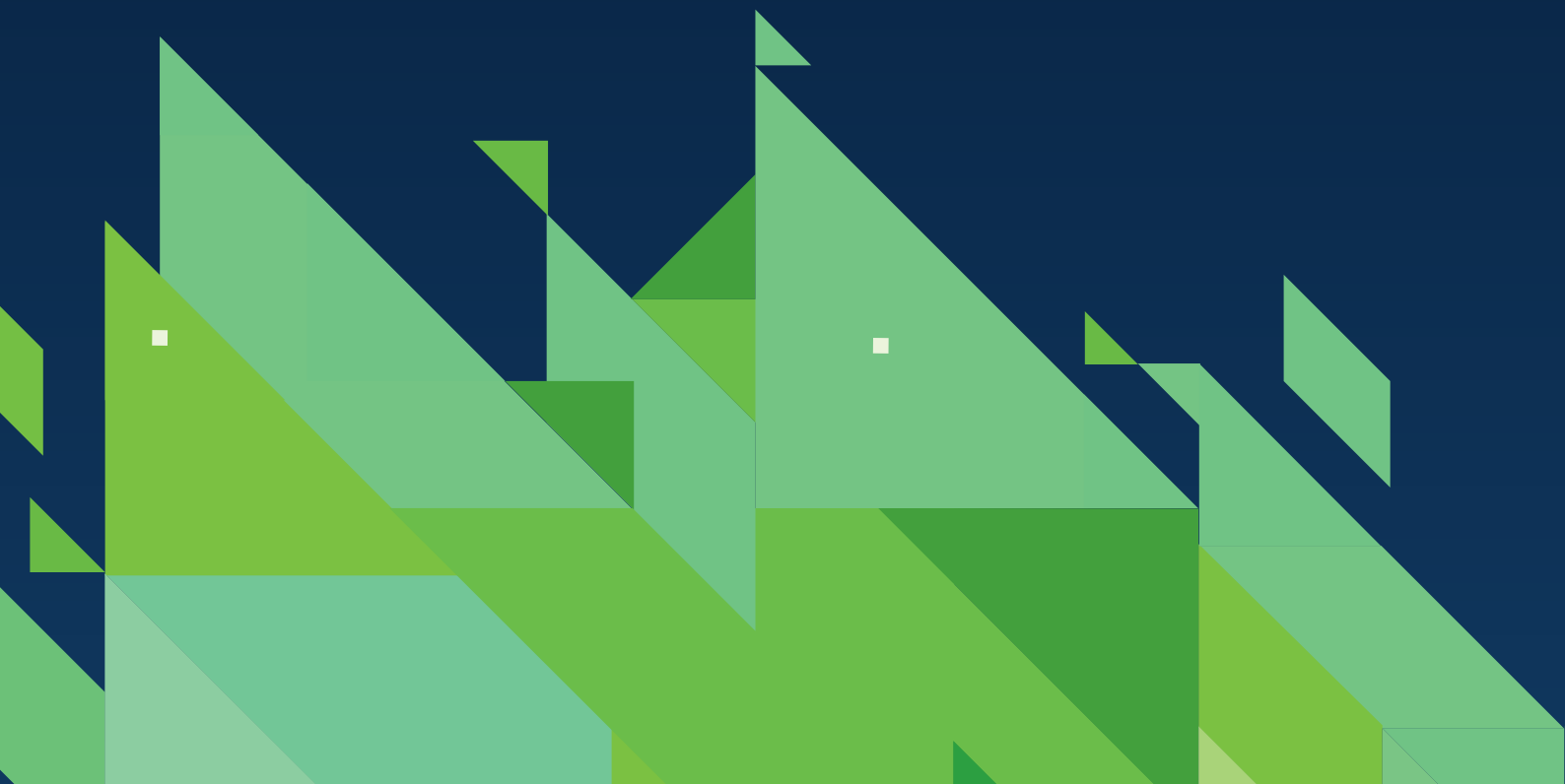




Economic outlook: A medium-term review of the Irish health and social care system

SHEELAH CONNOLLY AND FRANK WOLFE



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Abbreviations

AI	Artificial intelligence
CSO	Central Statistics Office
ED	Emergency department
EHDS	European Health Data Space
EHR	Electronic health record
ESRI	Economic and Social Research Institute
GP	General practitioner
GPN	General practice nurse
HSE	Health Service Executive
IHI	Individual Health Record
LOS	Length of stay
LTRC	Long-term residential care

Executive summary

Ireland's growing and ageing population is projected to significantly increase demand for a range of health and social care services in the coming years. Responding to these increasing demands, several plans and measures are in place to address the growing capacity requirements. While it is somewhat unclear how successful these measures will be in meeting the totality of future health and social care needs, there is an ongoing concern about the fiscal sustainability of the health and social care system. While Ireland's population is relatively young, approximately one-quarter of current government expenditure was allocated to health and social care in 2025, one of the highest proportions among European countries. Even within this budget, access to some healthcare services remains curtailed, with long waits for a range of services, and the majority of the population continues to pay out of pocket for primary care services.

The international literature identifies a range of potential policy options to ensure the fiscal sustainability of healthcare systems in light of changing demographic trends. These include saving for future expenditure requirements, exploring alternative financing mechanisms, reallocating or increasing public expenditure, improving efficiency and maximising population health. In this context, a number of measures are ongoing in Ireland, including saving for the future through the Future Ireland Fund and driving efficiency gains, in particular within the hospital setting. Other policy options, such as seeking alternative financing mechanisms (generally from private sources) and continuing to increase the allocation of public expenditure to healthcare, are likely to be less viable in the Irish context. Increased consideration could be given to policies which positively impact population health, both as a means of improving the quality of life of the population and reducing demand for health and social care services.

In addition to its impact on the health and social care system, demographic change will also have implications for other areas of government expenditure, including pensions. Demographic changes are occurring alongside a range of other major challenges, including an uncertain geopolitical environment, digitalisation (including rapid development in artificial intelligence), climate change and

decarbonisation. These challenges also bring potential opportunities for the economy and society as a whole, and specifically for the healthcare system. However, a cross-government and agency approach is required to harness all potential benefits, to ensure the fiscal sustainability of the healthcare system and the economy at large over the medium term.

Chapter 1

Introduction

By European standards, the Irish health and social care system is a complex mix of public and private provision and financing. Historically, the system was underfunded (Hennessy et al., 2021), access to services curtailed and health outcomes poor (Eighan et al., 2020). While expenditure¹ has increased significantly in recent years, and health outcomes are now generally on par with or exceed the European average (Eighan et al., 2020; Department of Health, 2025), capacity issues within the system remain. These capacity constraints were brought to the fore during the COVID-19 pandemic, when a weak digital infrastructure, relatively low levels of staffing across some sectors, outdated hospital infrastructure, a low number of hospital beds and limited intensive care facilities constrained the response to the pandemic (OECD, 2022). Attempts to address these limitations are ongoing (HSE, 2025; 2026).

In 2023, total health and social care expenditure in Ireland was approximately €35.1 billion, an increase of 81 per cent relative to 2014 (Central Statistics Office, 2025). Ninety-five per cent was current expenditure, and five per cent was capital expenditure. Government sources account for 77 per cent of current expenditure, with the remainder coming from out-of-pocket payments (11%) and private health insurance (12%) (Central Statistics Office, 2025). In 2025, government expenditure on health and social care comprised 24 per cent of all government expenditure, surpassed only by expenditure on social protection (Parliamentary Budget Office, 2026). In a comparative context, Ireland's relative position on health and social care expenditure is somewhat dependent on the measure of expenditure used (Wren and Fitzpatrick, 2020). However, regardless of the measure, spending on health may be considered high in Ireland, given the relatively young population (OECD, 2022; Conroy, 2025).

