Rialtas na hÉireann
Government of Ireland

Analytical Note 2024

International Comparisons of Irish Healthcare Expenditure

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June 2024

Rialtas na hÉireann Government of Ireland
IGEES
Seirbhís Eacnamaíoch agus Luacháil Rialtas na hÉireann
Irish Government Economic and Evaluation Service

Executive Summary – *International Comparisons of Irish Healthcare Expenditure, 2024*

Context:

- The introduction of Sláintecare in 2019 represented an inflection point in Irish healthcare policy. This, along with the impact of Covid-19 on the healthcare system and expanding budgets, make this an opportune time to reflect on Irish healthcare expenditure and to compare it to that of other countries. International comparisons can provide useful information about the scale and structure of healthcare sector funding.
- Throughout this paper, the Irish experience is compared to a set of 43 OECD and EU countries. However, the Irish healthcare system has a unique history, structure and composition. As such, comparisons of Irish healthcare sector metrics to those of other countries need to be undertaken and interpreted carefully.
- Total expenditure on the Irish healthcare system is growing but so too is the relative importance of State healthcare funding. Government expenditure on the Irish healthcare system grew by €10.3bn or 77% between 2015 and 2022.
- The growth of government funding of the healthcare sector outpaced the growth in overall government expenditure between 2015 and 2022. The growth of government funding of healthcare also outpaced the growth in GNI*.

Findings:

- In Ireland in 2022, 77 cents of every euro spent on healthcare was government funding, a higher figure than the average across OECD and EU states. It should be noted that Ireland does not have a social health insurance model and thus the Irish figures only comprise direct government spending.
- Ireland has the second highest proportion of healthcare funding as a share of overall government spending within the OECD and EU dataset; over one of every five euro of government expenditure is spent on the health sector based on OECD definitions. This is an increase on 17.9% in 2015.
- The Irish economy, when the GNI* metric is used, spends a particularly high proportion of national income on the healthcare sector, significantly above the OECD and EU average.
- Ireland has a relatively young population; in 2021, 14.8% of Ireland's population was 65 years of age or older compared to an OECD and EU average of 18.2%. This has implications for healthcare expenditure in the future as older cohorts are medically more expensive and have distinct care needs compared to the general population.
- Ireland's per capita expenditure on healthcare was at $5,861 (PPP) in 2021. This is 28% above the OECD and EU average of $4,587 (PPP); as such, compared to OECD and EU countries, Ireland has a lower than average proportion of older people but higher than average per capita healthcare expenditure.
- Irish healthcare expenditure per capita is above the OECD average, but per capita healthcare volume is below the OECD average.

Key Takeaway Points:

- The expenditure indicators show that healthcare is evidently well-funded relative to other OECD and EU countries, despite a relatively young population. The results also show that the sector has been a priority for budget funding in recent years.
- However, the Irish healthcare sector has been consistently spending more than budget allocations. This poses challenges especially in light of the ageing population, the myriad of demands on public funding and the need to ensure that expenditure levels are sustainable.
- Productivity, efficiency reforms and ensuring value for money will have to become increasingly central to healthcare funding discussions to ensure overall sustainability into the future.

Summary of Key Metrics - 2021

Metric	Ireland	Comparison
Demographics		
Population over the age of 65	14.8%	18.2% (OECD and EU countries)
Population over the age of 80	3.3%	4.9% (OECD and EU countries)
Public Contribution to Healthcare Expenditure		
Healthcare expenditure as a % of overall government expenditure	21.2%	16.4% (OECD and EU countries)
Share of all health expenditure that is from public sources	77.4%	76.2% (OECD and EU countries)
Health Expenditure		
All health expenditure as a % of GDP (and GNI* for Ireland)	12.2% GNI*	9.6% (OECD and EU countries)
Per capita spend on health in US$ PPP	$5,861 PPP	$4,587 PPP (OECD and EU countries)
Age adjusted health expenditure per capita compared to OECD	Index = 130	Index = 100
Non-adjusted health expenditure per capita compared to OECD	Index = 121	Index = 100
Healthcare Utilisation		
Volume of healthcare used compared to OECD	Index = 91	Index = 100[1]

[1] OECD (2023), Health at a Glance 2023: OECD Indicators, OECD Publishing, Paris, https://doi.org/10.1787/7a7afb35-en Figure 7.8

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1 Introduction and Context

1.1 Rationale

There is significant heterogeneity in the funding models, structures and regulation of healthcare systems internationally. However, despite their differences, all healthcare systems have the same objective; to improve the health outcomes of their populations within a sustainable budget. Although the Irish healthcare system has many unique components, looking to other countries provides policy makers with insight, and may inform novel ways of delivering healthcare and/or best practice approaches.

In recent years there has been a notable increase in funding for the Irish healthcare system, with a number of new development items focusing on increased capacity, especially in light of the Covid-19 pandemic and in the context of Sláintecare. This paper compares trends in healthcare funding in Ireland to a range of other developed countries.

1.2 Context

Healthcare systems are deeply linked to the social and economic history of the states in which they operate and even within the EU there is a large degree of diversity in health service structure, funding and regulation; for example, unlike the NHS, the Irish health service did not develop primarily through one defined policy programme but started as a number of voluntary bodies which evolved into what is now a defined health service.[2]

As Ireland has developed economically, so too has the health service. The Irish health service has gone through many significant changes in the past 25 years, including the abolition of Health Boards, the creation of the HSE, and more recently the implementation of the Sláintecare reform programme and the development of health regions. This latest shift is particularly relevant to this work, as the key aims of Sláintecare are starting to manifest in the data, particularly when looking at increasing levels of government spend on healthcare.

This paper compares various healthcare funding and expenditure metrics in Ireland to those of a basket of 43 EU and OECD States. As noted, there is significant heterogeneity in healthcare funding models internationally and the rationale for the use of these countries is that the average of a larger number of diverse industrialised countries will be more reasonable comparison to Ireland than a smaller group.

The paper will first outline the data sources and limitations, Section 3 will outline the main findings in terms of international healthcare expenditure and the final section provides some conclusions.

[2] For information, the Appendix sets out a table detailing differences in healthcare systems across a sample of OECD and EU countries.

2 Methodology and Limitations

2.1 Methodology

Significant consideration went into determining the optimal methodology for undertaking the analysis in this paper. This section outlines key methodological decisions that were made and outlines remaining limitations that should be considered by the reader.

- **Basket of Comparators:** European healthcare systems evolved independently and are distinct in terms of structure, funding models and regulation. In particular, unlike Ireland, many EU countries have universal healthcare systems or social health insurance models. A number have papers have been published recently which compare Ireland's healthcare expenditure to that of the EU-14 (i.e. the 14 countries that were members of the EU before 2004).[3] However, there is no a priori reason for Ireland to be particularly comparable to these countries in terms of healthcare; in fact, at least six of these countries have a majority social health insurance system, and in three countries, service provision is majority private.[4]

  Indeed, there is no country to which Ireland can be directly compared. To avoid the risk of bias by selecting a subgroup of countries, the broadest possible basket of comparator countries is used in this study; specifically, all countries sufficiently developed to be a member of the OECD or the EU. As such, throughout this paper Ireland is compared to 43 countries comprising all 38 OECD countries plus 5 EU member States which are not members of the OECD[5].

