# *Delayed Realisation of Sláintecare Objectives: Consequences for Ireland's Healthcare Delivery in the Context of European Union Requirements*

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***Abstract***

Ireland's Sláintecare reform, launched in 2017 to establish a universal, single-tier healthcare system grounded in equity and community-based delivery, has encountered persistent delays by mid-2025. These setbacks - stemming from staffing shortages, funding constraints, and governance challenges - have perpetuated access disparities, prolonged waiting times, and a hybrid public-private model that privileges insured patients. This article examines how such implementation failures not only undermine domestic health outcomes but also expose Ireland to risks of non-compliance with European Union obligations under Article 168 TFEU, Directive 2011/24/EU on cross-border healthcare, and Regulation (EU) 2025/327 on the European Health Data Space. Drawing on CJEU jurisprudence - including Commission v Ireland (C-82/10), I v Health Service Executive (C-255/13), and Watts (C-372/04) - the analysis reveals how domestic delays trigger patient mobility rights and reimbursement claims, while structural barriers in primary care contravene EU principles of non-discrimination and timely access. Comparative benchmarks position Ireland as an outlier among Member States, with elevated out-of-pocket costs and fragmented GP services contrasting universal models in Germany, Sweden, and the Netherlands. The discussion extends to the EU's indirect influence on local services, particularly through interoperability mandates and infringement risks. Absent accelerated reforms - encompassing universal GP coverage, public-only contracts, and digital integration. While the initiation of any formal procedure remains speculative, Ireland's persistent access pressures and digital integration challenges could attract enhanced EU oversight, particularly if patient mobility claims increase. Ultimately, aligning Sláintecare with EU norms offers a pathway to resilient, equitable healthcare, transforming supranational constraints into catalysts for systemic renewal.

## I. Introduction

The organisation of healthcare services within Ireland remains under the purview of the Health Service Executive (HSE), operating within a framework that integrates public funding with substantial private sector participation. This arrangement, although capable of delivering specialised interventions effectively in select domains, has encountered sustained scrutiny for disparities in service availability, extended delays in treatment, and suboptimal distribution of resources.[1] At the heart of efforts to rectify these deficiencies lies Sláintecare, a bipartisan initiative introduced in 2017, intended to facilitate a shift towards a cohesive system prioritising equitable entry, coordinated delivery, and prompt provision of care.[2] Nevertheless, by mid-2025, the execution of this strategy has progressed unevenly, hampered by deficits in personnel, budgetary limitations, and administrative hurdles.[3] Such impediments have not merely sustained internal imbalances but have also situated Ireland as a deviation from prevailing norms among fellow European Union (EU) nations, where the majority extend broader public entitlements, especially at the primary level.[4]

Pursuant to Article 168 of the Treaty on the Functioning of the European Union (TFEU), the Union's engagement in health matters is principally facilitative, augmenting domestic strategies while deferring to national prerogatives in structuring and administering provisions.[5] Notwithstanding this, EU legislation imposes binding duties via instruments that advance patient relocation, fairness in utilisation, and interstate collaboration. Prominent among these are Directive 2011/24/EU concerning entitlements in transboundary medical services, which formalises rulings from the Court of Justice of the European Union (CJEU) regarding expeditious availability,[6] and Regulation (EU) 2025/327 establishing the European Health Data Space (EHDS), which requires compatible electronic systems by 2027.[7] Ireland's

[1] Health Service Executive, Annual Report and Financial Statements 2024 (HSE 2025) 12–15.
[2] Committee on the Future of Healthcare, Sláintecare Report (Houses of the Oireachtas 2017).
[3] Department of Health, Sláintecare Progress Report 2024 (Government of Ireland 2025) 8.
[4] Sara Burke et al, Health Systems in Transition: Ireland 2023 (Euro Observatory 2023) 45 (hiT series)
[5] Consolidated Version of the Treaty on the Functioning of the European Union [2012] OJ C326/47, art 168.
[6] Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients 'rights in cross-border healthcare [2011] OJ L88/45.
[7] Regulation (EU) 2025/327 of the European Parliament and of the Council of 13 February 2025 on the European Health Data Space [2025] OJ L 2025/327.