Ongoing demographic change will result in a significant increase in the number of older people in Ireland in the coming years (Bergin and Egan, 2024). This will contribute to a substantial increase in the

¹ In this report, expenditure generally relates to expenditure on health and social care services.

demand, and associated capacity requirements, for a range of health and social care services, leading to questions on the fiscal sustainability of the system. Arising from the growing and ageing population, recent analysis from the Department of Finance projected significant increases in health and social care expenditure as a proportion of GNI*² in the coming years (Department of Finance, 2025a).

As Ireland's demographic structure changes, other developments with implications for the health and social care system are also occurring, including climate change, increased digitalisation and use of artificial intelligence, all within an uncertain geopolitical environment.

This report aims to consider the medium-term outlook for the Irish health and social care system. The report synthesises a wide range of evidence to illustrate the medium-term challenges (and opportunities) facing the system. The report also discusses potential approaches to address these challenges. While several reports and papers have examined specific challenges and potential responses in isolation, this report seeks to take a more holistic view of the system, considering the various challenges in tandem, and in doing so, potentially identifying how some policy responses may work across more than one domain.

The rest of the report is structured as follows: Chapter 2 summarises recent ESRI analysis examining how demographic change and policy reforms might impact the demand and associated capacity requirements for a range of health and social care services in Ireland to 2040. Chapter 3 considers the fiscal sustainability of the system in light of demographic change. Chapter 4 examines the potential challenges and opportunities arising from other ongoing changes, including climate change and decarbonisation, digitalisation and the uncertain geopolitical environment. Chapter 5 concludes.

² GNI* is an indicator of economic activity designed to measure the size of the Irish economy by excluding globalisation effects.

Chapter 2

Demographic change and the healthcare system

2.1 Introduction

In 2025, the health team at the Economic and Social Research Institute (ESRI) published six reports (funded under the Department of Health/ESRI Research Programme on Healthcare Reform), projecting demand and associated capacity requirements to 2040 for three key health and social care sectors (public acute hospitals, general practice and older people's services) at both the national and Health Service Executive (HSE) health region levels (Brick and Kakoulidou, 2025; Brick et al., 2025a; Connolly et al., 2025a; b; Walsh and Kakoulidou, 2025a; b). This chapter summarises the findings from these reports that are most relevant for exploring the sustainability of the health and social care system. The reader is referred to the specific reports for further details on the data, methods and assumptions underlying the findings.

2.2 Projected demand for health and social care services to 2040

2.2.1 Demographic change, 2022–2040

A key input for the ESRI health and social care demand and capacity projections is projections on population size and structure. While the Central Statistics Office (CSO) is the official source of population projections, ESRI population projections (Bergin and Egan, 2024) were used in the ESRI health and social care sector projections, as they were the only source of population projections at the HSE health region level (an integral component of the health sector projections).

The ESRI population projections are based on the 2022 Census of Population; full details on the data and methods used to develop the projections are provided in Bergin and Egan (2024). In short, three projection scenarios were estimated – central, low and high (Table 2.1). In each scenario, mortality and fertility are dealt with in the same way; however, migration differs across the scenarios. In the central scenario, net immigration is projected to average 35,000 per annum up to 2030 (with higher migration in 2025 and 2026); and 20,000 per annum thereafter. The low scenario assumes 10,000 less net immigration per annum, while the high scenario assumes 10,000 more net immigration per annum. For the mortality assumption, life

expectancy at birth is expected to increase from 81.1 in 2022 to 84.2 in 2040 for males, and from 84.6 to 87.1 over the same period for females. A constant fertility rate of 1.65 is assumed for each scenario.³

Table 2.1 Summary of main assumptions for population scenarios

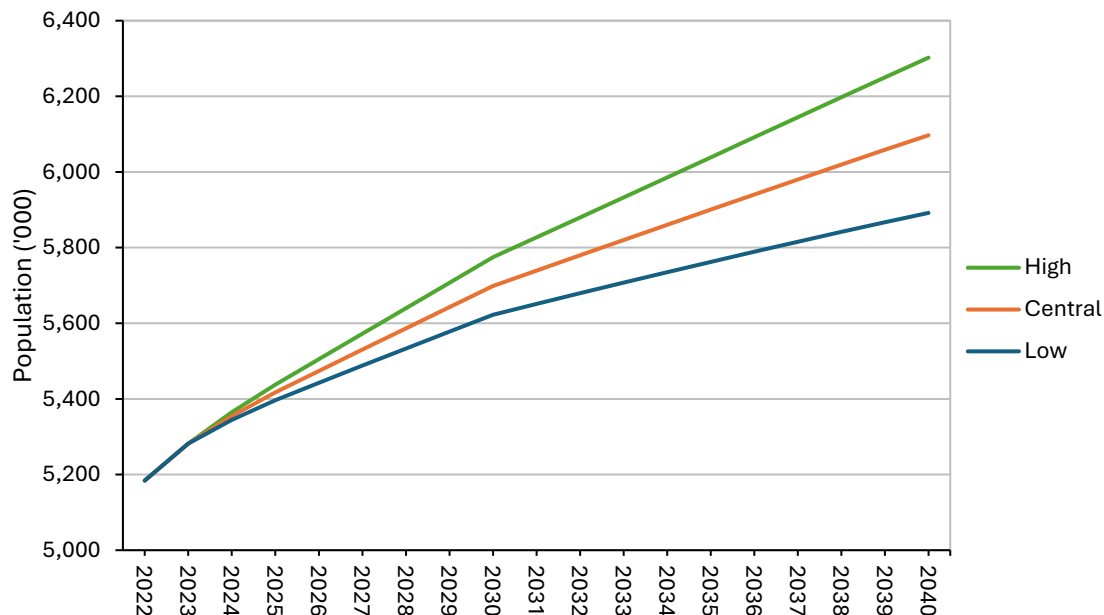
Assumptions	Central	Low	High
Mortality	Life expectancy at birth for males (females) is expected to increase from 81.1 (84.6) in 2022 to 84.2 (87.1) for males (females) in 2040	No change from central scenario	No change from central scenario
Migration	Net immigration to average +35,000 per annum (p.a.) to 2030 (higher at 45,000 in the short term) and +20,000 p.a. thereafter	Net immigration to average +25,000 p.a. to 2030 (higher at 35,000 in the short term) and +10,000 p.a. thereafter	Net immigration to average +45,000 p.a. to 2030 (higher at 55,000 in the short term) and +30,000 p.a. thereafter
Fertility	Total fertility rate is unchanged at 1.65 over the period	No change from central scenario	No change from central scenario

Source: Adapted from Bergin and Egan (2024).

³ In terms of migration assumptions, the ESRI projections are broadly comparable to the CSO M2 and M3 scenarios. The main point of difference is that the ESRI projections assume constant fertility to 2040, while the CSO projections assume a gradually declining fertility rate.

The ESRI (and other) population projections show that the population of Ireland will increase significantly in the coming years. Figure 2.1 shows the projected growth across the three scenarios (low, central and high) between 2022 and 2040. In the central scenario, the population is projected to increase by 863,000 by 2040, with an annual average population growth rate of 0.86 per cent. In the low scenario, the increase by 2040 would be 658,000 with an annual average growth rate of 0.67 per cent, while in the high scenario, an increase of 1.07 million would be expected, reflecting an annual average growth of 1.05 per cent.

