IHCA Pre-Budget Submission 2022

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Submission by:

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Foreword

The Irish Hospital Consultants Association (IHCA) represents over 95% of Hospital Consultants working in Ireland's acute hospital and mental health services. In this submission, the Association has set out in detail the capacity deficits that exist in our public hospital and mental health services, together with objective evidence of how these deficits are impacting on patient care.

Decisions concerning the 2022 Budget present an opportunity, if the recommendations in this submission are implemented, to ensure that acute hospital and mental health services can provide for the backlog in deferred care and ongoing, increasing demand.

Providing acute hospital care to patients in the context of Covid-19 and with ever growing waiting lists has and will continue to present significant challenges because of the overwhelming capacity deficits that have increased over the past decade. The only way to resolve these deficits is to create additional capacity in the system. This will require the reallocation and refocussing of current and capital expenditure in the 2022 Health Budget and an immediate decision by Government to address the ongoing and deteriorating Consultant recruitment and retention crisis. Trust is a key success factor but it has been broken by successive governments since 2011. It must be restored by honouring the 2008 Consultant Contract. Specifically, the Government needs to end the 2012 imposed Consultant salary for all who have taken up contracts in the interim and future appointees. It is the root cause of Ireland's Consultant recruitment and retention crisis. The Government must restore pay parity immediately to strengthen Consultant retention, to fill the 1 in 5 permanent Consultant posts that are vacant or filled on a temporary basis and to further increase Consultant staffing levels.

Given the continued Covid-19 physical distancing rules, infection control requirements and need to reduce our bed occupancy rates, our inpatient units, outpatient facilities and Emergency Departments are all under increased pressure and require an urgent expansion of public hospital capacity. The pandemic and more recently the cyberattack have served to expose the deep fundamental deficiencies in our health system which already existed.

There is a high risk, in the aftermath of the extraordinary challenges we have all experienced since March 2020, that accumulated stress, health and general wellbeing problems will adversely impact on healthcare staff. Added to this, the cyberattack on the HSE and public hospitals has had a devastating impact on the health service's ability to treat and manage patients. Returning to the stressful, overstretched 'business as usual' model is not an option if we are to avoid an even worse workforce crisis than was the case pre-Covid.

If the Government does not honour its commitments to end the inequity and address the deficits, Sláintecare will amount to little more than business as usual and growing numbers of patients awaiting care. The pandemic has clearly demonstrated that inflexible policies and ideologies will impede, not enable, solutions. This is equally true in the context of contract negotiations and the delivery of acute hospital care. The solutions are 'hiding in plain sight'. The Government must embrace them and implement them, so that our public health service becomes a more attractive place to work.

This submission includes a detailed analysis of how the ongoing deteriorating situation can be arrested and how public hospital and mental health services can be resourced to deliver timely care to patients and adequately address the challenges presented by demographic changes, technological requirements, unmet need and other pressures on the system.

Prof Alan Irvine, IHCA President

Executive Summary & Recommendations

The Association strongly recommends the Government takes the following priority actions in the 2022 Health Budget:

Summary

The 2022 Health Budget must fund increases in acute hospital capacity to provide timely care to patients and adequately address the challenges presented by demographic changes, technological requirements, unmet need and other pressures on the system. The significant decrease in inpatient, day case and outpatient activity in acute hospitals during the past 18 months of the pandemic will require a corresponding increase in acute hospital appointments and funding in 2022 to address the backlog of patients requiring essential care and address the ever growing waiting lists, which are approaching 1 million people waiting for public hospital care.

Investment in Human Capital

1. **It is essential to immediately fill the 1 in 5 permanent consultant posts which are vacant and fund further increases in Consultant staffing levels to improve access and treatment for the record number of people awaiting outpatient appointments and inpatient and day case essential surgical and medical care.**
2. **The loss of our highly trained specialists has resulted in the employment of agency staff at often twice the cost of retaining such staff through direct employment. This false economy highlights the importance of restoring pay parity for all Consultants contracted after October 2012, so that the Irish health service is more competitive in international recruitment and retention terms and better equipped to fill the increasing number of vacant permanent posts with doctors who are on the Medical Council Specialist Register.**
3. **The cost of resolving the two-tier consultant pay inequity has been calculated at 4% of the Winter Plan 2020-2021 and less than 1.4% of the additional allocation to Covid-19 health measures in 2021.**
4. **To reduce the serious risk of burnout among Consultant staff, the Government must immediately fill the 1 in 5 permanent consultant posts that are unfilled and increase Consultant staff levels further.**
5. **The 'unambiguous commitment' made by Minister for Health Stephen Donnelly in October 2020 to remedy the salary inequity in full for all Consultants must be honoured to restore trust between the Consultant body and the health service management and tackle the worsening recruitment and retention crisis.**