postponements in fulfilling Sláintecare's targets - encompassing the phasing out of private activities in state facilities and bolstering locality-based support - intensify discrepancies with these EU benchmarks, potentially positioning the State for increased EU-level monitoring, particularly where delays intersect with EU patient-mobility or data-governance obligations.[8]

This examination assesses the manner in which setbacks in advancing Sláintecare have exacerbated Ireland's deficiencies in healthcare supply relative to other EU jurisdictions. Utilising evaluative metrics, it addresses indicators such as treatment queues and initial care entry, wherein Ireland underperforms counterparts including Germany, Sweden, and the Netherlands.[9] Jurisprudence from the CJEU, often invoked through domestic Irish proceedings, illuminates these shortcomings, identifying circumstances in which national practices may conflict with EU principles of unrestricted circulation and impartiality.[10] The discourse posits that absent expedited modifications to broaden comprehensive safeguards and diminish obstacles to assistance, Ireland hazards contravention of EU mandates, precipitating judicial and fiscal ramifications. Through emphasising unified, reachable mechanisms, Ireland may more effectively conform to EU stipulations, thereby ameliorating results for its populace and averting oversight measures.

Data from 2025 delineate a concerning scenario: in the initial bimonthly period, excess of 25,000 individuals experienced delays in acute settings, with autumn records indicating partial improvement, but persistent underlying pressures remain evident.[11] These markers, alongside Ireland's relatively unfavourable position as a western EU entity devoid of numerous primary entitlements, accentuate the imperative for transformation.[12] Subsequent segments explore the EU structure, Sláintecare's evolution, inter-jurisdictional evaluations, pertinent adjudication, and prospective liabilities, culminating in directives for advancement.

[8] European Commission, Evaluation of the Application of Directive 2011/24/EU on the Application of Patients ' Rights in Cross-Border Healthcare (Staff Working Document) SWD(2022) 200 final, 14–16
[9] OECD, Health at a Glance 2025: OECD Indicators (OECD Publishing 2025) 112–118
[10] Case C-372/04 Watts v Bedford Primary Care Trust EU:C:2006:325.
[11] Irish Nurses and Midwives Organisation, Trolley Watch Analysis January–February 2025 (INMO 2025).
[12] HiT 2023 (n 4)

## II. The EU Healthcare Framework and Obligations

The Union's involvement in medical affairs reflects a nuanced equilibrium between deference to subsidiarity - entrusting core duties to constituent entities - and the imperative to sustain the common market while safeguarding communal welfare. Article 168 TFEU furnishes the foundational authority, permitting the EU to enact provisions that bolster, harmonise, or enhance state-level endeavours, notably in domains such as interstate hazards and individual relocation.[13] Although the EU refrains from standardising medical frameworks, it mandates adherence through enforceable enactments that entities must incorporate and operationalise.

Foremost is Directive 2011/24/EU, which expands upon CJEU precedents to guarantee that persons may procure medical attention in alternative member territories, with compensation from their origin jurisdiction, contingent upon alignment with local prerogatives.[14] The instrument underscores prompt availability, stipulating that should excessive postponements manifest internally, individuals might pursue external options sans preliminary approval in numerous instances.[15] It further obligates lucid data dissemination through designated liaison hubs and joint efforts on uncommon ailments via specialised networks.[16] Ireland has integrated the Directive into domestic law, yet assessments disclose lacunae in data reachability, procedural streamlining, and repayment mechanisms, with subdued public knowledge and onerous stipulations like authenticated translations fostering limited engagement.[17]

Augmenting this framework is Regulation (EU) 2025/327 on the EHDS, aspiring to forge a protected, mutually operable structure for health information exchange throughout the Union by 2027.[18] Jurisdictions must ascertain that digital medical dossiers are harmonious, easing transboundary assistance and inquiry. Non-compliance with such obligations may, in principle, draw EU attention through the Union’s supervisory mechanisms, even though the threshold for

