

Health Care & Long-Term Care Systems

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Ireland

Health care systems

1.14. IRELAND

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

Ireland has a GDP per capita of 33.9 PPS (in thousands), far above the EU average of 27. 9.

Population was estimated at 4.6 million in 2013.

Total and public expenditure on health as % of GDP

Total expenditure ([133]) on health as a percentage of GDP (8.9% in 2013) has increased over the last decade (from 7.3% in 2003, although it has decreased since the 2009 peak of 10%) but is still below the EU average ([134]) of 10.1% in 2013. Public expenditure has increased, though to a smaller extent: from 5.6% in 2003 to 6.0% of GDP in 2013. Again, it is below the peak of 7.2% in 2009. It is also below the EU average of 7.7% in 2013.

When expressed in per capita terms, total current spending on health at 3156 PPS in Ireland is above the EU average of 2988 in 2013. However, public current spending on health care is, at 2136 PPS, lower than the EU average of 2208 PPS in 2013.

Expenditure projections and fiscal sustainability

According to Eurostat 2013 projections, total population in Ireland is projected to increase from around 4.5 million in 2011 to 5.3 million in 2060.

As a consequence of demographic changes, health care expenditure is projected to increase by 1.2 pps of GDP, above the average growth expected for the EU (0.9) ([135]), 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 1.9 pps of GDP from now until 2060 (EU 1.6).

Overall, for Ireland no significant short-term risks of fiscal stress appear at the horizon, though some macro-financial variables point to possible short-term challenges.

Risks appear to be high in the medium term from a debt sustainability analysis perspective due to the still high debt at the end of projections (2026) and the high sensitivity to possible shocks to nominal growth and interest rates. High medium-term risks emerge also from the analysis of the sustainability gap indicator S1, again due to the high initial debt-to-GDP ratio and the projected costs of ageing, thus leading to overall high risks for the country in the medium term.

No significant sustainability risks appear over the long run, despite increasing costs of ageing, due a relatively favourable initial budgetary position.

Health status

Life expectancy at birth (83.1 years for women and 79.0 years for men in 2013) is close to the respective EU averages (83.1 and 77.6 years of life expectancy in 2013).([136]) However, healthy life years, at 68 years for women and 65.8 years for men, were far above the EU averages of 61.8 and 61.6 in 2013. The infant mortality rate of 3.5 deaths per 1,000 live births (0.35%) 3.5 lower than the EU average of 3.9 deaths per 1,000 live births (0.39%) in 2013, having gradually fallen over most of the last decade (from 0.51% % in 2003), although it has been relatively flat since 2006.

As for the lifestyle of the Irish population, data from the 2015 Healthy Ireland survey has shown that 23% of the Irish population aged 15 and over are regular smokers This 2015 Healthy Ireland survey also shows that 23% of the Irish population aged 15 and over are obese while the survey also shows a reduction in alcohol consumption from

([133]) 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.

([134]) 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.

([135]) I.e. considering the "reference scenario" of the projections (see The 2015 Ageing Report at http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

([136]) 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.

12.7 litres per capita in 2003 to 11 litres in 2015, but still above the EU average of 10.0 in 2012.

System characteristics

Coverage

All persons ordinarily resident in the country are entitled, subject to certain charges, to all in-patient public hospital services in public wards including consultant services and out-patient public hospital services including consultant services. Some groups are exempted from the charges (e.g. pregnant women, those suffering from certain medical conditions) and there is an annual cap of EUR 750 for these charges. A medical card ensures free access to all general practitioner services, prescribed drugs ([137]), emergency, inpatient, outpatient, certain dental aural ophthalmic and maternity care. Those with an income up to 50% above the income threshold for a medical card are eligible to free general practitioner services (GP visit card holders). Since Summer 2015 all children under 6 years of age (1st July 2015) and all persons of 70 years and older (4th August 2015) are eligible for free general practitioner services. The remainder of the population are not entitled to free GP services.([138]) Non-medical card holders are not covered for aural, ophthalmic and dental care and must also pay the first EUR 144 each month towards prescribed pharmaceuticals; thereafter the public health system covers 100% of the cost.