Investment in Physical Capacity

6. **The Government must fast-track in the shortest possible timeframe the opening of an additional 6,000 acute hospital beds and 4,500 community step-down and rehab beds, funded in the revised National Development Plan (NDP) by 2030. At least half of these should be delivered within the first three years of the plan.**
7. **It is essential all planned additional hospital beds are prioritised for completion and a programme of new builds commissioned without delay as the IHCA is concerned the promised additional 1,146 inpatient beds by end 2021 will not be delivered.**
8. **At a minimum, the Government must urgently double the ICU bed capacity to 579 beds as recommended in an HSE commissioned report a decade ago, and ultimately increase capacity further to over 640 ICU beds to bring the number up to the EU average. The existing public hospital ICU capacity of 300 beds is far too low.**

9. **Dedicated theatre and bed capacity to deliver essential scheduled care must be expanded across our acute hospital base, not just in three locations as currently proposed.**
10. **A sustained, multi-annual programme of additional capital spending in public acute hospitals and mental health services, is required to mitigate against the €1.34bn of underinvestment that has pertained over the past decade.**
11. **Significant increased capital funding is required to bring operating theatre capacity, equipment and other facilities up to acceptable standards. A full audit of MRIs and other diagnostic equipment should be carried out to inform a new capital replacement programme.**
12. **A national Electronic Health Record is a vital part of the health infrastructure for patients and healthcare professionals and needs to be properly resourced and implemented without delay. It is essential the lessons learnt from the cyber-attack are properly addressed by investing in new public hospital IT systems, replacing legacy IT equipment and upgrading cybersecurity.**

Timely Access to Care

13. **The 2022 Health Budget must provide increased acute hospital resourcing to provide the additional capacity that is required for the timely delivery of care and the reduction of unacceptable waiting lists. The substantial decrease in inpatient, day case and outpatient activity in acute hospitals due to the pandemic will drive significantly increased levels of demand for hospital care in 2022 and will require additional funding.**
14. **The Government's long-promised multi-annual waiting list reduction plan must be released without delay and provide realistic targets and timescales for the reduction of Ireland's shocking waiting lists.**
15. **Expansion of public hospital capacity, including the appointment of additional Consultants and increased physical capacity, represents the effective sustainable solution to reducing waiting list.**
16. **The Government needs to introduce and resource more ambitious waiting time targets including a maximum waiting time of 18 weeks in place of the current targets of 52 weeks following a GP referral for a consultant outpatient appointment and 64 weeks for inpatient/day-case public hospital treatment. The government must be transparent with the public and frontline staff about the size of the backlog of deferred care and set out how – in practical terms – it will be managed, as well as providing realistic targets and related timescales for the delivery of such care**.

Mental Health Services

17. **The 2022 Mental Health Budget needs to be set at a realistic level given the historic deficits in the service and the impact of the pandemic on the population's mental health.**
18. **The services available to patients and the per capita budgets for Mental Health Services across the different CHOs should be streamlined so they are broadly similar and at a sufficiently high level in all areas of the country**.

Governance

19. **The Association supports the restructuring of healthcare services to ensure greater alignment between community and hospital services, based on common geographic areas with the full integration of these services. For this realignment to work effectively all hospital and community health services should be merged into one organisation within specific geographic areas**.

1. Health Budget

1.1 Public Acute Hospital Resourcing

The 2021 current Health Budget of €20.623bn is 20.6% above the corresponding figure of €17.099bn for 2020 (**Figure 1, Appendix 1**).[1] However, this increase includes €1.677bn on Covid related spending, €735.7m to fund existing services for a full year and just €1.112bn for new measures, which equates to a more modest 6.5% increase.

The Acute Hospitals budget increased by €803.3m (14.8%) in 2021 to €6.2345bn, which included €210m for the Covid-19 Access to Care Fund and €189m to meet the full year cost of existing services.[2] This left €404.3m for new developments in 2021 or an increase of 7.4%.

The above allocation to meet 'Existing Levels of Service' (ELS) is clearly insufficient and this has been the case historically over the past decade or more, as evidenced by the frequent use of supplementary health budgets. It is vital that this under-resourcing is ended, and adequate funding is provided to satisfy the actual demand for acute hospital care.

There were almost 363,000 less outpatient appointments last year compared with 2019 and inpatient/day case activity in 2020 was down 255,000.[3] While public hospitals attempted to catch up on some of that lost activity this year, the activity targets for 2021 were still 194,000 short of 2019 levels. In addition to this backlog, more than 900,000 people are on NTPF waiting lists to be seen or treated by a hospital consultant. As the health service recovers from the pandemic and patients who have deferred seeking care start to come forward, the waiting lists are likely to grow rapidly.