Figure 2.1 Total population – Low, central and high population growth scenarios

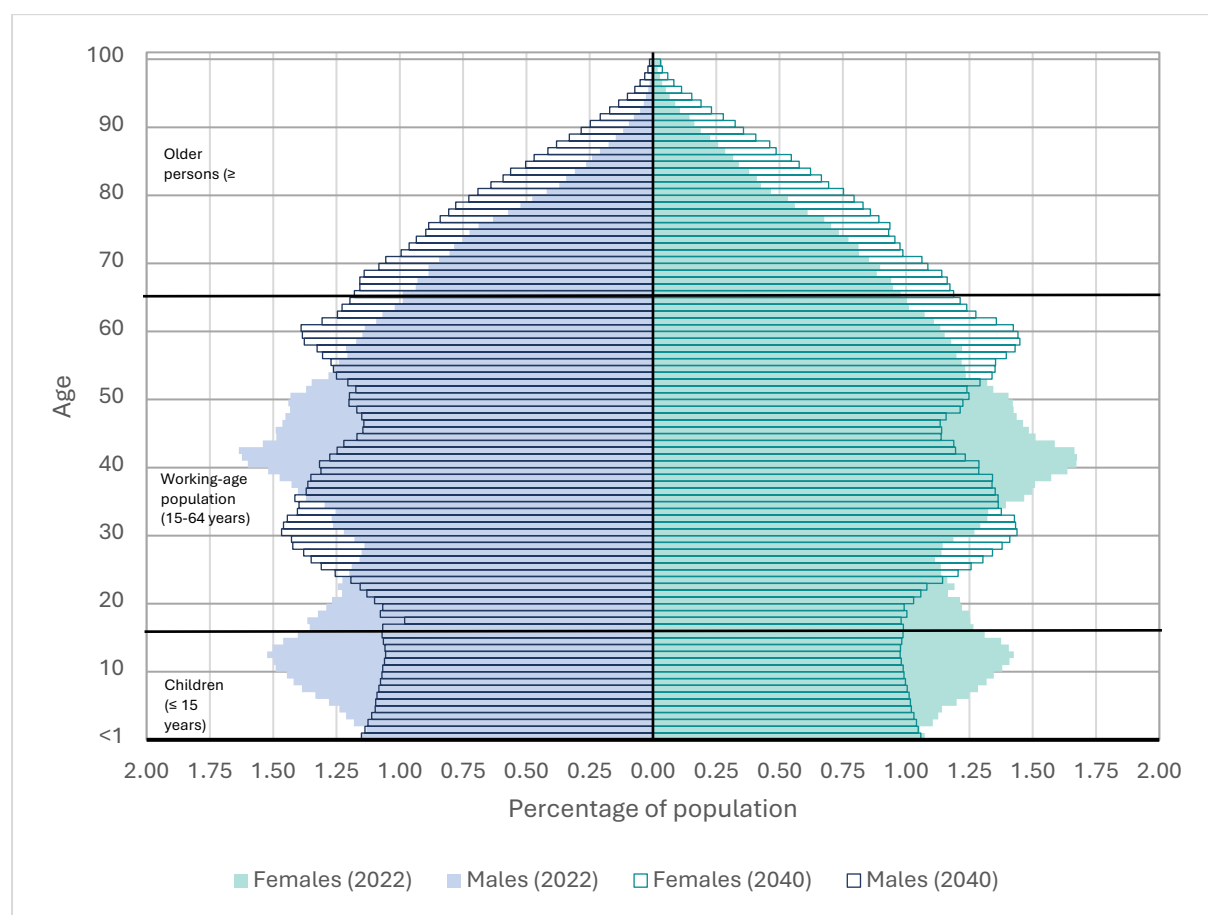


Source: Bergin and Egan (2024) – additional data provided by the authors.

Note: In each scenario (high, central, low), mortality and fertility are dealt with in the same way; however, migration differs across the scenarios. Further detail is available in Bergin and Egan (2024).

In addition to population growth between 2022 and 2040, there is also a projected change in the age structure. Figure 2.2 shows the distribution of the population across age groups for 2022 and 2040 based on the central population projection. Similar patterns are observed for both males and females, with decreases in the proportions of the projected population aged under 25 years and 35–50 years, and increases in the proportions of those aged 25–34 and over 50 years. The oldest age groups are projected to see the largest relative increase in growth between 2022 and 2040. For example, the population aged 65–84 years is projected to increase by almost 60 per cent, while the population aged 85 years and over is projected to more than double by 2040 (Walsh and Kakoulidou, 2025a).

Figure 2.2 Central scenario – population age pyramids for 2022 and 2040 (% of population)



Source: Bergin and Egan (2024); Brick et al. (2025a).

2.2.2 Projected demand for health and social care services to 2040

This section summarises the key findings of the six ESRI reports published in 2025, which projected demand and associated capacity requirements to 2040 for public acute hospitals, general practice and older people's services at both the national and HSE health region levels (Brick and Kakoulidou, 2025; Brick et al., 2025a; Connolly et al., 2025a; b; Walsh and Kakoulidou, 2025a; b).

Full details of the data, methods and assumptions underlying the projections are included in the respective reports. In short, the projections are based on the ESRI's healthcare projection tool, the Hippocrates model. The Hippocrates model is a healthcare projection model that projects from a bottom-up service or sectoral perspective. Within the model, the first step is to develop base-year age- and sex-specific activity rates for each service. Baseline estimates of activity are then projected based on a range of assumptions, including the size and structure of the population, healthy ageing and potential policy reforms. Population projections are based on the aforementioned ESRI population projections, while a range of assumptions were used about the relationship between increased life expectancy and health to reflect different healthy ageing effects. Where the data allow, existing and potential policy changes are also incorporated into the projections, with these differing across the services. For example, the hospital analysis includes assumptions on the impact on projected bed requirements of reducing occupancy rates, increasing the proportion of elective care delivered by day case and reducing waiting lists (Brick et al., 2025a), while the analysis of general practice includes assumptions on increasing the proportion of the population eligible for a GP visit card (Connolly et al., 2025a). Given the inherent uncertainty around any projection, assumptions are grouped to create a range of projection scenarios.

Table 2.2 shows the services and capacity metrics included in each of the three sectors. Note that not all services have both a demand and capacity metric: emergency department (ED) and outpatient projections, for example, are expressed as attendances, bed capacity is projected only for day-patient, inpatient and long-term residential care (LTRC) services, and home support is projected in hours because there is no equivalent capacity measure.

Table 2.2 Services and metrics included in the 2025 ESRI health and social care projections

Sector and services	Demand metric	Capacity metric
Public acute hospitals		
Emergency department (ED)	Attendances	–
Outpatient	Attendances	–
Day-patient	Discharges, bed days	Beds
Inpatient	Discharges, bed days	Beds
General practice		
General practitioner (GP)	Consultations	Workforce
General practice nurse (GPN)	Consultations	Workforce
Older people's services		
Home support	Hours	
Long-term residential care (LTRC)		Beds

Source: Brick et al. (2025a); Connolly et al. (2025a); Walsh and Kakoulidou (2025a).

Table 2.3 shows the current and projected demand for public acute hospitals, general practice and older people's services, respectively, at the national level to 2040. For each service, demand is projected to increase by at least 20 per cent over the period of analysis. However, for some services (including general practice nurse (GPN) consultations and home support hours), projected demand will be substantially greater. For example, demand for home support hours is projected to increase by between 57 per cent and 91 per cent by 2040.

The projected increases in demand are largely driven by increases in the size of the population and/or changes in the age structure of the population. Increases for services which are used across all age groups (such as general practitioner (GP) consultations and ED attendances) are driven more by increases in the size of the population, while increases for services more commonly used by older people (including hospital inpatient admissions and home support

services) are driven more by changes in the age structure of the population (Brick et al., 2025a; Connolly et al., 2025a; Walsh and Kakoulidou, 2025a). Population growth, for example, was projected to increase the demand for GP consultations by 20 per cent by 2040 (in the central scenario), while the ageing of the population was projected to increase demand by five per cent. For home support hours, a service predominantly used by the older old, the changing age structure was projected to increase demand by 85 per cent (in the central scenario), while population growth was projected to increase demand by 18 per cent.