Administrative organisation and revenue collection mechanism

In 2013, 67.7% 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. Each year the Parliament (Oireachtas) 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 for the Minister for Health's approval, its National Service Plan 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, as approved by Parliament, in delivering at a minimum, the levels of service which are provided for in the Plan. During the course of the year, detailed information related to service activity level and expenditure levels are provided to the Minister 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 32.3% in 2013) and is above the EU average (22.6% in 2013).

Note also that more than 40% of the private expenditure is voluntary community-rated health insurance ([139]) (which 45.8% of the population takes up) to help cover for a) cost-sharing (complementary insurance) when not eligible for a medical card, b) the services and goods excluded from the benefit basket (supplementary) and c) the same goods and services as the primary coverage

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

([138]) 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.

([139]) 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.

(duplicative). ([140]) 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 16.8% of all health-expenditure and have increased since their lowest value of 14.8 in 2007.

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 269, below the EU average of 344 in 2013, below the 2010 peak of 308 (before which it had been steadily increasing). The number of general practitioners (GPs) per 100 000 inhabitants was 73 in 2013, 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 837.

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. ([141]) 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 2013 the number of acute care beds per 100 000 inhabitants was 211, compared to an EU average of 356. The number has been decreased since 2003.

Inpatient hospital discharges per 100 inhabitants in 2013 were, at 13.5, below the EU average of 16.5. There were 20,270 day case discharges per 100,000 inhabitants in 2013, far above the EU average of 7,031. As a result, the ratio of day cases to longer stays is amongst the highest in Europe.

Acute care bed occupancy rates in 2010 were 93.8%, above the EU average of 70.2%. The rates have been increasing since a value of 85% in 2003.

Average length of stay has fallen from 6.5 in 2003 to 5.7 days in 2013, slightly below the EU average of 6.3.

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.

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

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. 40%

([140]) 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.

([141]) 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.

of the population as of June, 2013). ([142]),([143]) 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 practise 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. ([144])

Public remuneration of doctors is determined by the central government and following the severe economic crisis national authorities have been strongly controlling the 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 ([145]) prices on which the activity-based funding system is based and to manage the HIPE ([146]) 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 BE, DK, FR, DE, NL, ES, UK, FI and AT 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

([142]) The remaining 60% of the population must pay GPs on a private fee per visit basis.
([143]) 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.
([144]) Monitoring arrangements based upon measurement of activity and case-mix have been introduced.
([145]) 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.
([146]) HIPE (Hospital Inpatient Enquiry) is the principal source of national data on discharges from acute hospitals in Ireland.

reduction in drug expenditure through more rational prescribing.

Pharmaceutical spending as a proportion of current health spending increased from 15.4% in 2001 to 18.6% in 2010 and then fell to 17.8% by 2012 (OECD figures). .

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:

- Price Reductions

Price reductions of the order of 30% per item reimbursed have been achieved between 2009 and 2013; the average cost per item reimbursed is now running at 2001/2002 levels

- 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 EUR 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 Health (Pricing and Supply of Medical Goods) Act 2013 is expected to promote price competition, a greater use of generics and deliver lower medicine prices for the taxpayer and for patients. The act brought about significant structural change to the system of pricing and reimbursement of medicines in Ireland.

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. Generics now account for over 70% of the total off-patent market by volume and over 50% by value.

Reference pricing, which involves setting a common reimbursement amount for designated interchangeable groups of medicines, has delivered savings in the region of EUR 50 million in 2014 and a further EUR 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.

eHealth, Electronic Health Record

An *eHealth – Strategy for Ireland* was published in December 2013. This Strategy provided for the establishment of a new entity to be known as *eHealth Ireland* to be headed by a Chief Information Officer Though progress has been slower than initially set out, individual health identifiers (IHIs) – the cornerstone of eHealth development – are now finally reaching an operational stage. eHealth Ireland has now been established and a Chief Information Officer was recruited in 2014 and is working on various strands of work. IHIs have been created, as a proof of concept, for 95% of the population, and will when operational be piloted in key strategic systems in the acute and primary care sectors. By 2017, a maternity newborn system is to be rolled out, issuing an IHI to all newborns automatically. A business case for the development of an EHR for Ireland is being finalised and will be published later in 2016 for initial deployment following approval in the new National Children's Hospital.

Recently legislated and/or planned policy reforms

Legislation has been introduced to provide for 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.

The Government has embarked upon a major programme of health reform, the aim of which is to deliver universal healthcare, where access to healthcare is based on need and not on ability to pay.