This significant decrease in inpatient, day case and outpatient activity in acute hospitals during 2020 and 2021 and the resulting volume of deferred care will require a corresponding increase in additional acute hospital funding in 2022 to address the backlog of patients needing essential care. Unfortunately, these delayed medical interventions may require longer hospital stays, require more staff time and be more costly to treat.

Additional resourcing is required to:

- Provide acute hospitals with extra space to care for non-Covid and Covid infections and risks.
- Staff and resource additional beds and facilities.
- Fill the 1 in 5 permanent Consultant posts vacant due to the Government imposed salary inequity and expand Consultant staffing further.
- Cover inflation and the impact of demographics.
- End the rationing of acute hospital services.
- Address record waiting lists.

1.2 Maintaining Current Budget allocation to address Capacity Deficits

While the Department of Health has attempted to isolate Covid-19 related spending within specific subheads in the health budget, the Department has not clarified how the additional €1.88bn in current and capital Covid funding for Health in 2021 has been delineated between Covid and non-Covid expenditure.[4] While some costs can be clearly isolated such as those associated with testing and tracing, the Parliamentary Budget Office (PBO) has acknowledged that other costs are likely to be challenging to categorise and the relationship between the two is complex. The PBO says it may "not be entirely possible" to distinguish between the two cohorts of spending.[5]

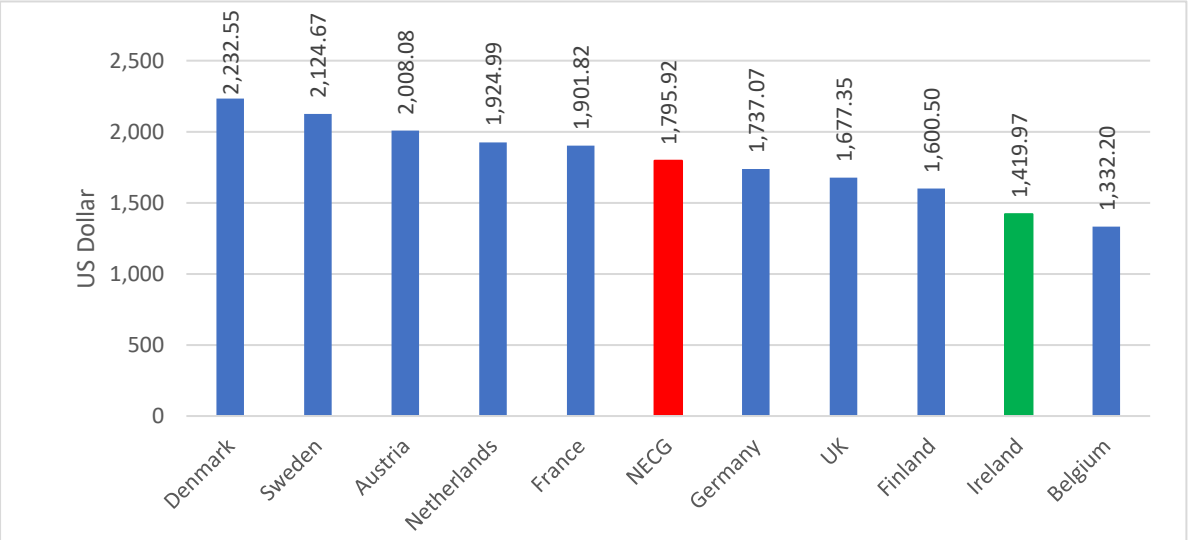
It is essential that current spending on health this year to deal with Covid is retained and redeployed in 2022 and in future years to deal with existing deficits in bed capacity, hospital facilities and Consultant staffing.

1.3 International Comparisons

Commentary that alleges a relatively high level of expenditure on health in Ireland has been challenged by the ESRI which has confirmed that **Ireland's per capita public health spend has been overstated and was 10th in the EU15 in 2017 when spending on social care was taken into consideration to ensure a like for like comparison with healthcare-related expenditure figures in the majority of other EU countries.**[6]

International comparisons confirm that the basic government expenditure on acute hospitals in Ireland amounted to $375.95 per capita (26%) less than the average for the Northern European Comparator Group (NECG) in 2019 (**Figure 2**).[7] **Ireland had the second lowest spend pre-Covid in this group.**

Figure 2: Government/ compulsory schemes, Acute Hospital spend in NECG Countries, per capita, current prices, current PPPs, 2019 (or nearest year)



Source: OECD.Stat. Government/compulsory schemes excludes voluntary insurance schemes – such as voluntary private health insurance – as well as household out-of-pocket payments. Data for the Netherlands is for 2020.