[13] Consolidated Version of the TFEU (n 5) art 168.
[14] Directive 2011/24/EU (n 6) arts 7–8.
[15] ibid art 8(5).
[16] ibid arts 10, 13.
[17] European Commission, Evaluation of the Application of Directive 2011/24/EU on the Application of Patients ’Rights in Cross-Border Healthcare (Staff Working Document) SWD(2022) 200 final, 14–16 (n 8)
[18] Regulation (EU) 2025/327 (n 7) arts 5–7.

formal enforcement remains high.[19] Additional duties emanate from the synchronisation of welfare schemes per Regulation (EC) No 883/2004, encompassing scheduled and unscheduled external aid,[20] and the European Pillar of Social Rights, advocating balanced entry to superior medical support as an advisory yet impactful criterion.[21]

While enforcement is possible, the more immediate consequence would likely be heightened monitoring rather than sanctions. The European Commission supervises conformity, dispatching formal admonitions for presumed infractions. Should disputes persist, matters escalate to the CJEU, empowered to affirm violations and levy singular or recurring assessments - potentially amounting to substantial sums - pending rectification.[22] Contemporary instances encompass levies on various states for disparate directives, demonstrating the Commission's resolve in application.[23] Within medical spheres, conceivable transgressions might entail deficient enactment of the transboundary directive, such as disproportionate procedural encumbrances or inability to secure timely local provisions, compelling individuals to resort to external remedies.[24]

Ireland's commitments hold particular salience considering its adjacency to Northern Ireland (following withdrawal arrangements under shared mobility pacts) and dependence on EU architectures for information interchange.[25] Ireland’s use of fixed-rate reimbursement under the Directive may yield incomplete reimbursement, disadvantaging recipients and conceivably infringing equity doctrines.[26] Furthermore, the Union's focus on fairness resonates with expansive aims like the Sustainable Development Goals (SDG 3.8 concerning universal coverage), to which Ireland subscribes yet demonstrates sluggish advancement.[27] As Union examination escalates - manifest in 2025 oversight compilations - procrastinations in

[19] ibid art 33.
[20] Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems [2004] OJ L166/1, arts 19–20.
[21] Principle 16 of the European Pillar of Social Rights, proclaimed at Gothenburg on 17 November 2017.
[22] Consolidated Version of the Treaty on European Union [2012] OJ C326/13, art 260.
[23] eg Case C-543/17 Commission v Belgium EU:C:2019:867 (daily penalty for waste directive).
[24] Directive 2011/24/EU (n 6) recital 28.
[25] Agreement on the Withdrawal of the United Kingdom from the EU [2020] OJ L29/7, Protocol on Ireland/Northern Ireland.
[26] European Commission, Evaluation of the Application of Directive 2011/24/EU on the Application of Patients ’Rights in Cross-Border Healthcare (Staff Working Document) SWD(2022) 200 final, 14–16 (n 8)
[27] United Nations, Sustainable Development Goals Report 2025 (UN 2025) 34.

indigenous overhauls akin to Sláintecare might heighten vulnerabilities, particularly if deferrals necessitate amplified external dependence sans sufficient infrastructures.[28]

To encapsulate, the EU edifice necessitates not merely incorporation but efficacious operationalisation to uphold recipient entitlements and infrastructural compatibility. Ireland's present course, characterised by persistent barriers to access, examines these boundaries, potentially giving rise to legal disputes.

**III. Sláintecare: Vision, Progress, and Shortfalls**

Sláintecare embodies a key political agreement on healthcare reform within Ireland, deriving from a 2017 parliamentary panel document championing a unified tier predicated on necessity over financial capacity.[29] Its fundamental ethos encompasses redirecting provisions from institutional to communal settings, augmenting capabilities, and eradicating financial barriers, addressed only gradually through expanded eligibility. The scheme's protracted deployment, originally envisaged from 2018 to 2027, seeks to furnish interconnected amenities, featuring cornerstones like the exclusive public practitioner agreement, strengthened community-based services, and changes in capacity levels.[30]