In April 2014, the *White Paper on Universal Health Insurance* was published which set out in some detail a proposed UHI model. Following its publication, the Department of Health initiated a major costing project, involving the ESRI, the Health Insurance Authority and others, to examine the cost implications of a change to the particular UHI model proposed in the White Paper.

The reports detailing the estimated cost of this UHI model were published on the 18 November 2015. Having considered the findings, it was concluded that the high costs associated with the White Paper model of UHI were not acceptable and that there was a need for further research and cost modelling in relation to the best means to achieve universal healthcare. This work will be carried out under the auspices of the joint Department of Health/ESRI Three-Year Research Programme on Health Reform. Both the research undertaken to date and that planned in the next phase of the costing exercise will assist in deciding on the best long-term approach to achieving the goal of universal healthcare.

In the meantime, work is progressing on key health reforms that are major milestones on the road to universal healthcare and have the potential to drive performance improvement and deliver significant benefits in terms of timely access to high quality care. They include: Healthy Ireland and the public health agenda; building sufficient capacity to satisfy unmet demand; the expansion and development of primary and social care and reforming structures, ICT and financial systems with key initiatives such as the phased extension of GP care without fees, the establishment of Hospital Groups and Community Healthcare Organisations, the implementation of activity-based funding and the improved management of chronic diseases.

The Irish National Dementia Strategy was launched in December 2014. This delivers on a commitment in the Programme for Government to

develop a national Alzheimer's and other dementias strategy to increase awareness, ensure early diagnosis and intervention and develop enhanced community based services.

The Department of Health and the HSE have agreed a joint initiative with the Atlantic Philanthropies to implement significant elements of the Strategy over the period 2014-2017. This National Dementia Strategy Implementation Programme represents a combined investment of EUR 27.5m, with Atlantic Philanthropies contributing EUR 12million, and the HSE contributing EUR 15.5million. This programme will promote a greater focus on timely diagnosis of dementia and on the value of early intervention, along with the long-term objective of making people in Ireland generally more aware and understanding of the needs of people with dementia, and of the contribution that those with dementia continue to make to our society.

A National Office for Dementia has been established within the HSE to coordinate the implementation of the Strategy.

A Monitoring Group, chaired by the Department of Health, has been established to assist with and advise on implementation of the National Dementia Strategy, including the National Dementia Strategy Implementation Programme.

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 sustainability of the health system.

Finally, the Department of Health has launched a pilot data collection of the private hospital sector. This is an important step in order close the current data gap, and allow statistics for Ireland to be viewed in a more comparable way with other Member States.

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 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

- 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 1.14.1: **Statistical Annex – Ireland**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	146	156	170	185	197	188	169	166	174	175	179	9289	9800	9934
GDP per capita PPS (thousands)	30.0	30.9	31.8	32.9	34.5	32.0	30.7	33.0	33.8	34.0	33.9	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	2.0	2.4	3.7	2.8	1.9	-4.2	-7.3	-1.5	1.8	-0.1	-0.6	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	5.0	7.0	2.9	2.0	6.6	9.4	2.6	-8.8	-3.7	1.7	0.0	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	7.3	7.6	7.6	7.5	7.9	9.0	10.0	9.2	8.7	8.9	8.9	10.4	10.1	10.1
Total current as % of GDP	6.6	6.8	6.9	7.0	7.2	8.3	9.2	8.5	8.0	8.1	:	9.8	9.6	9.7
Total capital investment as % of GDP	0.7	0.8	0.6	0.5	0.7	0.7	0.7	0.7	0.7	0.8	:	0.6	0.5	0.5
Total per capita PPS	2394	2681	2837	2991	3234	3424	3375	3045	3000	3063	3156	2828	2911	2995
Public as % of GDP	5.6	5.8	5.8	5.7	6.0	6.8	7.2	6.4	5.9	6.0	6.0	8.1	7.8	7.8
Public current as % of GDP	5.0	5.2	5.2	5.2	5.4	6.2	6.7	5.9	5.5	5.5	:	7.9	7.7	7.7
Public per capita PPS	1770	1964	2074	2176	2319	2443	2294	1983	2035	2070	2136	2079	2218	2208
Public capital investment as % of GDP	0.6	0.6	0.5	0.4	0.5	0.5	0.5	0.5	0.4	0.4	:	0.2	0.2	0.1
Public as % total expenditure on health	76.7	76.3	76.0	75.4	75.7	75.4	72.6	69.6	67.8	67.6	67.7	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	19.3	19.6	19.2	18.8	18.5	17.8	17.3	12.1	15.5	16.7	:	14.8	14.9	:
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	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	15.3	15.0	16.0	16.1	14.8	15.3	16.1	18.2	17.7	16.9	16.8	14.1	14.4	14.1