This is equivalent to **€1.588bn less funding for acute hospitals in Ireland compared with the NECG average** based on our current population, or **€316.80 per head less than the Northern European average** and **€593.83 per head less than Denmark**.[8]

Section 1 Recommendations:

The 2022 Health Budget must provide increased acute hospital resourcing to provide the additional capacity that is required for the timely delivery of care and the reduction of unacceptable waiting lists. The substantial decrease in inpatient, day case and outpatient activity in acute hospitals during the pandemic will drive significantly increased levels of demand for hospital care in 2022 and will require additional funding.

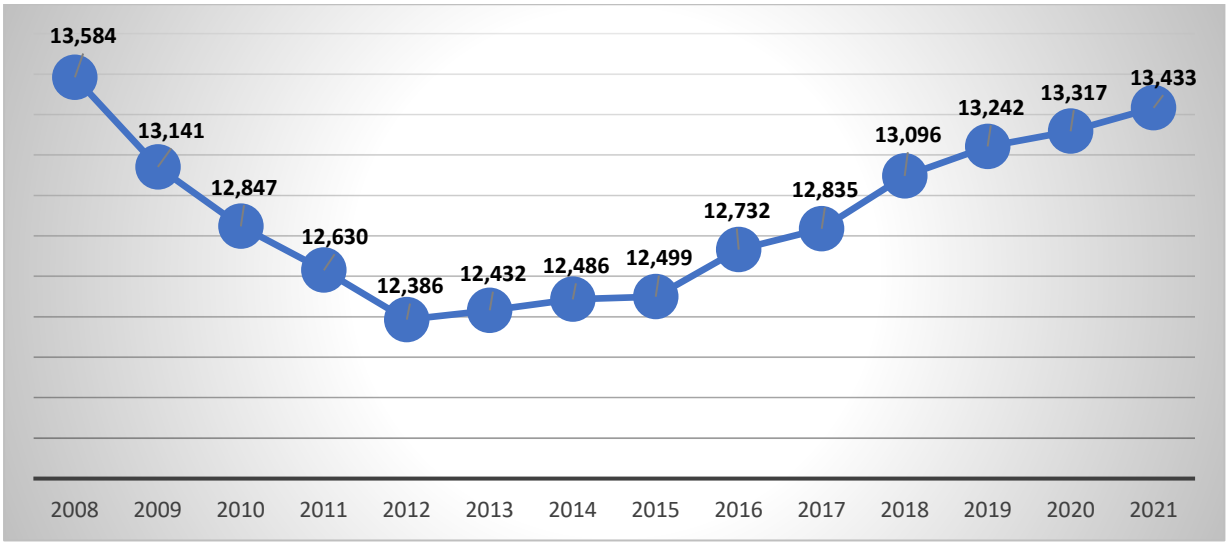
It is essential that current spending on health this year to deal with Covid is retained and redeployed in 2022 and in future years to deal with existing deficits in bed capacity, hospital facilities and Consultant staffing.

2. Public Acute Hospital Demand and Capacity

2.1 Demographics and Population Led Demand

The population has grown by 526,400 (11.7%) since 2008.[9] In contrast, public hospital inpatient and day case bed capacity has been cut by 151 beds (1.1%) between 2008 and March 2021 (Figure 3).[10]

Figure 3: Change in Total Average Inpatient and Day Case Beds 2008-2021 (March)



Sources: Department of Health Open Beds Report March 2021; Health in Ireland: Key Trends 2017 & 2019, DOH.

The most significant population growth has been in that cohort aged 65 and over, which increased by 53% since 2008.[11] This is three times the EU average growth rate (16%).[12] These demographic changes are one of the main factors driving the increase in demand as the utilisation of inpatient hospital care is over seven times greater among people aged 65 years and older compared to people aged 64 and younger.[13]

Recently published analysis from the Department of Health confirms that an **increase in expenditure of €324m is required in 2022 to maintain existing levels of Service (ELS) and meet demand from demographic changes alone, increasing to €385m in 2025**.[14] The proportion of the current 2021 Health Budget that was specifically referenced as being linked to demographic pressures was just €180m.[15] **Therefore there is a need to almost double the current funding allocated to demographic cost pressures alone to meet demand.**

Despite the 255,610 reduction in inpatient and day case activity in 2020 due to the pandemic compared with 2019 levels, 10,000 more inpatient and day case patients were treated in public hospitals last year compared with 2010 (**Figure 4, Appendix 1**).[16] However, a shortage of Consultants and acute hospital facilities pre-Covid had already resulted in a reduction in the number of inpatients public hospitals treated in 2019.[17] Irish public hospitals' **Average Length of Stay at 5.9 days is 18% less than that of the OECD36** (7.2 days) and **20% less than the EU27 average of 7.4 days**, indicating that there is little more that can be done to further optimise capacity use in our hospitals which has reached its limits (**Figure 5, Appendix 1**).[18]