- **Time Period:** The graphs in this paper show figures for 2015 and 2021. This displays changes in expenditure over time as well as Ireland's changing position relative to other countries. 2015 was selected as a base year partially due to data availability, and partially as it is a point in time that is somewhat removed from the financial crisis of 2008; it is well established that spend on public services contracted during this period. Using 2015 as a base allows for some element of the financial recovery to be captured, but is also before certain substantial changes within the health service were introduced, e.g. the Sláintecare reform programme and the creation of health regions.

- **Measure of Economic Activity:** GDP is the standard measure of economic activity and counts all output generated within the borders of a country regardless of whether that activity is carried out by domestic or foreign owned firms. However, GDP figures can be problematic due to the repatriation of profits by foreign owned firms. While this is an issue for all countries, it is especially challenging in an Irish context due to the high

[3] Such papers include ESRI (2020) How does Irish Healthcare Expenditure Compare Internationally? and Department of Health (2021) Impact of Demographic Change on Health Expenditure 2022-2025 as well as PBO (2023) Health Spending in Ireland – 2015 to 2023.

[4] Data is from Böhm, Katharina & Schmid, Achim & Götze, Ralf & Landwehr, Claudia & Rothgang, Heinz, 2012. "Classifying OECD healthcare systems: A deductive approach," TranState Working Papers 165, University of Bremen, Collaborative Research Center 597: Transformations of the State.

[5] Bulgaria, Croatia, Cyprus, Malta and Romania are EU members but not part of the OECD.

level of FDI activity which leads to a significant overstatement of domestic economic activity. GNI* (modified GNI) has been developed as an alternative metric and better captures the size of the Irish economy by excluding the effects of globalisation.[6] For completeness, the graphs in this document report figures for Ireland using both GDP and GNI* measures.[7]

- **Measure of Health Expenditure:** In this report, the term "health expenditure" refers to all expenditure within the State on healthcare, including private out of pocket spend by individuals, expenditure by private health insurance companies, and any money spent by the State on healthcare and health services. When "government expenditure" is referenced, this relates to direct spend by the State on healthcare and health services, which is administered in Ireland by the Department of Health and related agencies such as the Health Service Executive (HSE). In some graphs there is reference to "government/compulsory schemes" as a category of expenditure. This refers to spend by the State as well as spend by individuals on compulsory health insurance, which is a common model of health system funding in a number of countries including Germany, Switzerland and the Netherlands. Ireland does not have a compulsory social health insurance system, so all monies in this category are State funding.

- **Inclusion of Disability:** It should be noted that this paper includes disability expenditure to avoid discontinuities in the comparison. However, responsibility for disability services was transferred from the Department of Health to the Department of Children, Equality, Disability, Integration and Youth Affairs in March 2023.

- **Expenditure on Social Care:** Irish health expenditure also includes expenditure on social care. In analysing the impact of Ireland's inclusion of social care expenditure within health expenditure, the ESRI[8] noted that "…countries differ in their accounting and that OECD guidance is ambiguous, particularly in the area of long term care (LTC) expenditure. Although Central Statistics Office (CSO) data are produced in line with OECD guidelines, those guidelines are interpreted differently across a wide range of OECD countries".

  The OECD also conducted analysis in 2017[9] on LTC spending and the inclusion or exclusion of social care spending within health expenditure and found that a number of countries count LTC expenditure within health expenditure rather than social care.
  - Eight EU countries account for 100% of LTC expenditure within health expenditure; Austria, Belgium, Estonia, Greece, Ireland, Italy, Poland and Slovak Republic.
  - Six non-EU countries include 100% of LTC expenditure within health expenditure; Australia, Canada, Iceland, Japan, Korea and United States.

[6] GNI* is GNI minus the depreciation on Intellectual Property, depreciation on leased aircraft and the net factor income of redomiciled PLCs. More detail is available at Modified GNI - CSO - Central Statistics Office
[7] GDP figures are sourced from the OECD. GNI* figures for Ireland are sourced from the CSO.
[8] ESRI, 2020, How Does Irish Healthcare Expenditure Compare Internationally, Research Series Number 114
[9] OECD, 2020, Assessing the comparability of Long-Term Care spending estimates under the Joint Health Accounts Questionnaire

2.2 Limitations

The main limitation of this work is that, while certain aspects may be similar, no two healthcare systems will ever be completely comparable due to different historical contexts, country specific healthcare challenges and sectoral structures. Additionally, the demographics and economies of countries are not directly comparable, even within regions such as the EU. The largest sample of comparator countries as possible are used in this paper in order to capture the full range of funding structures and models and in the hope that the average of these countries captures well the average of all developed countries.

Data availability and comparability is another key limitation of this paper, as data published across countries and health systems may be subject to differing definitions and therefore not be directly comparable. The frequency with which data is published across countries is also a challenge, especially in light of the Covid-19 pandemic.

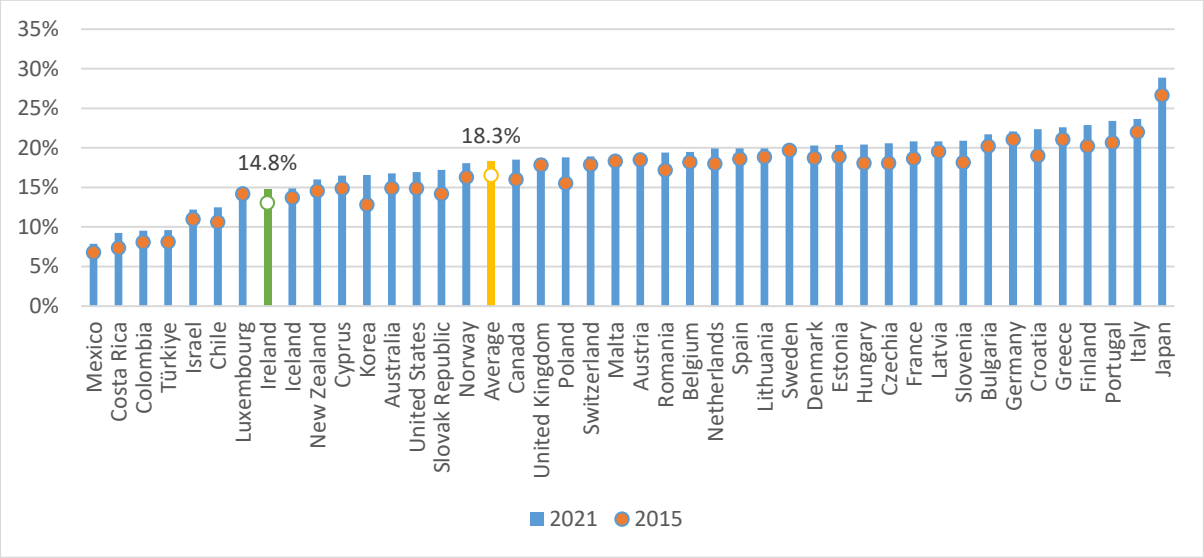
This paper does not explore the drivers of increased expenditure in Irish healthcare, which could include wage growth, the high labour intensity of healthcare, price growth, technological changes and economic development.