Reflecting, in part, access and capacity issues with the current health and social care system, several policy initiatives are underway to increase access and capacity. Where data and evidence allowed, such policy initiatives were incorporated into the projections of demand. For example, the public hospital projections included assumptions on reducing waiting lists, length of stay and bed occupancy rates, while the general practice projections included assumptions on increasing the proportion of the population eligible for a GP visit card. In general, the included policy reforms had a much smaller impact on projected demand relative to changes in the size and age structure of the population.

Table 2.3 Base year demand and additional demand, 2023–2040

Service	2023	Projected additional, 2023–2040	Total growth, 2023–2040
	N ('000)	N ('000)	%
Public acute hospitals			
Emergency department attendances	1,641	333–444	20%–27%
Outpatient attendances	4,563	950–1,298	21%–28%
Day-patient discharges	1,205	302–442	25%–37%
Inpatient admissions	652	145–253	22%–39%
General practice			
GP consultations	19,364	4,513–5,836	23%–30%
GPN consultations	5,715	1,829–2,081	32%–36%
Older people's services			
Home support hours	28,700	16,200–26,200	57%–91%

Source: Brick et al. (2025a); Connolly et al. (2025a); Walsh and Kakoulidou (2025a).

Note: Due to data availability, the base year for older people's services (2022) differs to that for public acute hospitals and general practice (2023).

The projected additional demand will result in increased capacity requirements across the health and social care system. Building on the projections of demand shown in Table 2.3, Table 2.4 shows the projected requirements for hospital beds (day-patient and inpatient beds), LTRC beds (short stay and long stay) and GPs and GPNs to 2040. Reflecting the different assumptions and scenarios, the projections include a range (which largely corresponds to low- and high-pressure scenarios).

Within the public hospital system, an additional 5,083–7,780 (day- and inpatient) beds will be required between 2023 and 2040 to meet the additional projected demand; while within the LTRC sector, an additional 20,695–27,207 (short and long stay) beds will be required by 2040. Within general practice, an additional 943–1,211 GPs and 761–868 GPNs will be required to meet the growing demand arising from a growing and ageing population, as well as policy reforms.

Table 2.4 Projections of capacity requirements for a range of health and social care services, 2023–2040

Service	2023	Projected additional, 2023–2040	Total growth, 2023–2040
	N	N	%
Day-patient hospital beds	2,606	653–955	25%–37%
Inpatient hospital beds	11,421	4,430–6,825	39%–56%
Short stay LTRC beds	3,745	2,686–3,520	72%–94%
Long stay LTRC beds	29,579	18,009–23,687	61%–80%
GPs (headcount)	3,928	943–1,211	24%–31%
GPNs (headcount)	2,288	761–868	33%–28%

Source: Brick et al. (2025a); Connolly et al. (2025a); Walsh and Kakoulidou (2025a).

Note: Projections of home support hours relate to 2022 rather than 2023.

Regions in the east of the country are projected to experience the largest increase in population growth in the coming years and consequently, the largest increase in demand for health and social care services (Brick and Kakoulidou, 2025; Connolly et al., 2025b; Walsh and Kakoulidou, 2025b). However, considerable increases in capacity are required across all regions.

2.3 Projected capacity requirements

Recognising the impact that demographic change will have on the demand for health and social care services, in addition to current capacity deficits, several plans and measures are in place to address the growing capacity requirements (HSE, 2025; 2026). The Acute Hospital Inpatient Bed Capacity Expansion Plan (Government of Ireland, 2024), for example, sets out a programme of expansion with a total planned increase of 3,378 new hospital beds between 2024 and 2031. If achieved, this would surpass the projected upper range of additional requirements for 2031, estimated by Brick et al. (2025a). The 2025 Programme for Government committed to providing more public LTRC beds and increasing home support hours (Department of the Taoiseach, 2025), while the National Development Plan for the health sector detailed plans to deliver on health digitalisation, increased bed capacity within public hospitals and LTRC facilities and invest in primary and community-based services and LTRC (Government of Ireland, 2025). In addition, there have been significant increases in the HSE workforce in recent years (HSE, 2024b), with plans to increase training places for a range of health and social care professionals.⁴

If successfully implemented, these measures would go some way to addressing growing capacity requirements. However, progress in delivery must be regularly monitored, as barriers to the delivery of timely infrastructure projects in Ireland, including the planning and regulatory environment and shortages of construction workers (Conroy and Timoney, 2024) could impede the delivery of planned increases in physical capacity.

In addition to increasing capacity, other measures are seeking to reduce demand for particular health and social care services. Within the hospital sector, for example, attempts to reduce growing bed capacity requirements have included reductions in the length of stay (Walsh et al., 2022) and the increased use of day surgery as an alternative to an inpatient admission (Brick et al., 2025b). The ESRI projections for public hospital beds have shown that reducing the length of stay in hospital could reduce bed requirements by up to 7.2 per cent by 2040 (Brick et al., 2025a). The introduction of the Public Only Consultant Contract and the removal of private practice from

⁴ [Minister Lawless announces €28.5m investment to deliver over 1,100 new third level healthcare places.](#)

public hospitals (Independent Review Group, 2019) could also contribute to an increase in hospital capacity for public patients in the short to medium term. However, while these measures could offset some of the growing capacity requirements, their impact is expected to be relatively small in comparison to the growing demands arising from a growing and ageing population (Brick et al., 2025a).

A key recommendation of the Sláintecare reform proposals (Houses of the Oireachtas Committee on the Future of Healthcare, 2017) was the re-orientation of the healthcare system away from the hospital setting towards increased delivery of care in the community. To this end, a number of community-based programmes have been introduced, including the Chronic Disease Management programme and the Integrated Care Programme for Older People (HSE, 2023), which seek to increase community healthcare services and reduce pressure on the hospital system. Projecting future hospital bed requirements, Brick et al. (2025a) found that reducing potentially avoidable hospitalisations (by increasing care in the community) could reduce bed requirements by up to 2.5 per cent between 2023 and 2040.

Within the long-term care sector, in keeping with the aspiration to increase delivery of care in the community, a new statutory home support scheme was proposed in the 2017 Sláintecare report (Houses of the Oireachtas Committee on the Future of Healthcare, 2017). The scheme has the potential to reduce demand for LTRC services (Walsh and Lyons, 2021; Walsh and Kakoulidou, 2025a) and to align with most people's preferences to remain in their home as they age (Fox et al., 2017). However, again relative to the growing demand arising from an ageing population, the impact of the proposed statutory home support scheme to reduce demand for LTRC is relatively small: in the ESRI projections of LTRC bed requirements, Walsh and Kakoulidou (2025a) estimated that the expansion of home support could reduce future long-stay bed requirements by approximately four per cent; however, the increases in demand arising from the growing population are many multiples of this number.

Chapter 3

Fiscal sustainability of the health system

3.1 Introduction

The previous chapter described how the ageing and growing population will contribute to a significant increase in the demand for a range of health and social care services in the coming years. While specific policies can be implemented to reduce this demand, it is unlikely that any single policy, or combination of policies, will be sufficient to offset the additional demands arising from the growing and ageing population. This chapter examines the fiscal context of the growing demand for health and social care services. It discusses current and projected healthcare expenditure in Ireland and explores policy responses that may help ensure the financial sustainability of the system in the medium term.

3.2 Fiscal context

In 2025, government expenditure on health and social care was approximately €25.8 billion, accounting for 24 per cent of total government expenditure. Meeting the projected increases in demand and associated capacity requirements detailed in Chapter 2 will require a significant increase in expenditure in the coming years (Department of Finance, 2025a).

A 2023 paper from the OECD, focusing on the period 2019–2040, projected that increases in health expenditure in Ireland (and the rest of the OECD) would rise at a faster pace than government revenues in the coming years (Lorenzoni et al., 2023) raising concerns about the sustainability of expenditure over the medium to long term. However, while that analysis projected that 24 per cent of government expenditure would be allocated to health and social care spending by 2040, it had already reached that level by 2025, reflecting a significant increase in public expenditure on health and social care in recent years.