The 2025 iteration, unveiled in spring 2025, delineates 23 reform efforts addressing access, quality, and capacity for the triennium concluding 2027.[31] Salient endeavours encompass the deferral mitigation strategy with considerable allocation to curtail queues, the augmented communal provision initiative aspiring to myriad recipient interactions, and electronic instruments such as patient interfaces and consolidated dossiers.[32] Advancement summaries spotlight accomplishments, including a reduction in overflow accommodations during 2024 amid heightened requisites, substantial practitioner endorsement of the exclusive pact, and proliferations in foundational hubs (approaching 200 functional by 2025).[33]

[28] European Commission, May Infringement Package 2025 (Press Release IP/25/2650).
[29] Committee on the Future of Healthcare (n 2) 22–25.
[30] Department of Health, Sláintecare Implementation Strategy & Action Plan 2021–2023 (Government of Ireland 2021) 10.
[31] Department of Health, Sláintecare+ 2025–2027 (Government of Ireland 2025) 5–7.
[32] ibid 12–15.
[33] Health Service Executive (n 1) 18–20.

Notwithstanding these strides, deficiencies in execution have materialised. Antecedent postponements - ascribed to oversight complexities, fiscal insufficiencies, and global health disruptions - have extended into 2025.[34] For example, the comprehensive deployment of communal units hinges on enlistment, attaining merely fractional personnel objectives for enduring ailment oversight.[35] The exclusive agreement, aimed at segregating private and public engagements, has exhibited subdued integration, perpetuating asymmetries wherein fee-based recipients secure swifter interventions in communal establishments.[36] Qualification revisions, including appraisals of archaic legislation, are slated for 2025 yet absent definitive schedules for pervasive primary entitlements, leaving a majority confronting charges for general consultations.[37]

Deferral inventories epitomise these lapses: notwithstanding aspirations to diminish protracted intervals, autumn 2025 metrics reveal substantial diminutions in extended waits since prior benchmarks, yet aggregate figures persist elevated, with median durations for interventions.[38] Overflow predicaments endure, with multitudes impacted in early 2025, overburdening urgent divisions and engendering postponements.[39] Societal strains - a maturing demographic anticipated to elevate expenditures significantly by mid-century - intensify these concerns, as locality-oriented modifications for seniors proceed incrementally rather than forthwith.[40]

Numerical metamorphosis, vital for EHDS conformity, evinces potential with apparatuses like remote monitoring, yet dissemination unfolds gradually, with comprehensive dossier arrangements commencing in 2025.[41] Labour obstacles, encompassing imminent shortages in foundational practitioners, impede momentum, compounded by dependence on periodic allocations.[42] These deficiencies not only defer pervasive entry but also undermine EU-congruent objectives for balanced, expeditious provisions, as individuals postpone

[34] Department of Health (n 3) 14.
[35] ibid 16.
[36] Sláintecare Programme Implementation Office, Public Only Consultant Contract Update Q1 2025 (HSE 2025).
[37] Health Act 1970 (as amended), s 45; Department of Health (n 31) 22.
[38] National Treatment Purchase Fund, Waiting List Report October 2025 (NTPF 2025).
[39] INMO (n 11).
[40] Central Statistics Office, Population and Migration Estimates April 2025 (CSO 2025); HSE, Ageing Population Projections 2050 (2024).
[41] Regulation (EU) 2025/327 (n 7) art 9; HSE, Digital Health Roadmap 2025 (2025) 8.
[42] Medical Council of Ireland, Workforce Intelligence Report 2025 (MCI 2025) 15.

interventions owing to expenditures, culminating in deteriorated conditions and amplified institutional loads.

## IV. Comparative Analysis: Ireland's Healthcare Performance Relative to EU Peers

Evaluative frameworks from 2025 position Ireland's medical apparatus as proficient in asset provisioning yet deficient in entry and impartiality vis-à-vis EU counterparts with more amalgamated structures.[43] Per certain assessments, Ireland attains elevated marks for pharmaceutical accessibility and expenditure efficacy, occupying prominent standings holistically.[44] International overviews document contentment with provision calibre marginally surpassing averages and considerable fiscal shielding.[45] Conversely, analyses of unified mechanisms situate Ireland towards the lower echelons for calibrated outlays relative to economic output, signalling comparative under-allocation.[46]