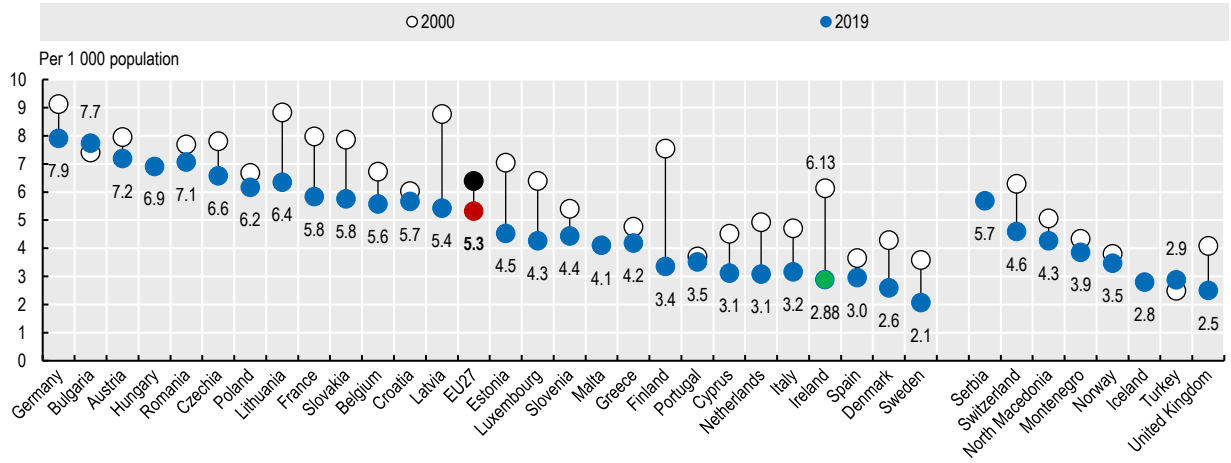
2.2 Acute Beds and ICU Beds - Capacity Requirements

The mismatch between the current capacity and demand for acute hospital care is driven by a number of persistent and fundamental factors that need to be addressed in the 2022 Health Budget.

Ireland has one of the lowest number of acute hospital beds in the EU, 46% below the EU27 average of 5.32 and one third the number in some European countries (**Figure 6**).[19] Ireland also has the highest hospital bed occupancy rates in the developed world.[20] The Covid pandemic has highlighted the need to have a sufficient number of hospital beds and flexibility in their use to address any unexpected increase in

demand, together with a sufficient number of Hospital Consultants and medical staff to provide care to patients.

Figure 6: Hospital beds per 1,000 of population in EU, 2000 and 2019 (or nearest year)



Sources: OECD Health Statistics 2020; Eurostat Database.

The dramatic decline in total hospital beds in Ireland from **6.13 per 1,000 population in 2000 to 2.88 in 2019** (a decrease of 53%) is the **second largest percentage fall across the EU over that period and has occurred at a time when Ireland's population increased by almost 1.13 million** (+30%), and when those aged 65 years and over increased in number by 64%.[21] **The number of acute hospital beds also declined on a population basis over this period, from 2.79 per 1,000 population in 2000 to 2.69 in 2019**.[22] **This is the equivalent of 498 beds less compared with 2000**.

Ireland also had the highest hospital bed occupancy rates in the developed world pre-Covid at 89.9%, well above the recommended maximum occupancy rate of 80%-85% and 23% above the EU average of 73.3% (Figure 7, Appendix 1).[23] Occupancy rates at this high level result in regular bed shortages, increased numbers of admitted patients being treated on trolleys, higher levels of healthcare acquired infections and cancellation of appointments plus growing waiting lists. Ensuring that bed occupancy is maintained at a level of between 80%-85% will be extremely challenging. It will not be possible unless the existing number of public hospital beds and other capacities are expanded rapidly.[24]

The IHCA recommends that a **minimum of 6,000 additional public hospital beds must be funded in a revised National Development Plan (NDP) due to be published in October**, in order to reduce bed occupancy rates and address the other risks identified above. The proposed increase of just 2,600 acute beds that was included in the 2018 NDP falls significantly short of the actual increase that is required.