Recent analysis by the Department of Finance projected health and social care expenditure for Ireland for several different scenarios out to 2065 (Department of Finance, 2025a). In the analysis, a distinction was made between ‘health’ expenditure, which includes expenditure related to the acute hospital system, community and primary care, mental health and other services and ‘long-term care’ which includes

residential long-term care, home supports, disability services and support payments for carers. In the ‘central’ scenario, total public healthcare expenditure (including health and long-term care expenditure) was projected to increase from 9.2 per cent of GNI* in 2031 to 12.6 per cent in 2065.⁵ Within this, health expenditure was projected to rise from 6.6 per cent of GNI* in 2031 to 7.7 per cent in 2065, while long-term care expenditure was projected to rise from 2.5 per cent to 4.8 per cent. Over the period of analysis, the average annual rate of growth for per-capita health and long-term care expenditure was projected to be 1.4 per cent, while GNI* per-capita growth was projected to grow at an annual average rate of 0.9 per cent. In an alternative ‘optimistic’ scenario (including an increase in productivity, improved cost control and positive assumptions on healthy ageing), healthcare expenditure was projected to increase from 8.7 per cent of GNI* in 2031 to 10.6 per cent in 2065. Within this scenario, health expenditure was projected to remain relatively stable as a share of GNI* at 6.2 per cent in 2031 and 2065. However, long-term care expenditure was projected to rise sharply from 2.5 per cent of GNI* to 4.3 per cent (Department of Finance, 2025a). This is explained by the high labour intensity of long-term care and the lower potential for productivity gains based on current technologies. In a more negative scenario (incorporating negative assumptions on population health, health system performance and demographic ageing), health expenditure is projected to increase from 9.7 per cent of GNI* in 2031 to 15.3 per cent in 2065 (Department of Finance, 2025a). Under this scenario, health expenditure would comprise 36 per cent of total government expenditure by 2065. In all these scenarios, long-term care emerges as the main driver of expenditure growth.

3.3 Potential policy response

There is some uncertainty in both how health and social care expenditure requirements (Department of Finance, 2025a) and the macroeconomy (Yakut et al., 2025) will evolve in Ireland in the coming years. However, it is relatively certain that the ageing and growing population will contribute to a significant increase in demand and expenditure requirements on health and social care, raising the

⁵ GNI* is an indicator of economic activity designed to measure the size of the Irish economy by excluding globalisation effects.

question of how to ensure the financial sustainability of the public healthcare system.

Both the national and international literature have identified several potential approaches to ensuring the sustainability of healthcare systems (Baltagi and Moscone, 2021). In this section, five potential approaches and their relevance in the Irish context are discussed. These are:

- (i) Saving for the future.
- (ii) Identifying alternative sources of financing.
- (iii) Increasing government expenditure or increasing the allocation to health and social care.
- (iv) Implementing efficiencies.
- (v) Improving population health.

3.3.1 Saving for the future – Future Ireland Fund

Recognising future challenges to the Irish economy, including population ageing, the Future Ireland Fund was established in July 2024 to support state expenditure in 2041 and beyond.⁶ The fund received an initial transfer of €4.3 billion in September 2024, an additional €4.1 billion in October 2024 and a similar amount in the 2025 budget. It is anticipated that in each year until 2035, the Government will contribute 0.8 per cent of gross domestic product (GDP) to the fund.

The fund is a welcome initiative, recognising and responding to the ageing population (as well as other risks) and the associated impact on public expenditure requirements. The Department of Finance notes that the success of the fund will depend on both continued contributions in the short to medium term, as well as achieving a sizeable return on investments (Department of Finance, 2025a). However, as noted by the Department of Finance, on its own, the fund is unlikely to cover all of the additional health and long-term care expenditure associated with the ageing population over a prolonged period of time, given other competing demands for the fund, including for the pension system. Consequently, alternative approaches to

⁶ <https://www.ntma.ie/business-areas/future-ireland-funds/future-ireland-fund>

ensuring the sustainability of the system are required (Department of Finance, 2024b).

3.3.2 Alternative sources of financing

Over the past 10 years, public expenditure on health and social care as a share of total health expenditure has remained relatively constant at approximately 77–79 per cent, with the majority of the remainder funded through out-of-pocket payments and private health insurance. A possible response to growing expenditure requirements is shifting expenditure from public to private sources (either by increasing out-of-pocket payments or private health insurance financing of healthcare) (Cullinan et al., 2021). This could be achieved by reducing the group of people who are entitled to publicly financed healthcare services, reducing the services that are included in the public system or decreasing the extent of coverage (which generally equates to increasing user charges). Such an approach has been used in the past in Ireland. For example, during the economic crisis, public expenditure as a share of total expenditure decreased from a high of 77 per cent in 2004 to 67 per cent in 2011 (Nolan et al., 2014), with a concurrent increase in private expenditure. This was achieved through a range of policy measures, including the abolition, in 2009, of the automatic entitlement to a medical card for those aged over 70 and an increase in user charges for a range of healthcare services. A reduction in the HSE workforce during the economic crisis (Fleming et al., 2022) also contributed to a reduction in publicly financed health expenditure.

A shift to greater private spending could reduce future fiscal pressures for the Government. However, the OECD notes that this strategy comes with risks, not least of which include reducing access to and the quality of publicly funded healthcare and potentially exacerbating health inequalities (OECD, 2024). Previous research has shown that while public hospitals at least appeared to manage relatively well undertaking more activity with fewer resources in the early years of the economic downturn, over time, hospital activity levels decreased, and waiting times increased (Burke et al., 2014).

A policy of shifting health and social care expenditure from the public to the private would conflict with existing Irish health policy (Sláintecare), which aims to reduce out-of-pocket payments on healthcare services (Houses of the Oireachtas Committee on the Future of Healthcare, 2017) and has, in recent years, included an increase in the proportion of the population entitled to a GP visit card,

the abolition of public hospital charges and an increase in the types of services included in the public system (e.g. contraception, IVF, etc.). Recent analysis for five European countries found that increasing out-of-pocket expenditure to address health financing gaps due to population ageing would contribute to a higher incidence of catastrophic and impoverishing health expenditure among households (Cylus et al., 2026), raising further concerns about this approach to ensuring fiscal sustainability for government expenditure.

Nonetheless, increased consideration could be given to the basket of services that are publicly funded, with the possibility of using health technology assessment techniques as a basis to exclude cost-ineffective interventions from public financing (OECD, 2024). Currently, health technology assessment is used in Ireland to inform decisions about the reimbursement of new drugs; however, it is used much less frequently to inform the introduction and/or continued use of other publicly provided/financed health and social care services (O'Mahony, 2021) (see Section 3.3.4 for further discussion).

3.3.3 Increase government expenditure or increase allocation to health and social care

An alternative method of addressing growing demand for health and social care is to increase total government expenditure or increase the allocation to health within the existing budget.

Increasing government expenditure to fund additional health and social care expenditure requires either additional debt financing or an increase in government revenues (OECD, 2024). While debt levels in Ireland have decreased over the past 10 years, they remain high (Department of Finance, 2024a) and it is unlikely that increasing debt to fund current expenditure on health and social care in the coming years would be a viable option. Increasing government revenue by increasing taxation (or social insurance) may be a viable option, with a 2022 OECD survey finding that nearly 60 per cent of Irish respondents were willing to pay an additional two per cent of their income in taxes/social contributions to improve access to healthcare (OECD, 2023b). However, given the current (2025/2026) cost-of-living crisis (Ó Ceallaigh et al., 2025) and that additional tax contributions are more likely to maintain the status quo (in light of growing demand for health and social care services) rather than improve access, it remains somewhat unclear how much, if any, taxpayers would be willing or able to contribute through increased contributions in this context.