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												**2009**	**2011**	**2013**
Population, current (millions)	4.0	4.0	4.1	4.2	4.3	4.5	4.5	4.5	4.6	4.6	4.6	502.1	504.5	506.6
Life expectancy at birth for females	80.7	81.1	81.3	81.7	82.1	82.4	82.7	83.1	83.0	83.2	83.1	82.6	83.1	83.3
Life expectancy at birth for males	75.7	76.1	76.7	76.9	77.3	77.9	77.8	78.5	78.6	78.7	79.0	76.6	77.3	77.8
Healthy life years at birth females	65.4	64.2	64.0	64.9	65.6	65.1	65.2	66.9	68.3	68.5	68.0	:	62.1	61.5
Healthy life years at birth males	63.4	62.5	62.9	63.2	62.9	63.5	63.9	65.9	66.1	65.9	65.8	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	66	60	59	57	53	55	50	48	117	110	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	5.1	4.6	3.8	3.9	3.2	3.8	3.3	3.6	3.5	3.5	3.5	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	3.13	2.99	3.01
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	0.18	0.18	0.19
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.10	1.10	1.20	1.20	1.30	1.50	1.60	1.60	1.40	1.40	:	1.60	1.55	1.44
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	0.31	0.31	0.32
Prevention and public health services	:	:	:	:	:	:	:	:	:	:	:	0.25	0.25	0.24
Health administration and health insurance	:	:	:	:	:	:	:	:	:	:	:	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	2.73	2.61	2.62
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	0.16	0.16	0.18
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.72	0.79	0.84	0.90	0.94	1.10	1.23	1.22	1.13	1.13	:	0.79	1.07	0.96
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	0.13	0.12	0.13
Prevention and public health services	0.20	0.20	0.20	0.20	0.20	0.20	0.20	:	:	:	:	0.25	0.20	0.19
Health administration and health insurance	0.14	:	:	:	:	:	:	:	:	:	:	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.14.2: **Statistical Annex - continued – Ireland**

Composition of total as % of total current health expenditure	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	16.7%	16.2%	17.3%	17.1%	18.1%	18.1%	17.3%	18.8%	17.6%	17.3%	:	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	3.2%	3.3%	3.3%
Prevention and public health services	:	:	:	:	:	:	:	:	:	:	:	2.6%	2.6%	2.5%
Health administration and health insurance	:	:	:	:	:	:	:	:	:	:	:	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	14.3%	15.3%	16.0%	17.2%	17.3%	17.6%	18.2%	20.8%	20.7%	20.3%	:	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	1.6%	1.6%	1.6%
Prevention and public health services	4.0%	3.8%	3.8%	3.8%	3.7%	3.2%	3.0%	:	:	:	:	3.2%	2.7%	2.5%
Health administration and health insurance	2.8%	:	:	:	:	:	:	:	:	:	:	1.4%	3.5%	3.5%

Expenditure drivers (technology, life style)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
MRI units per 100 000 inhabitants	:	:	:	0.80	0.85	0.90	1.19	1.24	1.31	1.24	1.33	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	0.9	0.9	0.8
CTS per 100 000 inhabitants	:	:	1.1	1.3	1.4	1.4	1.5	1.5	1.6	1.7	1.8	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	:	:	:	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.1
Proportion of the population that is obese	:	:	:	:	23.0	:	28.5	:	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	:	:	:	:	29.0	27.0	:	:	:	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	12.7	14.3	13.4	13.4	13.4	12.4	11.3	12.8	12.0	11.8	:	10.3	10.0	9.8

Providers	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Practising physicians per 100 000 inhabitants	:	:	:	272	280	290	301	308	267	271	269	329	335	344
Practising nurses per 100 000 inhabitants	:	1246	1236	1274	1296	1288	1274	1294	1261	1260	1240	840	812	837
General practitioners per 100 000 inhabitants	51	52	51	51	53	52	54	56	72	72	73	:	78	78.3
Acute hospital beds per 100 000 inhabitants	280	278	276	270	265	256	234	221	217	209	211	373	360	356