The 2018 NDP recommended 260 additional acute public hospital beds on average per year,[25] but this was not reflected in the HSE's three-year Capital Plan 2019-2021 which significantly reduced the target to 160 per year on average[26], a 40% reduction on the NDP provision which was at the lower end of the Capacity Review range.[27] The HSE Capital Plan 2021 published in August fails to commit to the delivery of any specific number of additional acute hospital beds from its €983.17m budget.[28]

The IHCA is concerned that the additional 1,146 inpatient beds by end 2021 promised in Budget 2021, which if opened and staffed would bring the total number of inpatient beds to 11,879, will not be delivered.[29] While the HSE Winter Plan provided funding for 892 additional acute inpatient beds to be delivered by April 2021,[30] it is understood that **by July the number of beds actually delivered was some 58 beds short of that April target.**[31] If, as anticipated by Minister Donnelly in July, a further 229 additional

inpatient beds are opened between now and the end of the year, it would suggest a total of 1,063 acute inpatient beds are due to come on stream for the year - **83 beds short of the total 1,146 inpatient beds promised in Budget 2021.[32] The recently published Sláintecare mid-year Progress Report confirmed 843 out of the 929 planned acute beds have been delivered - 86 beds short of target.[33]**

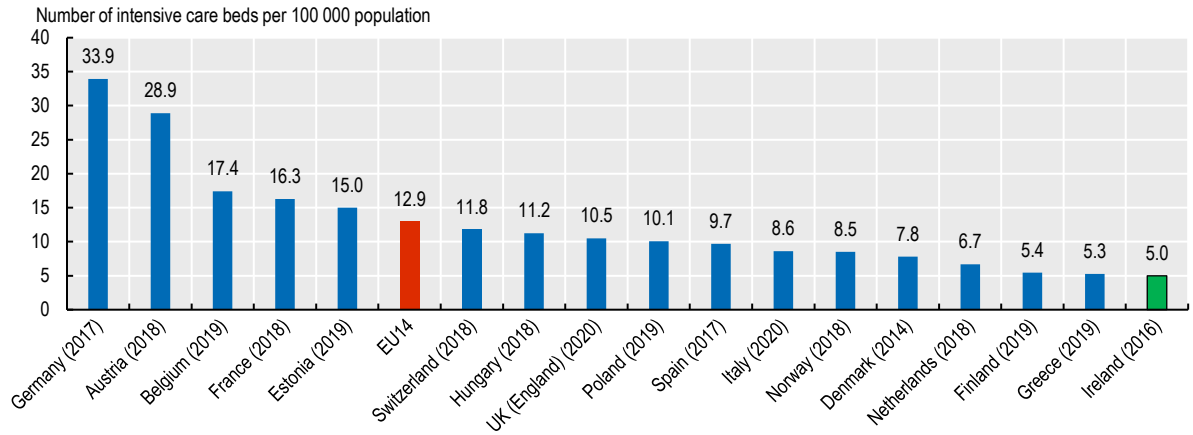
It is essential all planned additional hospital beds are prioritised for completion and a programme of new builds commissioned without delay as the IHCA is concerned the promised additional 1,146 inpatient beds by end 2021 will not be delivered.

The IHCA recommends that a minimum of 6,000 additional public hospital beds must be funded in the revised National Development Plan (NDP) by 2030 and that at least half of these are delivered within the first three years of the plan.

2.2.1 ICU Bed Capacity Requirements

Between February 2020 and January 2021 over 1,100 critically ill adult Covid patients were admitted to ICUs and HDUs in Ireland.[34] Increased ICU bed capacity is paramount in meeting surges in demand from Covid-19 and is an important indicator of a health system's capacity to respond to such crises. Pre-Covid, the variation in **ICU capacity across 17 European countries ranged from 34 ICU beds per 100,000 people in Germany to a low of just 5 ICU beds per 100,000 people in Ireland - less than half the EU average (Figure 8)**.[35]

Figure 8: Number of ICU Beds in EU per 100,000 population before Covid-19 crisis, latest year available



Source: Health at a Glance: Europe 2020; Data refer to adults only in Belgium and Ireland; to all ages in Germany, England and Spain. Data in France exclude beds in constant monitoring units and paediatric ICUs.

OECD data also shows that **65% of ICU beds in Ireland were occupied by Covid-19 patients at the height of the first wave of the pandemic in 2020** (**Figure 9, Appendix 1**).[36] This is second only to Italy (78%), according to a study on the impact in eight selected EU countries. **The share of ICU beds occupied by Covid patients in Ireland was double that in Denmark (33%) and more than five times the percentage in Austria (12%).**

In response to this pressure on hospitals and ICU beds, surge capacity measures were introduced equivalent to 70 ICU beds and provided an ICU/HDU bed capacity of up to 350 beds on 1 December 2020.[37] Although peak ICU occupancy did not 'breach' the 350 figure at a national level during the third wave in January 2021, many hospitals experienced overwhelming surges locally of critically ill Covid patients. **At a minimum, this additional ICU surge capacity needs to be opened and staffed on a permanent basis.**

Despite the HSE/DOH commissioned 2009 Prospectus Report recommending that the number of ICU beds should be doubled from 289 to 579 beds by 2020, a 2019 HSE report found that there were then only 249 ICU beds pre-Covid – 40 fewer than 10 years previously.[38] Updates in mid-August 2021 confirm that there are now around 300 acute ICU beds open, a rise of around 45 since the start of the pandemic.[39]