An alternative to increasing overall government expenditure is to increase the allocation to health and social care within existing budgets (OECD, 2024). The OECD, however, note that this is only likely to be a viable option for countries with existing relatively low allocations to health (OECD, 2024). In 2021, across the OECD, health spending accounted for an average of 15 per cent of total government spending; however, the percentage was 21 per cent in Ireland (OECD, 2024) with further increases in subsequent years (Parliamentary Budget Office, 2024). Consequently, in light of other demands on government expenditure in the coming years (Department of Finance, 2025a), it is unlikely that the growing expenditure requirements can be met by increasing the proportion of government expenditure allocated to health.

One area where there may be scope to fund increased expenditure is through the use of earmarked taxes (Cullinan et al., 2021). In Ireland, there are several (non-earmarked) taxes on products which are deemed to harm population health (including tobacco, alcohol and sugar-sweetened drinks), which are, in part, motivated by public health concerns (Commission on Taxation and Welfare, 2022). While the revenue generated from these taxes is not currently allocated to the health budget, such an allocation does appear to be legally feasible (Office of the Attorney General, 1999) and consideration could be given to such an approach. However, the revenues raised from such taxes are likely to be relatively small and tend to decrease over time as consumers and manufacturers change their behaviour. Further, consideration could be given to broadening the tax base. The Commission on Taxation and Welfare, for example, has previously recommended broadening the tax base to ensure the sustainability of the taxation system against future challenges (including demographic change), thereby limiting the need to increase tax rates (Commission on Taxation and Welfare, 2022).

3.3.4 Implement efficiency gains

Efficiency gains have the potential to offset some of the additional expenditure requirements associated with a growing and ageing population. However, the offset is likely to be relatively small relative to the increase in expenditure requirements associated with demographic change.

Brick et al. (2025a), for example, estimated how some efficiency measures within the public hospital system could offset some of the

growing demands associated with a growing and ageing population. They estimated that the projected bed requirement of 9,515 in 2040 (status quo scenario) could be reduced by between 1,200 and 1,500 if the average length of stay was reduced (holding everything else constant); while reducing avoidable hospitalisations (through the greater provision of care in the community) could reduce bed requirements by between 249 and 534. On a more macro level, recent work by the OECD for Ireland, benchmarking the efficiency of health expenditure over the period 2004–2019 against 16 high-income countries, found that up to 15 per cent of current health expenditure could be reduced, while maintaining current life expectancy, if Ireland were to fully exploit the gains achieved by the best-performing countries (Sicari and Sutherland, 2023).

However, addressing this type of wasteful expenditure presents significant challenges.

Existing attempts to ensure that the efficiency of publicly financed health and social care expenditure include the use of cost-effectiveness analysis to inform the approval of public expenditure on pharmaceutical interventions. However, the cost-effectiveness threshold (at €45,000 per quality-adjusted life year) is high, and yet many drugs that exceed this threshold are approved (O'Mahony and Coughlan, 2016; O'Mahony, 2021). Further, despite the introduction of generic substitution in 2016, the use of generics in Ireland is still low by international standards (Sicari and Sutherland, 2023), though this could, in part, be related to the mandatory price reductions on originator medicines once their patent expires, helping to manage prices (Sicari and Sutherland, 2023). Non-pharmaceutical interventions are generally not subject to any cost-effectiveness analysis, resulting in discrepancies in funding for pharmaceutical and non-pharmaceutical interventions.

Attempts to increase efficiency in the hospital sector include reductions in the length of stay (Walsh et al., 2022) and the increased use of day surgery as an alternative to an inpatient admission (Brick et al., 2025b). Though variation in day-surgery rates and high rates for some procedures in an international context (OECD, 2023a) suggest that there may be room for further improvements in this area. Other ongoing initiatives to improve efficiency include the development of the chronic disease management programme (which seeks to provide care in the community as a means of reducing pressure on the hospital

system), virtual hospital wards and the transition from a five-day to a seven-day hospital service. In 2024, a Savings and Productivity Taskforce⁷ was established to co-ordinate efforts to drive savings and efficiencies across the HSE, while an interactive dashboard, presenting data at hospital level on various indicators of productivity, was also launched in order to provide greater transparency and to identify areas of best practice and underperformance. At the health system level, the move towards the six HSE health regions and the introduction of a Population-Based Resource Allocation funding model seek to promote efficiency and equity in both outcomes and distribution of resources (McCarthy et al., 2022); though several key services remain outside of the proposed model in the first instance (Walsh and Hill, 2024).

Improving the efficiency of the Irish health and social care system is a key concern for policymakers and, as detailed above, a number of initiatives have or are in the process of being implemented. It is too early to say what impact these measures will have on the demand and delivery of health and social care services. For all measures, an evidence-based approach is required, with the effectiveness and cost-effectiveness of different initiatives assessed and adjusted as needed. However, such an approach is data-intensive and unlikely to be widely feasible until data availability is improved. In this context, a significant amount of resources has been allocated to improve data and digitisation across the health sector, and the introduction of the European Health Data Space⁸ should improve data availability in the coming years.

3.3.5 Improving population health

A further approach to addressing the ageing of the population and the projected increase in capacity requirements is to focus on maximising the population's health status. While the ageing of the Irish population is inevitable, there is some potential to influence the health status of people as they age and consequently the need for health and social care services. There have been significant increases in life expectancy

⁷ <https://www.gov.ie/en/department-of-health/collections/productivity-and-savings-taskforce>

⁸ https://health.ec.europa.eu/ehealth-digital-health-and-care/european-health-data-space-regulation-ehds_en

in Ireland over the last 30 years and a reduction in avoidable mortality⁹ (European Observatory on Health Systems and Policies/OECD, 2025). However, there is little evidence on how health status has evolved. Analysis from other countries shows a mixed picture on health trajectories, with the observed trajectories depending on, among other things, the measure of health status, as well as the age group and time period under consideration¹⁰ (Crimmins, 2015; Kingston et al., 2017).

There are several different approaches that could be employed to improve population health. Research from England focusing on future population health noted that there was a need to move away from a system focusing on diagnosing and treating illness, towards one that is based on promoting wellbeing and preventing ill health (Buck et al., 2018). In this context, the research recommended a focus on (i) the wider determinants of health, including income, education, housing and transport, (ii) health behaviours and lifestyles, including smoking, alcohol consumption, diet and exercise and (iii) the role of place and communities in influencing health (Buck et al., 2018). The development of ‘Healthy Ireland’ (a government-led initiative that seeks to improve the health and wellbeing of everyone living in Ireland) in 2013, the goal of which is to prevent chronic disease by encouraging healthy lifestyle behaviours and creating healthier environments,¹¹ was an important step in this context. However, trends in the prevalence of various health behaviours in Ireland show a somewhat mixed picture since the inception of Healthy Ireland, with the findings depending on the measure under consideration. While the prevalence of binge drinking and smoking has decreased over time (Ipsos B&A, 2025), there has been little change in rates of overweight and obesity (Ipsos B&A, 2024), though new drugs in this area may impact on rates of overweight and obesity in the coming years. In recent years, the uptake of some vaccinations has decreased. Further, health inequalities persist and, in

⁹ Avoidable mortality measures premature deaths (generally under the age of 75) that could be avoided through preventable public health measures or treatable medical care.

¹⁰ When analysing population health changes over time, it is necessary to distinguish between ageing effects (e.g. a change in health status which occurs among all cohort, independent of the time period, as each cohort grows older) and a cohort effect (a change which characterises populations born at a particular point in time but which is independent of the process of ageing) (Blanchard et al., 1977).

¹¹ <https://www.gov.ie/en/healthy-ireland/campaigns/healthy-ireland/>

some cases, have increased over time (Duffy et al., 2022; Devlin et al., 2025).