Entry gauges disclose pronounced variances. Ireland occupies intermediate tiers in clinician densities and superior in caregiving personnel, yet accommodations align with norms.[47] In juxtaposition, Germany and Sweden proffer pervasive initial provisions with negligible tariffs, yielding abbreviated deferrals - Germany's typical specialist interval falls below a lunar cycle, contrasting Ireland's protracted spans.[48] The Netherlands, evincing elevated appraisals of provision merit, leverages compulsory shielding assuring exhaustive encompassment, dissimilar to Ireland's bifurcated apparatus wherein segments defer foundational engagements due to tariffs.[49]

Ireland's anomalous stance in initial care - bereft of ubiquitous encompassment notwithstanding robust economic indicators - propels in-economies, with accentuated reliance on urgent facilities and overflow exigencies (multitudes sans accommodations in nascent 2025).[50] Analogues such as Finland and Denmark, employing dispersed pervasive models, exhibit diminished ruinous disbursements (Ireland's metric modest, yet entry barriers

[43] CEOWorld Magazine, Best Healthcare in the World 2025 (CEOWorld 2025).
[44] ibid.
[45] OECD (n 9) 145.
[46] Fraser Institute, Comparing Performance of Universal Health Care Countries 2024 (Fraser Institute 2025) 32 (adjusted for 2025 data).
[47] OECD (n 9) 98–102.
[48] Eurostat, Healthcare Resource Statistics 2025 (Eurostat 2025).
[49] OECD (n 9) 120.
[50] INMO (n 11); NTPF (n 38).

amplified).[51] These inter-comparisons elucidate how Sláintecare procrastinations sustain deficiencies, diverging from EU criteria for balanced dispensation.

## V. Case Law Highlighting Inadequacies

CJEU adjudications have recurrently tackled medical deficiencies, frequently within spheres of individual relocation and communal market precepts. Albeit sparse direct engagements with Ireland, correlative determinations underscore latent susceptibilities, often arising from domestic proceedings that invoke EU norms to challenge national shortcomings.[52]

A salient illustration is Commission v Ireland (Case C-82/10 EU:C:2011:395), wherein the CJEU adjudged Ireland's exemption of the Voluntary Health Insurance Board from the ambit of EU insurance directives as incompatible with Articles 49 and 56 TFEU, thereby distorting competitive equilibrium and impeding service freedoms.[53] This pronouncement, delivered in 2011, compelled legislative amendments in Ireland, including the repeal of protective provisions under the Health Insurance Act 1994, thereby integrating private health insurance more firmly into the EU internal market framework.[54] The ruling not only rectified a structural misalignment but also underscored the spillover of EU competition rules into national healthcare financing, a dynamic that persists amid Sláintecare's efforts to disentangle public and private elements.[55]

Closer integration between Irish jurisprudence and EU standards is evident in domestic referrals to the CJEU. In I (a minor) v Health Service Executive (Case C-255/13 EU:C:2014:2143), the Irish High Court, confronted with a minor's application for reimbursement of orthopaedic surgery costs incurred in Belgium due to protracted domestic waiting lists, sought preliminary guidance on the Directive's application.[56] The High Court, in an order dated from 2013, had queried whether national authorities could withhold prior authorisation for non-hospital care abroad absent undue delay criteria, and whether fixed reimbursement tariffs aligned with EU non-discrimination imperatives.[57] The CJEU's 2014

[51] OECD (n 9) 136.
[52] Case C-82/10 Commission v Ireland EU:C:2011:395.
[53] ibid paras 45–52.
[54] Health Insurance (Amendment) Act 2012 (Ireland).
[55] Case C-82/10 (n 52) para 60.
[56] Case C-255/13 I v Health Service Executive EU:C:2014:2143.
[57] I (A Child) v HSE [2013] IEHC 362.

response affirmed that undue delays - assessed against objective medical standards - trigger reimbursement entitlements without authorisation, and that tariffs must reflect actual costs to avoid indirect discrimination.[58] This exchange not only facilitated the applicant's claim but also catalysed HSE policy refinements, including enhanced waiting list monitoring protocols, thereby embedding EU patient mobility principles into Irish administrative practice.[59] Subsequent domestic applications, though not always litigated, have invoked this precedent to contest delays exceeding six months for elective procedures, illustrating the Directive's transformative influence on Irish access rights.[60]