Outputs	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Doctors consultations per capita	:	:	:	:	3.3	:	:	3.8	:	:	:	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	13.7	13.8	13.6	13.7	13.7	13.5	13.2	13.0	12.9	13.7	13.5	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	9,749	10,466	10,667	15,542	16,500	17,425	18,404	18,998	19,311	20,016	20,270	6368	6530	7031
Acute care bed occupancy rates	85.0	85.0	86.0	87.0	87.0	88.8	89.2	91.4	91.9	92.6	93.8	72.0	73.1	70.2
Hospital curative average length of stay	6.5	6.4	6.5	6.3	6.1	6.2	6.1	6.0	5.9	5.9	5.7	6.5	6.3	6.3
Day cases as % of all hospital discharges	41.5	43.1	44.0	53.2	54.6	56.3	58.1	59.3	60.0	59.4	60.0	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	2013	2020	2030	2040	2050	2060	Change 2013 - 2060	EU Change 2013 - 2060
AWG reference scenario	6.0	6.3	6.9	7.3	7.3	7.2	1.2	0.9
AWG risk scenario	6.0	6.5	7.4	8.0	8.1	7.9	1.9	1.6

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

Population projections	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %	EU - Change 2013 - 2060, in %
Population projections until 2060 (millions)	4.6	4.6	4.6	4.7	5.0	5.3	14.3	3.1

Sources: EUROSTAT, OECD and WHO

Ireland

Long-term care systems

2.14. IRELAND

General context: Expenditure, fiscal sustainability and demographic trends

GDP per capita in PPS thousand is at EUR 33.9 and far above EU average of EUR 27.9 in 2013. Ireland has a population of 4.6 million inhabitants.([395]) During the coming decades the population will steadily increase to 5.3 million inhabitants in 2060. Thus, Ireland is facing a considerable increase of its population by 14%, while the EU average population is estimated to increase by 3%.

Health status

Life expectancy at birth for both women and men was, in 2013, respectively83.1 years and 83.1 79 years and is close to the EU average (83.1 and 77.6 years respectively). However, the healthy life years at birth for both sexes are 68.0 years (women) and 66years (men) significantly above the EU-average (61.8 and 61.6 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 (27.7% and 32.5% respectively in 2013). The percentage of the population indicating a self-perceived severe limitation in its daily activities has decreased since 2004, (although it has registered a year-on-year increase in 2013) and is significantly lower than the EU-average (5.6% against 8.7%).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 0.22 million residents living with strong limitations due to health problems in 2013, an increase of 74% is envisaged until 2060 to slightly more than 0.38 million. That is a more steep increase than in the EU as a whole (40%). Also as a share of the population, the dependents are becoming a bigger group, from 4.7% to 7.2%, an increase of 52% (EU: 36%).

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 0.7 pps of GDP by 2060.([396]) 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 2.3 pps of GDP by 2060. Overall, for Ireland risks appear to be high in the medium term from a debt sustainability analysis perspective due to the still high debt at the end of projections (2026) and the high sensitivity to possible shocks to nominal growth and interest rates. No significant sustainability risks appear over the long run, despite increasing costs of ageing, due a relatively favourable initial budgetary position.([397])

System Characteristics ([398])

The National Positive Ageing Strategy (NPAS) was published in 2013. It is the first policy document focused on the care 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 Home 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 Home Subvention Scheme which hugely

([395]) This is according to Eurostat data.

([396]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

([397]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

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

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 2014, 10.3m hours HH were provided to approximately 47,000 clients and 13,200 people were in receipt of a HCP at any given time. In 2015, a total of 10.45m hours of HH were provided to 48,000 people; approximately 15,450 HCPS were in place at any one time and almost 200 people were provided with an Intensive HCP over the course of the year. Projected targets for 2016 are the same as the 2015 outturn figures.

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 2016, over 2,000 short-stay residential care beds will be provided, together with over 300 transitional care beds, aimed at reducing delayed discharges from acute hospitals.

Services are provided on the basis of assessed health-care need and there is no means-testing. Other services include day care for about 20,000 people and meals-on wheels service.