While improving population health represents a potential opportunity, given the multitude of factors that influence health, it is a challenging policy objective as it generally requires co-ordinated action across departments and agencies and may involve targeted efforts to support more disadvantaged groups. Further, while improving population health is a desirable goal in its own right, there is relatively little evidence linking population health improvements and a reduction in total health and social care expenditure (Jha, 2019). Climate change and economic instability may also have adverse effects on population health (see sections 4.3 and 4.5), although some climate policy initiatives could provide co-benefits to health (section 4.5).

3.4 Summary

Several measures can be undertaken to help ensure the sustainability of the public health and social care system, some of which are already in place, including saving for the future, seeking efficiency gains and improving population health. There is, however, much uncertainty about the extent to which these measures might offset growing demands and expenditure requirements. The OECD finding that up to 15 per cent of current health expenditure could be reduced, while maintaining life expectancy, is promising. However, where this involves reducing or removing services, implementation is likely to be challenging. In light of recent CSO data¹² which shows that increases in healthy life years (that is, the number of years that a person at birth is expected to live in a healthy condition) have stalled in recent years, a further focus on population health appears warranted.

Other measures to ensure the sustainability of the publicly financed healthcare system are likely to be less feasible in the Irish context. A measure of moving expenditure from the public to the private would conflict with the current health policy (Sláintecare). While increasing the proportion of government expenditure to health and social care is unlikely to be feasible in light of other demands on such expenditure, including on pensions and other challenges.

¹² <https://www.cso.ie/en/releasesandpublications/hubs/p-wbhub/well-beinginformationhub/mentalandphysicalhealth/healthylifeyears>

Chapter 4

Wider economic and societal considerations

4.1 Introduction

The previous chapters discussed the potential impact of demographic change on health and social care demand and associated expenditure requirements in Ireland in the coming years. Demographic change will also have other implications, including increased demand for pensions and a reduction in the relative number of people of working age, potentially impacting on tax revenues and the supply of the health and social care workforce. Further, demographic change is occurring alongside other changes related to climate change and decarbonisation, digitalisation and an uncertain geopolitical environment (Department of Finance, 2025b). This chapter briefly considers how workforce shortages, climate change and decarbonisation, digitalisation and the uncertain geopolitical environment might affect the health and social care system in the coming years, as demographic change drives increasing demand.

4.2 Workforce shortages

A key concern for the future health and social care system is whether there will be a sufficient workforce available to meet the additional demands arising from a growing and ageing population. While there have been significant increases in publicly employed health and social care professionals in recent times (Fleming et al., 2022), significantly more staff will be required in the coming years to meet the increasing demand due to demographic change (Keegan et al., 2022; Connolly et al., 2025a) and to make the required capacity expansions feasible.

Growing requirements for health and social care professionals are not unique to Ireland, and several international organisations have published guidelines seeking to address projected shortages. A recent report from the OECD and European Commission, for example, identified several potential short- and medium-term strategies to address workforce shortages, including increasing retention of the existing workforce, increasing training places, task shifting and improving productivity, as well as bringing in staff from abroad (OECD/European Commission, 2024).

Challenges to ensuring an adequate health and social care workforce in the coming years have been recognised by the Irish Government

(Department of Health, 2017) and there has been an increased focus on workforce planning in recent years across the Department of Health and HSE (HSE, 2019; Caulfield et al., 2022). Training places and courses for a range of health professionals have increased, with plans for further expansion in the coming years (HSE, 2024b; Department of Further and Higher Education, Research, Innovation and Science, 2025). Task shifting, too, has been introduced with, for example, an increased role for community-based pharmacists as a means of reducing pressure on GPs and increasing access to timely healthcare for patients (Department of Health, 2024b). However, less progress has been made in other areas. Retention of existing healthcare professionals continues to be an issue (Hanlon et al., 2024; McEvoy et al., 2025). Further, recent research suggests that there is evidence of a decrease in interest among younger people in Ireland in pursuing a career in nursing (OECD/European Commission, 2024). The extent to which recruiting additional staff from abroad for Ireland is desirable is questionable; the OECD/European Commission note that an overreliance on foreign-trained workers risks exacerbating workforce shortages in source countries, which are often lower-income countries with health workforce constraints, and Ireland already has one of the highest stocks of foreign-trained doctors and nurses in the OECD (OECD/European Commission, 2024). There may be an opportunity to encourage Irish-trained health professionals to return to Ireland. However, challenging working conditions have been identified as a driver of the emigration of Irish doctors and a deterrent to return (Humphries and Byrne, 2026). Further, housing shortages and costs could also act as a deterrent to healthcare workers choosing to live and work in Ireland.

While growing demand for health and social care services will result in an increasing need for health and social care professionals, it will also require other workforce groups. Infrastructural needs (e.g. hospital/long-term residential care facilities, primary care centres, etc.) within the health and social care sector, for example, will drive demand for construction (and associated) workers. Previous research has estimated that almost 80,000 additional construction workers would be required to address Ireland's infrastructure deficit (Conroy and Timoney, 2024), with many more required for infrastructure requirements to keep up with growing demand for health and social care.

4.3 Geopolitical uncertainty

The global and Irish economy have faced repeated economic shocks in recent years (Barrett et al., 2026). The re-election of President Trump in 2024 has brought much uncertainty around potential tariffs on imports to the US, impacting the global economic outlook (IMF, 2025). Recent work from the ESRI has shown that the imposition of tariffs by the US on the rest of the world would have a significant negative impact on the Irish macroeconomy, which in turn would negatively impact the public finances (Egan and Roche, 2025). Other global events too have the potential to impact the Irish economy in the short to medium term. This report was written approximately three months into the Iran crisis, and it remains unclear how long the crisis will last and what impact it will have on the global and Irish economy in the medium term. However, price increases have already occurred, and it is anticipated that such prices will continue to rise through 2026 and 2027, which has the potential to dampen both global and Irish economic activity (Barrett et al., 2026).

Given the significant proportion of public expenditure which is currently allocated to health and social care, any deterioration in the public finances would inevitably impact the availability of resources for publicly financed healthcare services. Given the growing demand for health and social care services detailed above, such a reduction in the health budget would have a detrimental impact on Ireland's ability to deliver the required health and social care services for an ageing and growing population, including capital projects. Further, a downturn in the public finances in the short to medium term would likely constrain Ireland's ability to save for future challenges through, for example, the Future Ireland Fund. Any deterioration in the public finances would significantly limit the policy options available to policymakers (detailed in section 3.2) to deal with the growing demand arising from demographic change in the coming years.

In addition to the potential negative impact on public finances, global uncertainty could also negatively impact the Irish healthcare system in other ways. Writing in *The British Medical Journal*, Flynn Murphy notes that the reconfiguration of US trade relations and a pledge to make all of the country's essential drugs and their inputs at home is threatening the stability of medical supply chains (Murphy, 2025), potentially leading to price increases and shortages.

Economic instability and downturns in economic activity brought about by globalisation or other international crises could also negatively impact population health in Ireland, exacerbating demand pressure on the healthcare system. Cost-of-living crises can have deleterious effects on psychosocial stress and health behaviours, and can bring about food and fuel poverty and housing insecurity (Broadbent et al., 2023). These population health effects could increase morbidity and mortality, especially for already vulnerable segments of the population (Meadows et al., 2024).

4.4 Digitalisation

Digital health is playing an increasing role in health systems across the OECD through electronic health records (EHRs), the use of population health data for monitoring and policy, and the integration of digital tools such as telemedicine into routine clinical care (OECD, 2023a). This increased digitalisation brings both opportunities and challenges. Digitalisation has the potential to increase productivity through efficiencies across the health sector (Department of Finance, 2025a), as well as potentially improving access to healthcare, patient safety and monitoring. However, challenges must be overcome to avail of the potential opportunities that digitalisation offers.