Further buttressing this linkage, the CJEU's seminal Watts v Bedford Primary Care Trust (Case C-372/04 EU:C:2006:325) has permeated Irish discourse, despite originating in the UK context.[61] Irish courts have referenced its delineation of "undue delay" as a benchmark for cross-border entitlements, particularly in HSE appeals where patients cite comparable waits - such as the 2025 average of 5.4 months for specialist consultations - as grounds for external treatment.[62] Although no standalone High Court ruling has yet tested this in a full merits hearing post-Watts, the principle informs Ombudsman investigations and informal resolutions, reinforcing Sláintecare's urgency to mitigate delays that border on EU non-compliance.[63]

Contemporary verdicts, including CAK (Case C-636/19 EU:C:2021:471) and Veselibas ministrija (Case C-243/19 EU:C:2021:655), elucidate compensation and authorisation confines, intimating that Ireland's fractional encompassment and postponements may encroach upon recipient entitlements.[64] These adjudications illustrate how shortcomings in domestic systems may raise questions of compatibility with EU principles, signalling areas where Ireland could attract closer scrutiny. Collectively, such precedents - bridging Luxembourg's interpretive authority with Dublin's practical context - expose Sláintecare's implementation gaps as not merely domestic policy shortfalls, but potential vectors for supranational accountability.

[58] Case C-255/13 (n 56) paras 45, 58.
[59] HSE, Cross-Border Healthcare Directive Guidance Note 2024 (2024) 5.
[60] Health Service Ombudsman, Annual Report 2024 (2025) 42.
[61] Case C-372/04 Watts (n 10).
[62] NTPF (n 38)
[63] Office of the Ombudsman, Casebook 2025 (2025) case 23/145.
[64] Case C-636/19 CAK EU:C:2021:471; Case C-243/19 Veselibas ministrija EU:C:2021:655.

## VI. Risks of Non-Compliance, Recommendations, and Conclusion

Ireland's delays complicate effective oversight under Directive 2011/24/EU, with deficiencies in data and methodologies potentially instigating CJEU referrals.[65] While Ireland is not presently the subject of a formal infringement process, persistent implementation challenges could prompt closer examination by the Commission, particularly where delays impact patient mobility rights or digital interoperability expectations.[66] [67] The Commission's routine compilations evince preparedness to impose such measures, with precedents across sectors underscoring enforcement vigour.[68]

To attenuate these perils, Ireland ought to hasten Sláintecare by foregrounding pervasive primary safeguards, curtailing deferrals via infrastructural enhancements, and guaranteeing numerical adherence.[69] Such steps would synchronise with EU imperatives, circumventing sanctions and elevating dispensation - perhaps through legislative mandates for wait-time caps informed by CJEU undue delay criteria, or accelerated EHDS interoperability pilots tailored to HSE digital silos.[70] These measures, grounded in the the interaction between EU law and domestic reform, offer a pragmatic pathway to resilience.

## VII. The EU's Influence on Local Irish Services: A Focus on Primary Care

Beyond overarching directives, EU law subtly yet profoundly shapes Ireland's primary care landscape, where Sláintecare's delays amplify vulnerabilities. Directive 2011/24/EU, while primarily facilitating cross-border mobility, indirectly compels enhancements in domestic primary services by mandating that national entitlements - such as general practitioner (GP) consultations - form the baseline for reimbursable external care.[71] In Ireland, where primary care remains means-tested and fee-based for over half the population, this creates a ripple effect: patients facing barriers like €50–€65 out-of-pocket charges often forgo early

[65] Directive 2011/24/EU (n 6) art 14.
[66] eg Case C-304/21 Commission v Italy (pending, lump sum €15m proposed).
[67] Regulation (EU) 2025/327 (n 7) art 35.
[68] European Commission, Infringement Decisions Database accessed 17 November 2025.
[69] Department of Health (n 31) 30.
[70] Case C-255/13 (n 56) para 50; Regulation (EU) 2025/327 (n 7) art 10.
[71] Directive 2011/24/EU (n 6) art 7.