3 Analysis of Demographics and Health Expenditure

3.1 Demographic Indicators

Ireland has a relatively young population. As of 2021, Ireland's share of the population over the age 65 was 14.8%, compared to the OECD and EU average of 18.3% (see Figure 1). By contrast, 33.6% of Irish people are below the age of 25, compared to an OECD and EU average of 31.2%. [10]

Figure 1 Percentage of the Population over the Age of 65, Ireland, OECD and EU Countries, 2015 and 2021



Source: OECD Data

The Department of Finance[11] published analysis in 2021 that indicated that the share of the Irish population over the age of 65 is set to grow much faster than other cohorts between now and 2070 stating "the size of the population in Ireland aged 65 and over, and 80 and over will increase dramatically between 2019 and 2070. The change in the composition of the population will be much more dramatic than most other EU member states". These projections indicate growth of approximately 165% in the over 65 cohorts, while the population aged 20 to 64 is anticipated to grow by just under 20% over the same period.

However, Ireland's life expectancy is already higher than the OECD and EU average, 82.4 years compared to 80.1 years. In addition, Ireland's older population declare themselves to be especially healthy; in 2021, 65.8% of the Irish population over 65 rated their own health as good or very good compared to an OECD average of 45.9%.[12]

[10] The data in Figure 1 is sourced from the OECD and is are based on demographic projections. The Irish Census 2022 results provide more up to date details on the Irish population. OECD figures find that 14.8% of the population was above the age of 65 in 2021. This compares to 15.1% according to Census 2022. The OECD states that 33.6% of Irish people were below the age of 25 in 2021. The 2022 Census figure was 32.2%.

[11] Department of Finance, 2021, available at: SPU 2016 - 1c05826e-5682-4537-952d-fce5abb6db33.pdf (www.gov.ie)

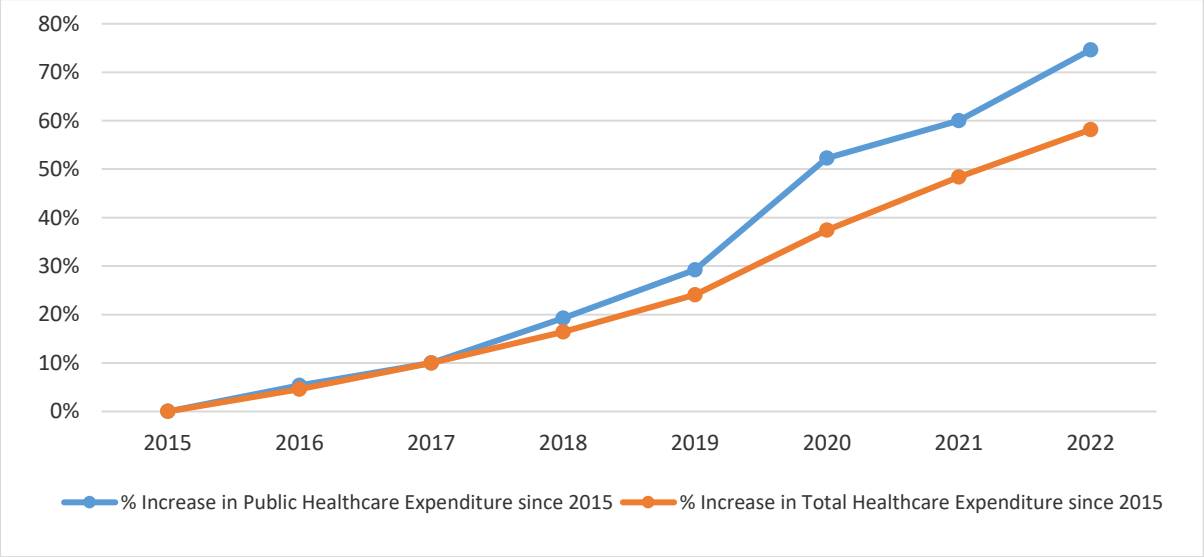
[12] OECD, 2023, Health at a Glance 2023 : OECD Indicators | OECD iLibrary (oecd-ilibrary.org)

3.2 Expenditure

Healthcare in Ireland is available from both public and private service providers. Private healthcare services can be paid for out of pocket or through private health insurance. Individuals, especially in the context of strong economic growth and high incomes, may make the decision to purchase private health insurance.

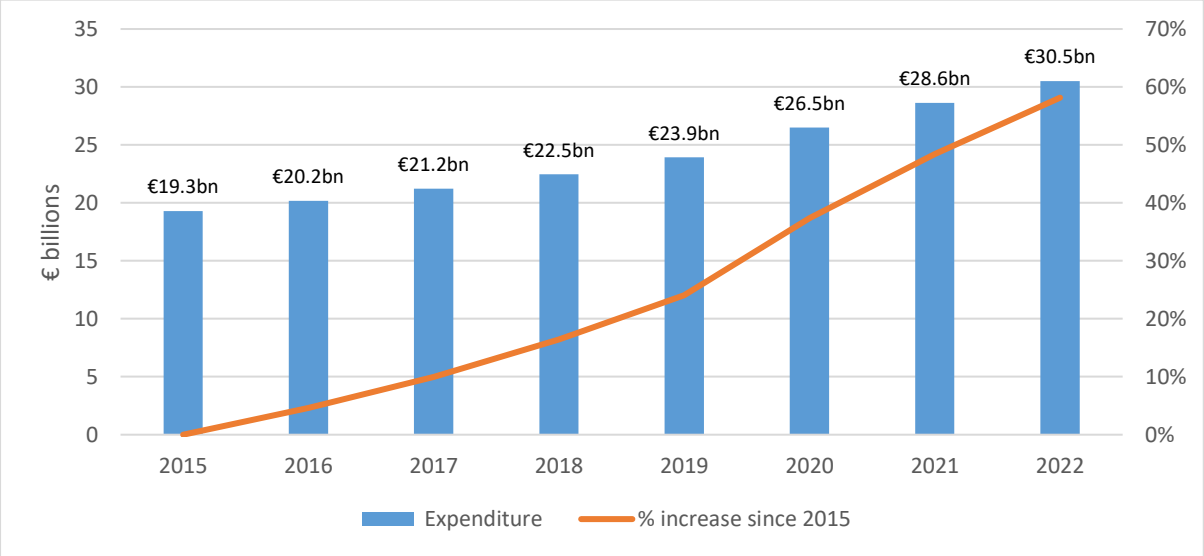
Total healthcare expenditure comprises both public and private payments. Expenditure on Irish healthcare is growing but so is the relative importance of State funding. Public funding of healthcare grew at a faster rate than overall expenditure between 2015 and 2022, increasing by 77% compared to an increase of 58% in overall health expenditure (Figures 2 and 3). Over this period, healthcare expenditure from all sources grew by €11.2bn.