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 Primary Care, Social Care (Disabilities & Older People) and Mental Health at the Department of for 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.

Home Care Packages are aimed at those requiring medium to high support in the community. 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 need 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. The first EUR 36,000 of assets, or EUR 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 Help, Meals-on-Wheels and Respite or Day Care. In more complex cases, enhanced Home Care Packages (HCPs) may be provided. Home Care Packages are an additional support over and above existing mainstream community services. 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 full-time 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.

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 Cabinet Committee on Social Policy will oversee the implementation of the Strategy.

The National Carers Strategy was published in July 2012 and sets the strategic direction for future 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 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.

Policy reforms under preparation/adoption

It is estimated that there are currently 47,000 people with dementia in Ireland. This number is expected to rise to approximately 132,000 by 2041. Given the increasing numbers of people with dementia, the Government gave a commitment to "Develop a national Alzheimer's and other dementias strategy to increase awareness, ensure early diagnosis and intervention and development of enhanced community based services". The Irish National Dementia Strategy was published in December 2014.

Possible future policy changes

The Review of the Nursing Home 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 progress the recommendations contained in the Review. 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 2.14.1: **Statistical Annex – Ireland**

GENERAL CONTEXT

GDP and Population	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
GDP, in billion euro, current prices	146	156	170	185	197	188	169	166	174	175	179	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	30.0	30.9	31.8	32.9	34.5	32.0	30.7	33.0	33.8	34.0	33.9	26.8	27.6	28.0	28.1	27.9
Population, in millions	4.0	4.0	4.1	4.2	4.3	4.5	4.5	4.5	4.6	4.6	4.6	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	:	:	:	:	:	:	:	:	:	:	:	1.0	1.0	1.0	1.0	:
Per capita PPS	:	:	:	:	:	:	:	:	:	:	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	:	:	:	:	:	:	:	:	:	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	80.7	81.1	81.3	81.7	82.1	82.4	82.7	83.1	83.0	83.2	83.1	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	75.7	76.1	76.7	76.9	77.3	77.9	77.8	78.5	78.6	78.7	79.0	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	65.4	64.2	64.0	64.9	65.6	65.1	65.2	66.9	68.3	68.5	68.0	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	63.4	62.5	62.9	63.2	62.9	63.5	63.9	65.9	66.1	65.9	65.8	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	22.2	24.1	25.4	24.9	24.5	26.2	28.3	26.5	26.7	27.7	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	6.6	6.7	6.1	5.9	5.5	5.4	5.2	4.9	4.9	5.6	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
Number of people receiving care in an institution, in thousands	:	:	:	:	22	22	22	22	23	23	27	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	51	52	53	54	55	56	65	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	1.7	1.7	1.7	1.7	1.7	1.7	2.0	2.0	2.2	2.2	2.3	2.1
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	21	19	18	17	17	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

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

PROJECTIONS

Population	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
Population projection in millions	4.6	4.6	4.6	4.7	5.0	5.3	14%	3%
Dependency								
Number of dependents in millions	0.22	0.24	0.28	0.32	0.35	0.38	74%	40%
Share of dependents, in %	4.7	5.3	6.1	6.8	7.0	7.2	52%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	0.7	0.7	0.9	1.1	1.3	1.4	111%	40%
AWG risk scenario	0.7	0.8	1.2	1.7	2.4	3.0	350%	149%
Coverage								
Number of people receiving care in an institution	27,410	31,738	39,813	51,499	63,866	75,023	174%	79%
Number of people receiving care at home	65,385	74,533	89,658	108,890	128,331	143,888	120%	78%
Number of people receiving cash benefits	0	0	0	0	0	0	:	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	2.0	2.3	2.8	3.4	3.9	4.2	106%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	42.6	43.8	46.7	50.5	55.0	57.8	36%	23%
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	0%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	0.0	0.0	0.0	0.0	0.0	0.0	:	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	34.9	35.0	35.4	36.1	36.7	37.3	7%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	65.1	65.0	64.6	63.9	63.3	62.7	-4%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	39.0	37.0	35.6	35.8	38.0	36.8	-6%	-2%
Unit costs of home care per recipient, as % of GDP per capita	30.4	29.2	28.9	30.0	32.6	32.2	6%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	:	:	:	:	:	:	:	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)