Currently, the Irish healthcare system has a relatively weak digital infrastructure (Sicari and Sutherland, 2023), with impacts on the delivery of care, monitoring of the health system and planning (Page et al., 2024). There is limited use of individual health identifiers (IHI) and EHRs, while key national datasets are in the custody of a range of different institutions, with little ability to link at the national level (Oderkirk, 2021). At a more basic level, for many public health and social care services provided in the community, there is a lack of a systematic minimum dataset (Walsh et al., 2021), and there is very little data available on privately provided services, even when they are publicly financed.

In recent years, however, there has been much emphasis and funding for increased digitalisation across the health system, with the COVID-19 pandemic acting as a catalyst for increased adoption of tools like ePrescribing, eReferrals, and telemedicine (Walsh et al., 2021). In 2024, the Irish Government published its Digital Health Framework (Department of Health, 2024a); and in 2026, the Health Information

Act¹³ was passed. The Health Information Act aligns with the European Health Data Space (EHDS) set of rules that provide common standards and practices, infrastructures and a governance framework that healthcare authorities should work towards.¹⁴ It remains to be seen how quickly health and social care providers begin providing the requisite data, how digital health records will be disseminated across health and social care providers in the system, and how EHRs will operate in practice. However, the appropriate legislative framework is an essential first step in prioritising health data in the Irish context (Connolly et al., forthcoming).

In recent years, there has been a rapid escalation in the development and use of artificial intelligence (AI). Within the healthcare sector, there are a myriad of potential opportunities from AI, including more accurate diagnoses, personalised treatment plans, a more efficient allocation of resources and shortening of administrative tasks (Chustecki, 2024; European Commission, 2025). A recent survey highlighted the widespread use of AI in clinical practice in Ireland, with 58 per cent of physicians reporting use of AI in a number of domains, including supporting clinical decision-making, documentation and administration (Glynn, 2026). However, harnessing the potential of AI in the health sector comes with challenges; these include a need for appropriate and up-to-date guidelines and governance in a rapidly evolving area, a potential lack of transparency in decision-making, a potential compromise of patient data privacy and biases within AI algorithms (Chustecki, 2024). Among Irish physicians, concerns have also been raised about the gap between adoption and preparedness, with a need for additional and ongoing training required (Glynn, 2026). Currently, AI as a technology for healthcare is in its infancy, but the capabilities and cost of using AI are expected to continue to change rapidly over time. It is difficult to assess how beneficial and cost-effective different applications of AI in clinical practice will be.

For all technological developments within the healthcare sector, careful monitoring is required to ensure that some people, or groups of people, are not left behind. In addition to investing in digital infrastructure and tools, some investment may be required to build

¹³ Health Information Act 2026 – No. 10 of 2026 – Houses of the Oireachtas.

¹⁴ <https://www.european-health-data-space.com>

trust in digital healthcare systems and AI to increase people's capacity to engage with such services (McHugh and Connolly, 2025).

4.5 Climate change and decarbonisation

Somewhat similar to digitalisation, climate change and decarbonisation bring both challenges and opportunities for the Irish health and social care system.

Climate change will increasingly impact population health in the coming years. Increasing high-temperature days increase the risk of circulatory, respiratory and infectious diseases and lead to excess mortality, even in Ireland's temperate climate (Rocque et al., 2021; Duffy et al., 2024). Groups who are already at risk of poor health, including older people, those with chronic illness, infants and the socio-economically disadvantaged, are most at risk, potentially worsening existing health inequalities (Paterson and Godsmark, 2020). Such health impacts result in greater demand on the existing healthcare system, while other impacts of climate change, including increased flood risk and extreme wind events, can damage infrastructure, impacting healthcare delivery through power outages and transport disruptions (Environmental Protection Agency, 2025). Further, climate change-induced international conflict and economic instability can all indirectly strain population health (Duffy et al., 2024) and threaten international pharmaceutical supply chains.

Given that healthcare contributed almost five per cent of Ireland's carbon emissions in 2018, the sector has a role to play in decarbonisation (OECD, 2025). Within the health sector, hospital care in particular is emissions-intensive (OECD, 2025). Consequently, policies that seek to reduce hospital services and improve efficiency (e.g. increasing management of chronic disease in the community, reducing length of stay, reducing avoidable hospitalisations) also have the potential to reduce emissions. Beyond these measures, the main scope for decarbonisation in healthcare is reducing emissions in the supply chains for pharmaceuticals and medical inputs (OECD, 2025), although such approaches require substantial costs in investment and training workers (OECD, 2025; Tesfaye et al., 2025).

More broadly, decarbonisation policies have the potential to positively impact population health. Decarbonising transport by improving vehicle fuel type and efficiency, and by reducing car use, has the potential to improve air quality, thus reducing illness and premature

deaths from particulate matter and nitrogen oxides (Jennings et al., 2020; Hoy et al., 2025). Substituting car use for active travel (e.g. cycling and walking) brings additional health benefits by increasing physical activity (Karlsson et al., 2020). Initiatives to improve home insulation, as outlined in the National Retrofit Plan (Department of the Environment, Climate and Communications, 2021), both save energy and can reduce excess winter deaths, illnesses and mental health issues associated with living in a cold environment (Jennings et al., 2020; Jammet, 2023). Finally, proliferation of low-carbon diets with less red meat would likely reduce rates of cardiovascular disease, stroke and obesity (Jennings et al., 2020).

Chapter 5

Conclusions

The growing and ageing population will contribute to significant increases in demand, and associated capacity requirements, for a range of health and social care services, in the short to medium term. Reflecting these increasing demands, several plans and measures are in place to address the growing capacity requirements, with a particular focus on increasing the workforce and hospital capacity. Other initiatives are seeking to improve the efficiency of the system through, for example, reorienting the system towards primary care and seeking increased efficiencies within the hospital sector. While these measures are to be welcomed, the ageing of the population means that there will be an ongoing need to ensure that existing and planned capacity keeps up with the growing demand. In particular, there is an urgent need to focus on those services which are predominantly used by older people, including long-term care. While these services are expected to experience the largest increases in the coming years, plans to scale up capacity in these areas are less advanced than those for hospitals. Importantly, there is a need to consider what can be done to improve population health, both as a means of maximising population quality of life and managing future health and social care demands.

The growing demands for health and social care raise questions about the fiscal sustainability of the system. While Ireland's population is relatively young (compared to other European countries), already approximately one-quarter of current government expenditure is allocated to health and social care. Even within this budget, access to some healthcare services remains problematic, with long waits for a range of healthcare services, and the majority of the population continues to pay out of pocket for primary care services.

The increasing expenditure requirements are coming at a time of great uncertainty for Ireland (and the world). Geopolitical tensions, increased digitalisation and climate change all bring challenges to the Irish economy and society in general and for the healthcare system in particular. Further, while the COVID-19 pandemic might be regarded as a once-in-a-lifetime event, it is a reminder that shocks can and do significantly impact the health and social care system.

Taking a broad perspective of the ongoing and forthcoming challenges for the health and social care system requires consideration of approaches which may have multiple positive impacts. Policies tackling climate change, for example, can also have co-benefits for population health, in particular policies which focus on air quality, physical activity, housing quality and green space (Becvarik et al., 2024).

Increased digitalisation comes with costs and, in the health sector at least, Ireland is playing catch-up. However, increased digitalisation can both directly and indirectly increase the efficiency of the healthcare system. Direct impacts include automating administrative tasks and increasing the delivery of remote health services. Indirect benefits include better data, allowing more nuanced planning and evaluation of various health technologies and interventions. Achieving such co-benefits is complex and will require a whole systems approach, which involves multiple relevant government departments and agencies. However, such an approach is essential to ensuring the sustainability of the Irish health and social care system in light of a range of competing challenges.

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