Figure 2 Cumulative Percentage Increases in Irish Public Health and Total Health Current Expenditure, 2015 and 2022



Source: OECD and Department of Public Expenditure, NDP Delivery and Reform Data

Figure 3 Expenditure from all Sources on Irish Health Sector, 2015 to 2022



Source: OECD Data

Figure 4 displays the breakdown of State expenditure across the various sectors of the Irish healthcare system and shows that acute hospitals and social care accounted for over half of overall State healthcare expenditure in 2022. Figure 5 shows expenditure over time across the different health subheadings, with the largest sectoral growth increase in primary care. This is likely a result of changing funding prioritisation arising from Sláintecare[13]; a significant aim of the Sláintecare reform programme is to deliver care at the earliest opportunity, at the lowest level of intensity, and as close to the community as possible. Covid-19 expenditure is captured within "other", which explains the growth seen in this category from 2020 onwards.

Figure 4 Composition of State Expenditure across Irish Health Sector, 2022[14]

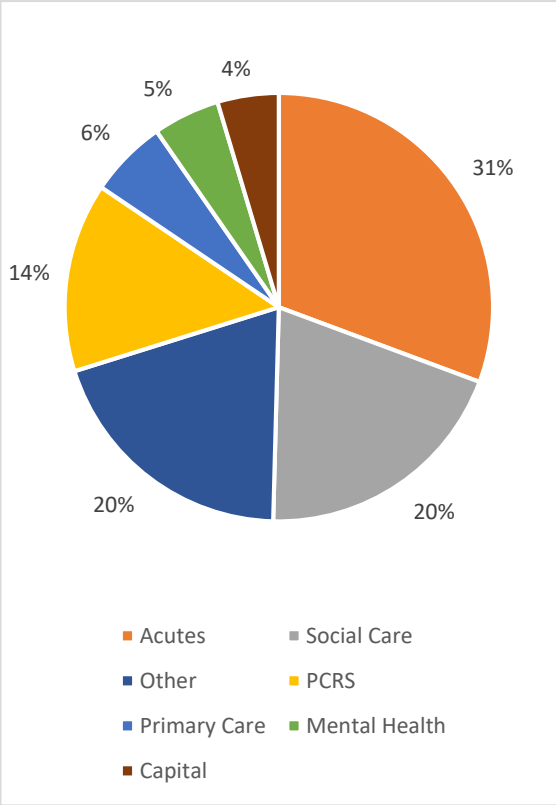
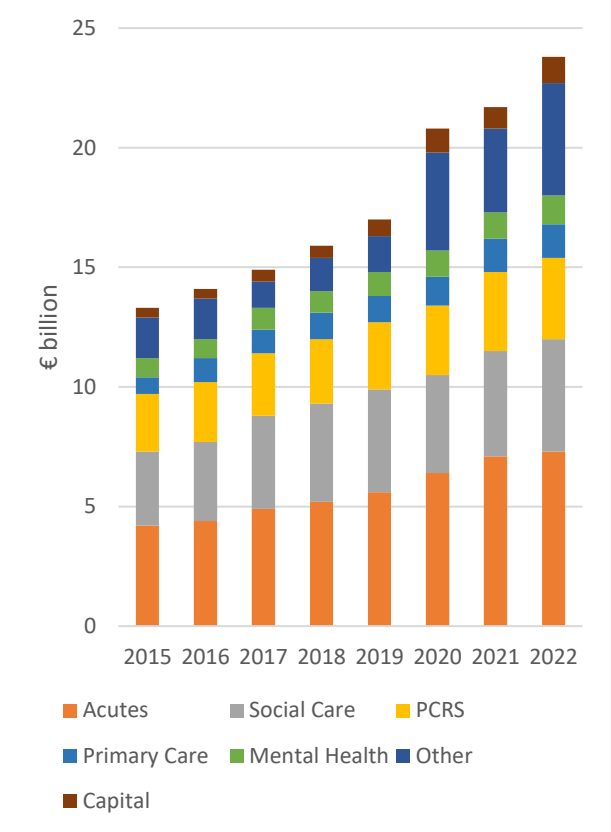


Figure 5 State Expenditure by Health Sector, 2015 to 2022[15]



Source: Department of Public Expenditure, NDP Delivery and Reform Data

3.3 Healthcare Expenditure and Economic Activity

3.3.1 Health Expenditure as a Proportion of Overall Government Expenditure

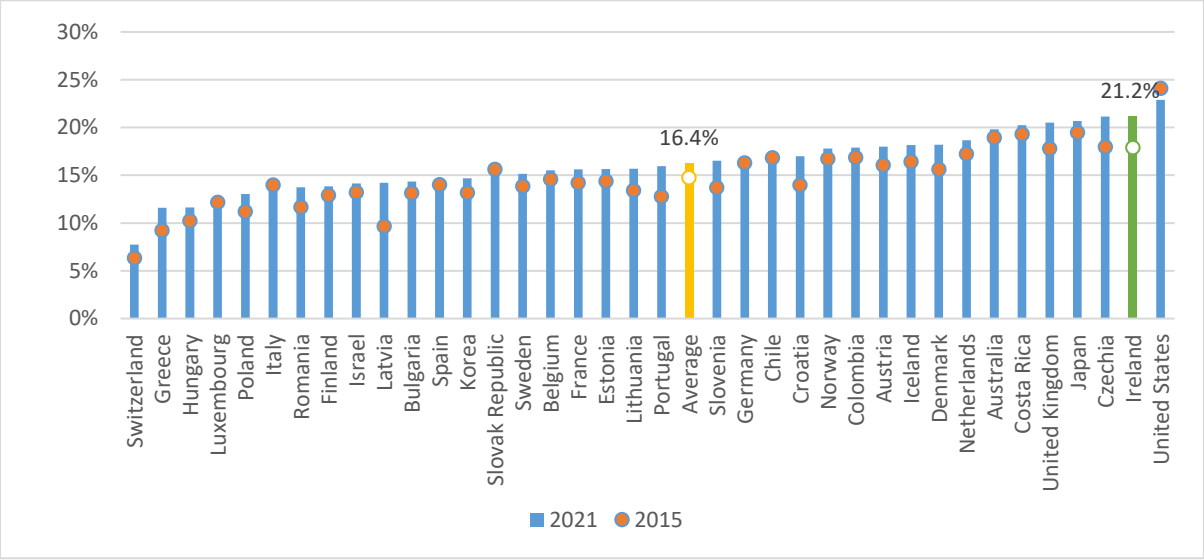
Ireland has the second highest proportion of healthcare funding as a share of overall government spending within the OECD and EU dataset; over one of every five euro of government expenditure is spent on the health sector (21.2%). This is an increase on 17.9%

[13] For more information on Sláintecare see gov.ie - Sláintecare (www.gov.ie)
[14] The "other" category includes, inter alia, covid-19 expenditure, health and wellbeing, pensions, State claims, European Health Insurance Card, treatment abroad and cross border healthcare.
[15] The "other" category includes, inter alia, covid-19 expenditure, health and wellbeing, pensions, State claims, European Health Insurance Card, treatment abroad and cross border healthcare.

in 2015 (Figure 6). Total health expenditure by the Irish State increased by 77% between 2015 and 2022. As such, the funding being provided to healthcare is a larger proportion of an increasingly large budget. This illustrates increased prioritisation of healthcare by the State.