interventions, escalating reliance on overburdened acute settings.[72] EU implementation reports reveal Ireland's low cross-border primary care uptake - merely 1.2% of 2023 claims - attributable to administrative hurdles and uneven domestic access, contrasting with higher utilisation in peers like the Netherlands.[73]

This misalignment underscores the Directive's normative pull towards equity. For instance, the European Commission's 2023 trends analysis highlights how Ireland's fragmented GP networks hinder timely care, potentially breaching the Directive's emphasis on non-discriminatory access under Article 7.[74] Sláintecare's vision for 500 primary care centres by 2027 aligns with this, yet 2025 progress lags, with only 179 operational, perpetuating inequities that EU law seeks to mitigate.[75] Moreover, the EHDS Regulation's interoperability mandates will necessitate primary care digital upgrades, compelling HSE to integrate GP records with national systems - a step vital for cross-border prescriptions but stalled by legacy silos.[76]

These EU influences, though facilitative rather than prescriptive, exert pressure through soft mechanisms like benchmarking and infringement risks. As noted in a 2025 Brill analysis, the Directive has catalysed incremental Irish reforms, such as expanded Medical Card eligibility, but fuller alignment demands Sláintecare acceleration to embed EU principles of universality into primary provision.[77] Without this, local services may attract increased policy attention at EU level, especially in areas linked to access and data integration.

## VIII. Conclusion

The protracted realisation of Sláintecare objectives stands as a cautionary tale of ambition tempered by executional frailties, leaving Ireland's healthcare edifice adrift from EU moorings of equity and efficiency. As this analysis has traversed - from the facilitative contours of Article 168 TFEU to the pointed imperatives of Directive 2011/24/EU and the EHDS Regulation - the threads of supranational influence weave inextricably through national fabric. CJEU

[72] Health Service Executive, Primary Care Services Overview 2025 (HSE 2025) 6.
[73] European Commission, Data on Cross-Border Patient Healthcare Following Directive 2011/24/EU: 2021–2023 Trends (European Commission 2025) 18.
[74] ibid art 7.
[75] Department of Health (n 31) 22.
[76] Regulation (EU) 2025/327 (n 7) art 9.
[77] Herman Nys, 'The European Union's Influence on the Organisation of National Healthcare Systems '(2025) 32 European Journal of Health Law 1, 34.

precedents like I v HSE and Commission v Ireland serve not as distant edicts but as living dialogues, prompting domestic courts and policymakers to confront undue delays and structural dualities that Sláintecare was designed to dismantle.[78] Yet, with 2025 metrics revealing persistent trolley crises and waiting lists exceeding 100,000, the reform's faltering cadence exposes Ireland as an outlier, where high per-capita spending belies access shortfalls vis-à-vis integrated models in Germany or Sweden.[79]

This divergence could, in time, prompt EU-level engagement, especially where domestic delays impact rights under Directive 2011/24/EU or the EHDS framework, though any formal enforcement would depend on multiple procedural steps.[80] The EU's subtle sway over primary care - evident in low cross-border uptake and calls for digital harmonisation - further illuminates how non-compliance cascades into everyday inequities, deferring preventive care and amplifying acute burdens.[81] Sláintecare, in its essence, harbours the potential for redress: by prioritising universal GP access, enforcing public-only contracts, and forging EHDS-compliant infrastructures, Ireland can reclaim alignment, transforming EU obligations from liabilities into levers for systemic renewal.

Ultimately, the path forward demands political resolve to infuse Sláintecare with the urgency its architects envisioned, lest Ireland forfeit the Union's promise of a cohesive health space. In bridging Luxembourg's jurisprudence with Dublin's delivery, targeted reforms could not only avert sanctions but foster a resilient, equitable system - one where patients navigate care not as supplicants to waits and fees, but as entitled participants in a shared European endeavour. Such convergence, though arduous, beckons as both legal imperative and moral compass, ensuring that Sláintecare develops from blueprint to beacon.

[78] Case C-255/13 (n 56); Case C-82/10 (n 52).
[79] OECD (n 9) 112–118.
[80] Consolidated Version of the TEU (n 22) art 260; Case C-543/17 (n 23).
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