Our ICU beds normally operate at almost full capacity, which is not safe, as the recommended occupancy rate for ICU should be 75% or less.[40] We need to urgently expand our ICU bed numbers at a much faster rate than is currently the case.[41]

Phase two of a proposed Critical Care Strategic Plan is due to see a further 117 beds added through the development of new build capacity at five hospitals, which, if delivered, would increase overall critical care capacity to 446 beds.[42] However, this additional expansion has yet to be funded and is insufficient given that it will still leave a deficit of 133 ICU beds compared with the recommended level of 579 beds that featured in the Prospectus Report a decade ago. In addition, the public hospitals' critical care needs are now much higher as the 2009 Prospectus Report did not provide for increased demands on ICU presented by a serious pandemic. To obtain the EU average of 12.9 ICU beds per 100,000 population, Ireland would require 646 ICU beds.[43]

The Government needs to urgently expand our ICU bed numbers to the minimum 579 recommended a decade ago and further increase critical care capacity to over 640 beds to reach the EU average number of ICU beds on a population basis. This is essential to avoid delays in ICU admission, cancellation of essential surgery, increased incidence of hospital-acquired infection and to cater for potential Covid-19 surges.[44]

2.3 Essential Scheduled Care Surgical Facilities

It is essential to rapidly expand and develop co-located, protected, surgical facilities for the provision of essential scheduled care across our hospitals with minimum delay.

While plans are being advanced for three elective hospitals in Cork, Dublin and Galway, it is expected they will take many years before they are operational and it is not expected that expansion will be sufficient. The Association believes **dedicated theatre, bed capacity and other facilities to deliver elective scheduled care must be expanded across our acute hospital base, not just in three locations as currently proposed.**

2.4 Increased Waiting Lists

One of the most damaging consequences of these capacity deficits, combined with the consultant recruitment and retention crisis, is the unacceptable delays in providing care to patients and growing waiting lists, which confirm that nearly 1 million people are waiting for public hospital care (**Figures 10 and 11, Appendix 1**). There were 66,167 (8%) more people on various National Treatment Purchase Fund (NTPF) waiting lists in August compared with 2020, with a total of 907,617 people waiting for hospital treatment or an appointment to be assessed by a Hospital Consultant.[45]

More than 200,000 people are also waiting for diagnostic scans such as MRIs, CTs and ultrasounds, with a quarter of these (50,472) waiting over a year.[46] These are not on any NTPF list, so public hospital waiting lists already well exceed a million people waiting for hospital treatment.

The shocking increase in NTPF waiting lists is the strongest indicator yet that the immense backlog of care arising from not only the pandemic but also the persistent underinvestment in hospital infrastructure, bed capacity and Consultant recruitment is dangerously close to overwhelming our health service. With waiting times of four to seven years for children requiring an MRI under a general anaesthetic at Crumlin Hospital, even the Minister for Health has accepted that this effectively means there is no service available.[47]

The August 2021 waiting list figures confirm:

- **652,344 outpatients nationally are waiting to be assessed by a consultant**, an increase of 41,348 (6.8%) over the past year alone and **an increase of more than 288,000 (79%) compared with seven years ago**;

- The Outpatient waiting list has increased by over **173,000 (36%) since May 2017, when Sláintecare reforms were launched**;
- **263,354 people are waiting over a year for a Consultant outpatient appointment**, an increase of over 20,000 (8%) in the past year and more than **six times the equivalent in 2014**; a record **192,764 are now waiting longer than 18 months to be assessed by a Consultant**;
- 75,720 patients are wating for inpatient/day case treatment, with 20,284 of these patients waiting longer than a year for treatment and a **record 14,263 waiting +18 months**;
- **98,394 children** on are on some form of NTPF waiting list to be treated or seen by a Hospital Consultant.
- There has been a **3,040 (17.6%) increase in those waiting over a year for inpatient and day case treatment since July 2020.**
- The number **waiting longer than a year for hospital treatment has increased from 386 to 20,284 in the past nine years - a 52-fold increase since 2012**, when the then Minister for Health imposed pay discrimination on hospital consultants contracted after that date.