However, it should be noted that a high proportion of health expenditure within State expenditure is not necessarily positive, as there are associated opportunity costs. The over-prioritisation of health could result in constrained funding for equally valuable services provided by the State such as social welfare or educational supports. It also leaves the health system vulnerable to fiscal risks such as a severe contraction in tax revenue.

Figure 6 Health expenditure as a proportion of overall government expenditure, Ireland, OECD and EU Countries, 2015 and 2021[16][17]



Source: OECD Data

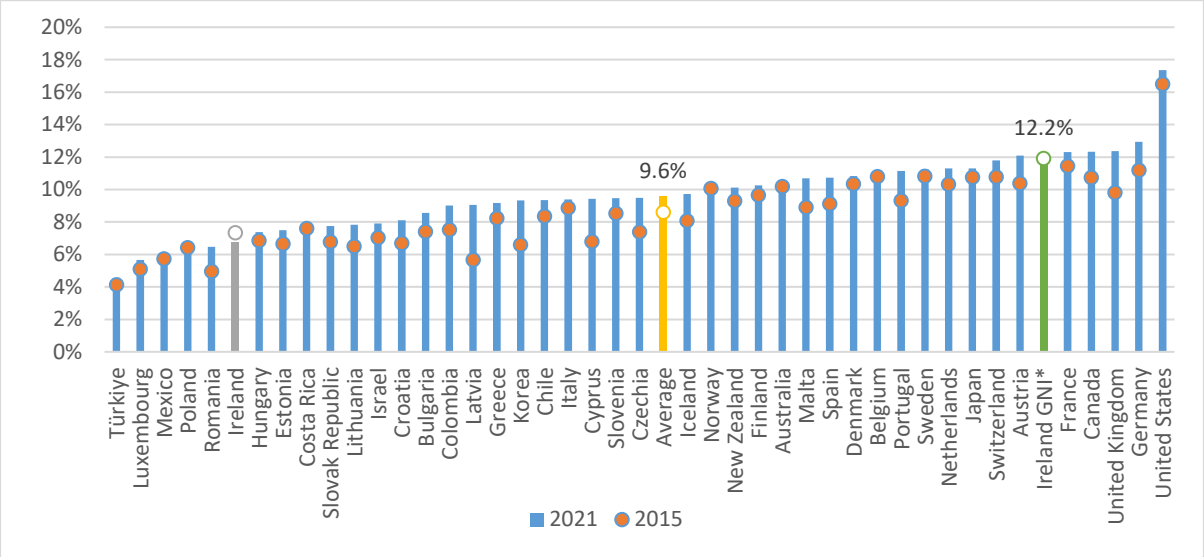
3.3.2 Total Health Expenditure

Just under 12% of the income from economic activity (as measured by GNI*) was spent on health expenditure in Ireland in 2015, a figure which increased to 12.2% by 2021 (Figure 7). The average OECD and EU figure also increased over time, but remains significantly below the Irish figure. The rationale for using GNI* as a measure of economic activity in Ireland is set out in Section 2.1.

[16] Costa Rica and Korea data is from 2020

[17] Canada, Cyprus, Malta, Mexico, New Zealand, Türkiye did not provide data to the OECD on this metric.

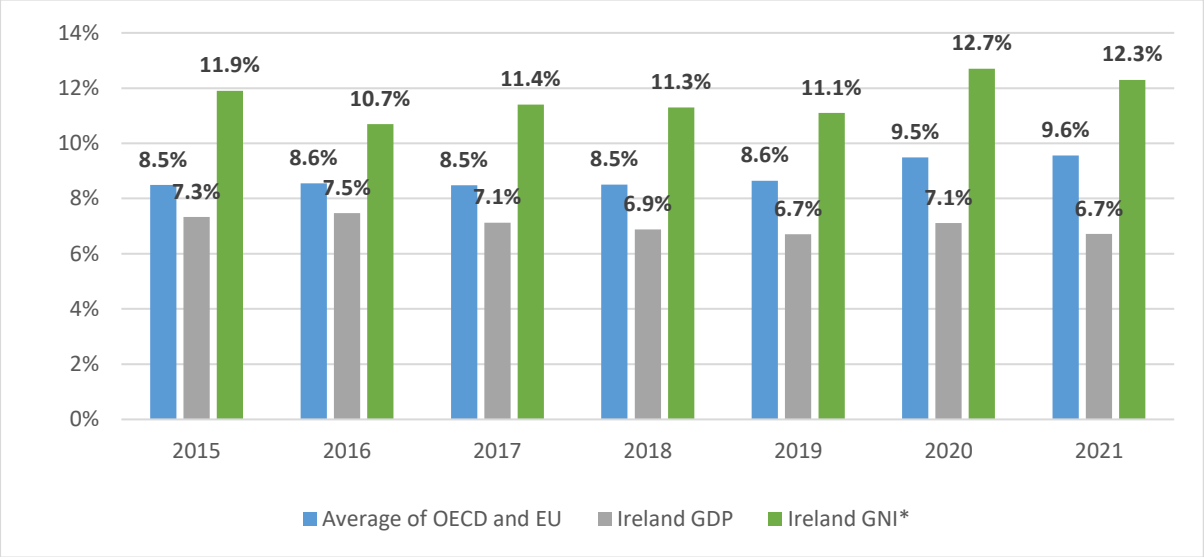
Figure 7 All Health Expenditure as % GDP (and GNI), Ireland, OECD and EU Countries, 2015 and 2021*[18]



Source: OECD and CSO Data

Figure 8 shows health expenditure as a percentage of GDP for the average of EU and OECD countries, and as a percentage of GNI* for Ireland for every year between 2015 and 2021. This expenditure is relatively stable up until the outbreak of the Covid 19 pandemic. This graph also shows clearly the importance of using GNI* rather than GDP for Ireland, with the artificially high GDP figure skewing the health expenditure as a proportion of the economy figure downwards.

Figure 8 All Health Expenditure as % GDP (and GNI) OECD/EU Average 2015 to 2021*



Source: OECD and CSO Data

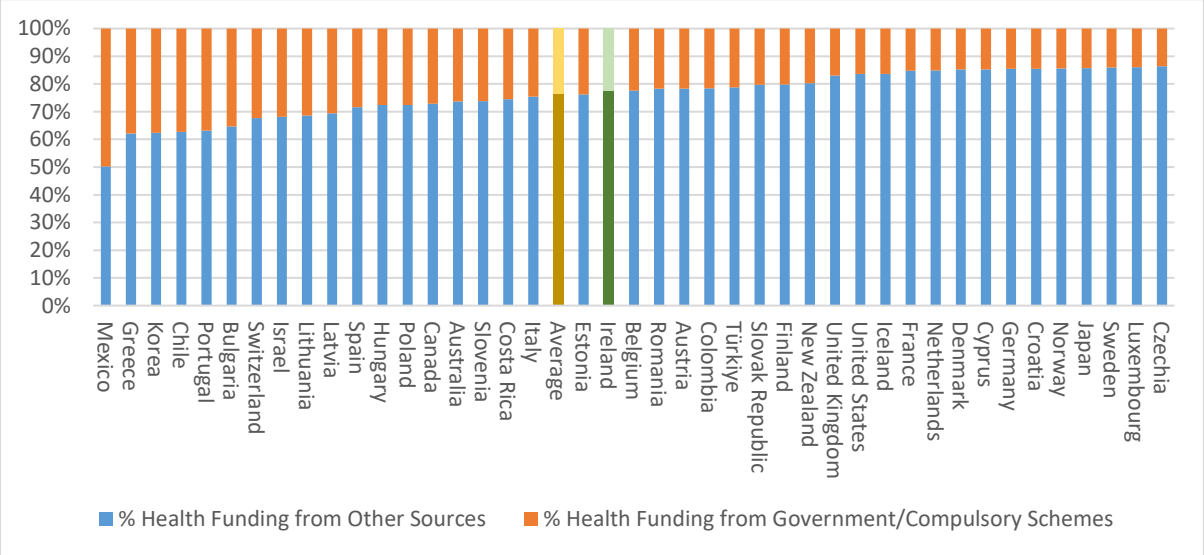
[18] Malta data is from 2020

3.4 Government Expenditure as a Percentage of Health Expenditure

The increased importance of the State in terms of Irish healthcare funding can be seen below. In Ireland in 2021, 77.4 cents of every euro spent on healthcare was government funding (Figure 9). This proportion has increased since 2015 when it was 71.8 cents and shows that government expenditure increased proportionally faster than private, indicating that there is a declining reliance on private healthcare in Ireland.

The Irish State accounts for a greater proportion of health expenditure than the average across OECD and EU states (76.2 cents in 2021). This is particularly striking given that Ireland doesn't have a social health insurance model and thus the Irish figures only comprise direct government spending.

Figure 9 Public and Private Composition of Health Expenditure, Ireland, OECD and EU Countries, 2021



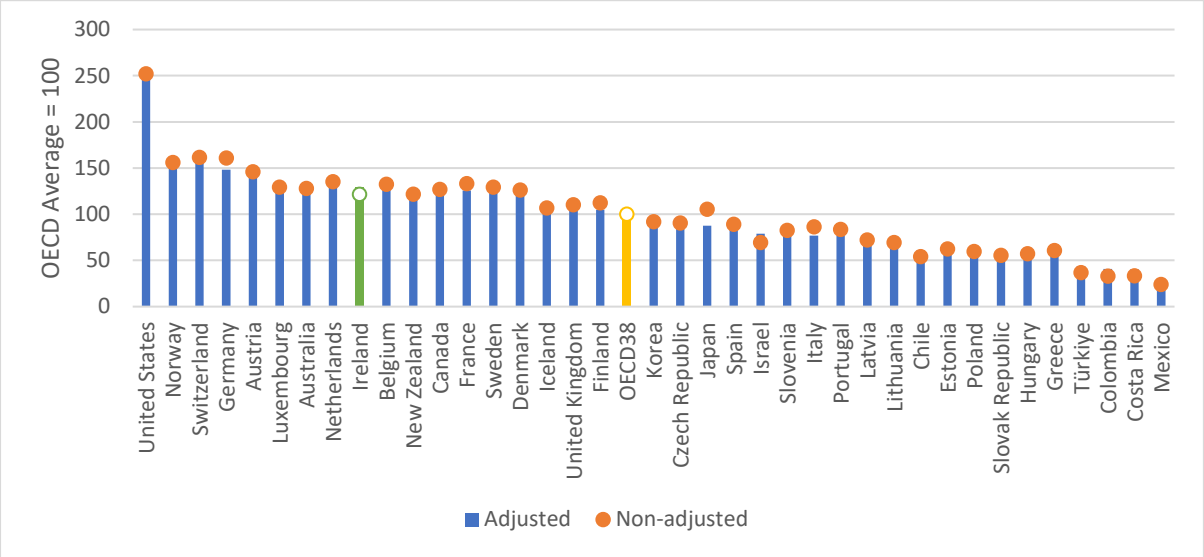
Source: OECD Data

3.5 Age and Expenditure

Figure 10 shows that Ireland's per capita health expenditure is higher than the OECD 38. The graph also shows that Ireland could expect higher health spending relative to the OECD average if a standard population structure was applied. This illustrates that expenditure is particularly high given the age of our population. This finding is supported by IGEES (2018)[19], which found that after adjusting public spending for health to account for differences in the age structure, Ireland's public spending on health was significantly above the European Area average (without adjustment the public health to GDP ratio was close to the average).

[19] Meaney, K., V. Oyewole and J. Bedogni (2018), Comparative Levels and Efficiency of Irish Public Spending, IGEES https://assets.gov.ie/7322/262f606010344ca3adeba2c88087add6.pdf

Figure 10 Age Adjusted Health Expenditure per Capita, 2022



Note: Health spending relative to OECD average (OECD=100) after indirect standardisation based on a derived OECD age-spending profile. Adjusted in this case refers to health expenditure per capita if an OECD standard population structure was applied.
Source: OECD Data

Figure 11 below looks at both the proportion of older adults and expenditure on health across 38 EU and OECD countries. The graph is divided into four quadrants; each country is graphed relative to the average percentage of the population over the age of 80 and the average per capita expenditure on healthcare across these countries. These quadrants illustrate four scenarios:

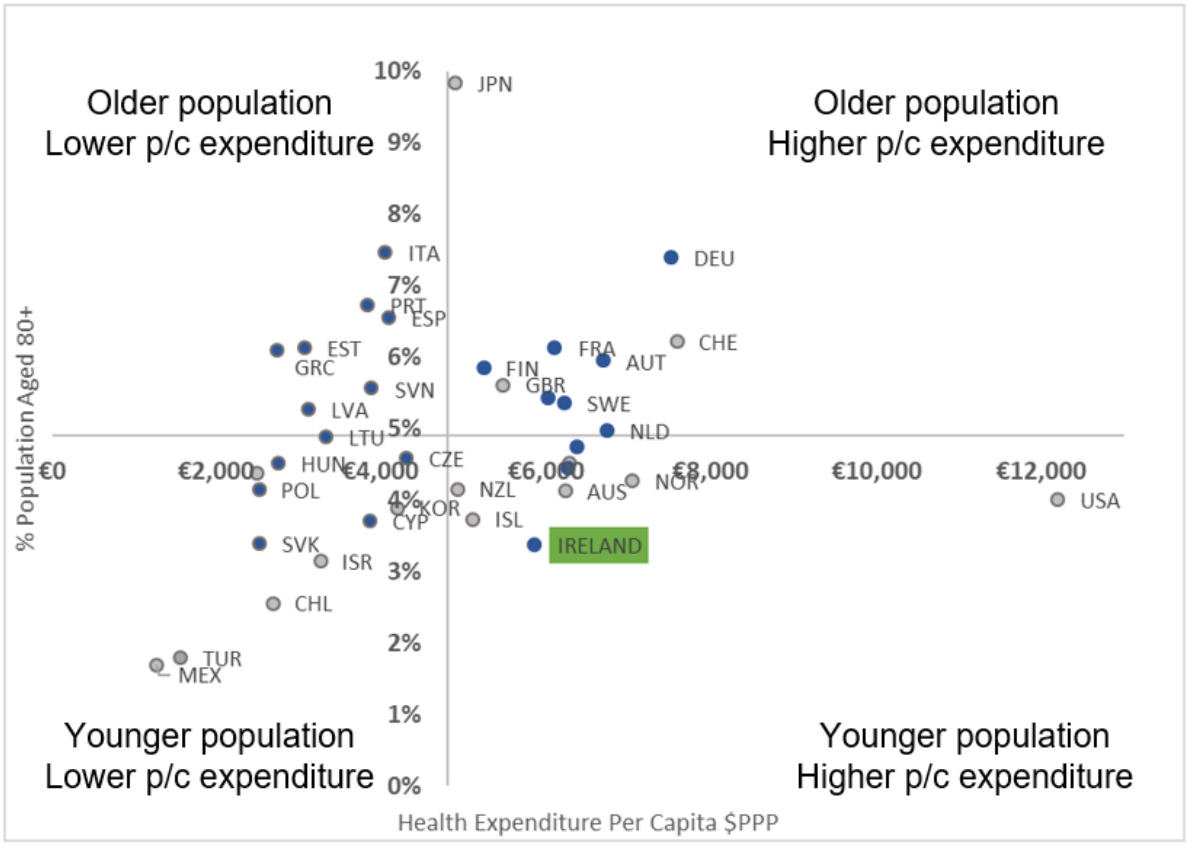
- **Top Right -** Higher than average proportion of older people, higher than average per capita healthcare expenditure, e.g. Germany, UK and France
- **Top Left:** Higher than average proportion of older people, lower than average per capita healthcare expenditure, e.g. Greece and Italy
- **Bottom Right:** Lower than average proportion of older people, higher than average per capita healthcare expenditure, e.g. Ireland
- **Bottom Left**: Lower than average proportion of older people, lower than average per capita healthcare expenditure, e.g. Slovak Republic and Poland

A priori, given that older adults are particularly expensive in terms of healthcare consumption, it could be assumed that those countries with larger older populations would have higher per capita expenditure and that those with younger population would have lower per capita health expenditure, i.e. that the points on Figure 11 will form a line from bottom left to top right. This pattern is not clear however, and in particular, as the graph shows, Ireland is in the bottom right quadrant. Countries here have a lower than average proportion of the population over the age of 80, but have an above average per capita expenditure on health. 3.4% of Ireland's population are above the age of 80, but the per capital health expenditure is $5,861 (PPP)[20]. By comparison, 4.9% of the population of the 38 EU and OECD member

[20] The per capita figures in this section are expressed in US$ PPP or purchasing power parity. PPPs are the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries. A disadvantage of converting expenditure using PPPs is that

states for which we have data are above the age of 80, and the average per capita expenditure is $4,797 (PPP), 22% below the Irish figure[21]. As such, this figure provides additional evidence that healthcare in Ireland is expensive by international standards, especially given our younger population. This is a cause for concern given the increased costs of healthcare associated with an ageing population and the implications for the health budget, and broader government spending.

Figure 11 Quadrant Graph; Population over the age of 80 vs per Capita Health Expenditure ($PPP), 2021



Source: OECD Data
Note: EU countries are shaded in blue

while it considers prices, it also includes prices of goods unrelated to the health sector. A health specific purchasing power parity index (international basket of goods) would be preferable.

[21] The average per capita expenditure is different to that cited for the OECD/EU dataset elsewhere in this paper as this graph does not include all countries due to data limitations.

3.5.1 Box 1: Healthcare Costs Compared to Usage

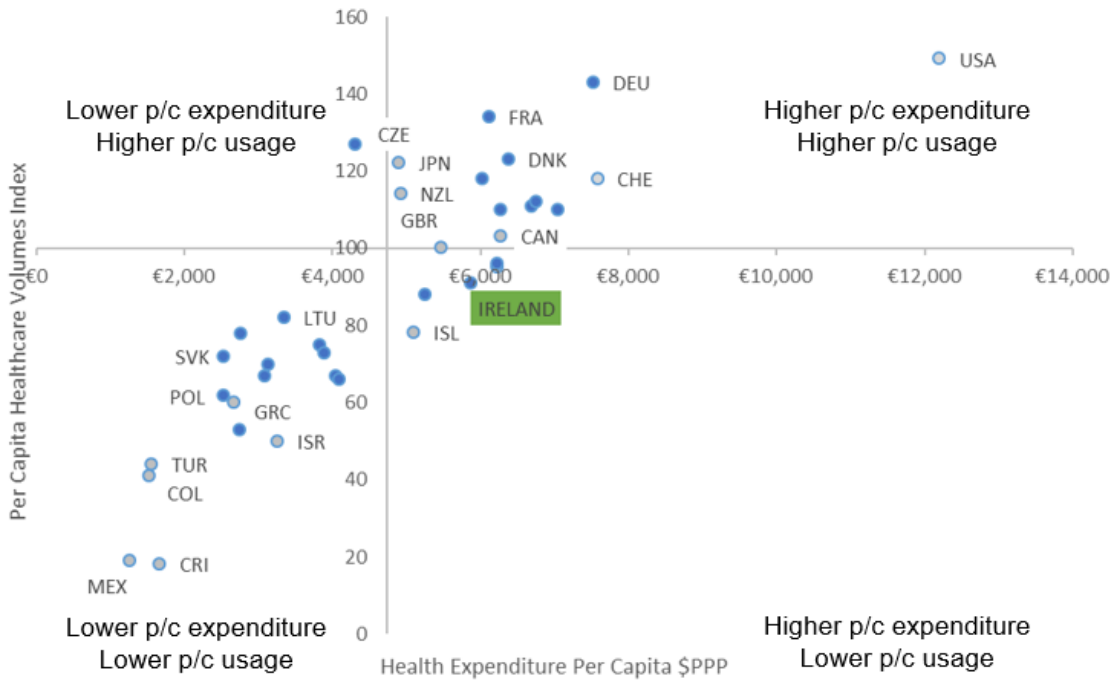
A measure of the price paid for health care and the quantity consumed gives an insight into why health spending differs across countries. The OECD computes a metric of the volume of healthcare consumed per capita by removing the health price component from healthcare expenditure. Differences in the per capita volume of care are influenced by the age and disease profile of a population, the organisation of service provision, the use of prescribed pharmaceuticals, as well as issues with access leading to lower levels of care being used.

Figure 12 graphs per capita healthcare volumes against per capita healthcare expenditure across 37 OECD countries. The graph is divided into four quadrants; each country is graphed relative to a per capital healthcare volume index and the average per capita expenditure. These quadrants illustrate four scenarios:

- **Top Right:** Higher than average per capita healthcare expenditure, higher than average per capita healthcare volume e.g. Germany, France, USA
- **Top Left:** Lower than average per capita healthcare expenditure, higher than average per capita healthcare volume e.g. Czech Republic
- **Bottom Right:** Higher than average per capita healthcare expenditure, lower than average per capita healthcare volume e.g. Ireland, Iceland
- **Bottom Left**: Lower than average per capita healthcare expenditure, lower than average per capita healthcare volume e.g. Slovak Republic, Colombia and Poland

Ireland is in the bottom right segment indicating that expenditure per capita is above average, but per capita healthcare volume is below the average for the OECD. It is noted, however, that these figures are from 2021 when Covid 19 was having a significant impact on healthcare services internationally. Different public healthcare approaches would have impacted the volume of healthcare uptake; Ireland, for example, had significant reliance on lockdown measures in order to attempt to curtail Covid-19 outbreaks. As such, access to healthcare settings was reduced for the majority of the population.

Figure 12 Health Expenditure (per capita $PPP) and Per Capita Healthcare Volumes, 2021



Source: OECD Data

Note: EU countries are shaded in blue

Note: Further information on the computation of the per capital healthcare volumes index is available at https://www.oecd.org/health/health-systems/International-Comparisons-of-Health-Prices-and-Volumes-New-Findings.pdf and https://www.oecd.org/els/health-systems/health-purchasing-power-parities.htm

4 Conclusion

This paper compares healthcare funding across a range of developed countries. The results clearly illustrate that Ireland has high and increasing levels of health funding compared to other countries in the OECD and EU, and that there an increasing share of public funding in keeping with the goals of Sláintecare. In addition, Ireland has a relatively young population but is already spending as much as significantly older countries.

Total health expenditure in Ireland has grown by €10.3 billion or 77% between 2015 and 2022, with total expenditure on health reaching €30.5 billion in 2022. This has resulted in healthcare expenditure per capita reaching $5,861 in 2021; this is 28% greater than the OECD average. Public expenditure as a share of overall health expenditure has also grown substantially, increasing from 71.8% in 2015 to 77.4% in 2022. As noted in this report, in the case of Ireland this metric refers exclusively to government expenditure as our model of health funding does not include compulsory health insurance. In Ireland, health expenditure as a proportion of overall government expenditure rose from 17.9% in 2015 to 21.2% in 2021. Over the same period the OECD and EU average healthcare expenditure as a proportion of overall government expenditure increased from 14.7% to 16.2%.

The strong levels of Irish healthcare investment have been possible partly due to very robust growth in the Irish economy. Between 2015 and 2022, GNI* grew by 68%, however this growth was surpassed by the rate of growth in public health expenditure illustrating the increased importance the government places on healthcare. Overall, 21% of Irish government expenditure is spent on the healthcare system (based on OECD definitions); this is the second highest proportion of spending in the OECD and EU and a clear indication that Irish healthcare is a State priority.

However, despite the high and increasing levels of funding, the Irish health sector has been consistently spending more than budget allocations. This poses challenges, as the increases in public expenditure to provide these public services should over the medium term be aligned to expenditure levels that can be sustained by the economy and its medium term growth path. This is particularly noteworthy for health in Ireland given the relatively young population but health spending that already more closely resembles a country with a much older population.

This paper has a specific expenditure focus and did not seek to explore the effectiveness of the Irish health sector in terms of its outputs and outcomes, nor consider the sector's value for money. However, it is clear that the levels of increased spending, and overspending, in the health sector in recent years must be considered in light of the ageing population as the higher than average per capita healthcare expenditure but lower than average per capita healthcare volumes. As such, productivity, efficiency and maximising value for money will have to come increasingly central to health funding discussions in Ireland over the coming years.

5 Appendix

Classifications of OECD healthcare systems

Country	Funding Mix	Regulation	Service Provision
Ireland	*Majority tax, minority private/SHI/insurance*	*State*	*Public private mix*
Australia	Majority tax, minority private/insurance	State	Public private mix
Austria	Majority SHI, minority State	Societal	Public private mix
Belgium	Majority SHI, minority tax/private/insurance	State	Majority private
Canada	Majority tax, minority private/SHI/insurance	State	Majority private
Czechia	Majority SHI, minority tax/private/insurance	State	Majority private
Denmark	Majority tax, minority private/insurance	State	Public private mix
Estonia	Majority SHI, minority tax/private	State	Public private mix
Finland	Majority tax, minority private/SHI/insurance	State	Public
France	Majority SHI, minority tax/private/insurance	State	Public private mix
Germany	Majority SHI, minority tax/private/insurance	Societal	Majority private/SHI
Hungary	Majority SHI, minority tax/private/insurance	State	Public private mix
Iceland	Majority tax, minority private/SHI	State	Majority public
Italy	Majority tax, minority private/SHI/insurance	State	Majority public
Japan	Majority SHI, minority tax/private/insurance	State	Majority private/SHI
Korea	Majority SHI, minority tax/private/insurance	State	Majority private/SHI
Luxembourg	Majority SHI, minority tax/private/insurance	State societal mix	Majority private/SHI
Netherlands	Majority SHI, minority tax/private/insurance	State	Public private mix
New Zealand	Majority tax, minority private/SHI/insurance	State	Public private mix
Norway	Majority tax, minority private/SHI	State	Majority public
Poland	Majority SHI, minority tax/private/insurance	State	Public private mix
Portugal	Majority tax, minority private/SHI/insurance	State	Majority public
Slovak Republic	Majority SHI, minority tax/private	State	Public private mix

Slovenia	Majority SHI, minority tax/private/insurance	Societal	Majority public
Spain	Majority tax, minority private/SHI/insurance	State	Majority public
Sweden	Majority tax, minority private/insurance	State	Public private mix
Switzerland	Majority SHI, minority tax/private/insurance	Societal	Majority private
United Kingdom	Majority tax, minority private/insurance	State	Majority public
United States	Majority private, minority tax/insurance	Private	Majority private

This table is based on Böhm, K., Schmid, A., Götze, R., Landwehr, C. and Rothgang, H., 2012. "Classifying OECD healthcare systems: A deductive approach,"TranState Working Papers 165

Definitions Table

Item	Working Definition
Funding Mix	Refers to the technical majority (+50%) funding source is, "tax" is non-ring-fenced taxation, "private" is out of pocket payments, "SHI/social security" is any social security payments, social insurance contributions, or other specific ring-fenced payments, "insurance" is health insurance not provided by the State
Regulation	Regulation refers to what actor (State, private actor or society actor) controls regulation of the system of financing, the access of providers to healthcare markets, the remuneration of service providers, the access of patients to service providers, and the definition of the benefits package. Where the Bohm et al paper categorises regulation on an overall basis as State it is categorised as State, however, some sub-elements of regulation may not be entirely State controlled.
Primary Care	Care at outpatient level including GPs and dentists
Pharmacy Sector	Pharmacies involved in the dispensing of medications to patients, does not refer to the pharmaceutical industry/broader drug reimbursement policy
Acute Care	Care at acute level, hospital sector
Public Coverage	The degree to which the population is covered financially for health services, where total coverage is all care free at point of use, and no coverage is all care to be covered by out of pocket payments or private health insurance. SHI refers to a model wherein persons pay social insurance payments to a SHI body/government and in return receives carefree or for a reduced amount at point of use. Co-payment/cost capping refers to a model wherein the patient pays a portion of the cost or the cost up to a set amount and the State pays the rest.
Social Health Insurance	A method of healthcare funding wherein a not for profit body that is outside of the State collects payments, similar in many cases to traditional private insurance, and uses these payments to fund health services. In many cases these payments are compulsory for most or all citizens.

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