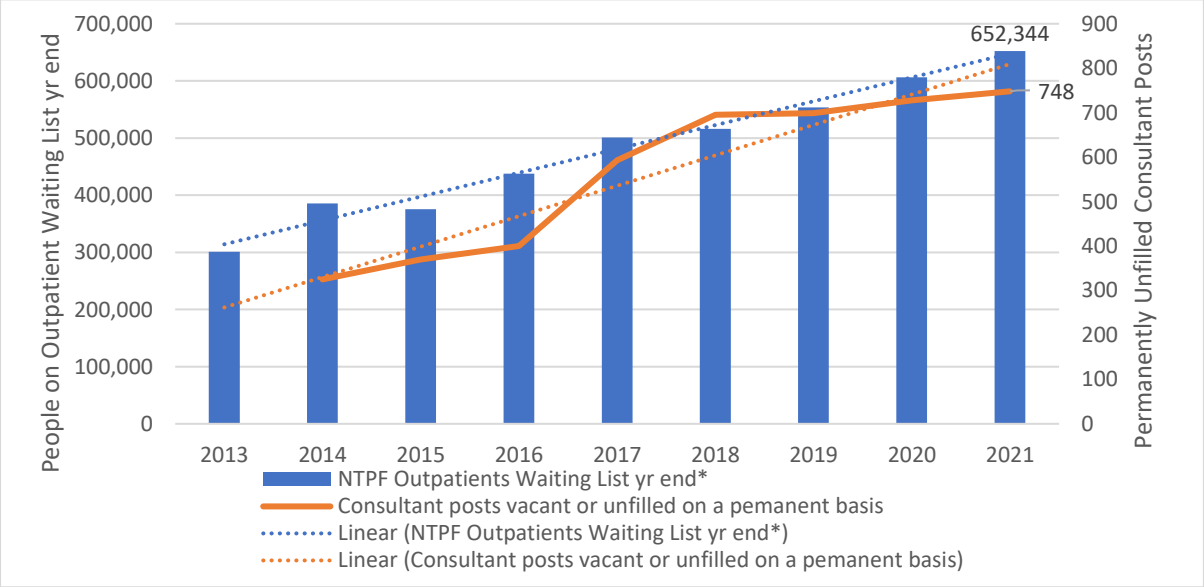
Theses waiting times are likely to worsen in the coming months as more people who have deferred seeking care because of Covid concerns present for care. Hospital Consultants will be facing a tsunami of deferred care as we continue to emerge from lockdown.

The cyber-attack on the HSE and public hospitals has had a further negative impact on the health service's ability to treat and manage patients and on lengthening waiting lists.

2.4.1 Vacant Consultant Posts and Waiting Lists

Figure 12 below plots the waiting list data against known Consultant vacancies at various points in time, as confirmed in HSE reports and Parliamentary Questions (see detailed analysis in **Section 4.2** below). **The graph suggests there is a clear linear trend and relationship between growing waiting lists and increasing levels of Consultant posts that are vacant or not filled on a permanent basis (Figure 12).**

Figure 12: Outpatient Waiting Lists and Consultant Vacancies/Permanently Unfilled Posts, 2013-2021*



Sources: See endnote[48]

2.4.2 Clearing Waiting Lists, Reducing Waiting Times and Setting Targets

Without filling the one in five permanent hospital consultant posts that are currently not filled as needed and appointing significant additional consultants, annual levels of public hospital activity will not increase

above pre-Covid 2019 levels. Even if this is done, **it could still take over a decade to clear the backlog of deferred hospital care and bring outpatient waiting lists under control**. If our acute public hospitals only match the pre-pandemic levels of activity seen in 2019, waiting lists will continue to grow.[49]

In terms of clearing the backlog of deferred care associated with the pandemic, if inpatient/day case activity in 2022 increased to 105% of 2019 levels, the **inpatient/day case waiting list would begin to come down but may not come back to pre-pandemic levels and clear the backlog of deferred care until Q1 of 2025**.[50]

The scale of the backlog in outpatient appointments is similarly significant**.** Achieving a sustained increase in outpatient activity at a level equivalent to 105% of 2019 levels over the coming years would start to reduce the waiting lists. However, the Covid backlog may not be cleared until around Q4 of 2023 and it might not be until mid-2027 before the current unacceptable outpatient waiting lists are reduced to a manageable level in such a scenario.[51] **If the backlog was cleared at a slower pace with outpatient activity more realistically increased to just 102% of 2019 levels, the build-up of deferred care may not be cleared until around Q3 of 2026 and it could possibly take until 2035 - in 14 years' time - before the current unacceptable outpatient waiting lists were reduced.[52]**

The government must be transparent with the public and frontline staff about the size of the backlog of deferred care and set out how – in practical terms – it will be managed, as well as providing realistic targets and related timescales for the delivery of such care. Outsourcing the delivery of care and seeking additional capacity from the private sector are stop gap measures and will not be sufficient. Expansion of public hospital capacity represents the most effective, sustainable mechanism for reducing waiting lists. This will require the appointment of additional consultants, on terms to be agreed with their representative bodies, together with more facilities and better infrastructure to take us through the difficult years ahead.

Existing HSE waiting time targets are also excessive and unambitious compared with other countries. Waiting times for specialist consultations and elective treatments in 17 OECD countries confirm that **Ireland has the highest target waiting times**.[53]

The HSE wants to "progress towards" achieving the ambitious waiting time targets of 10 weeks for a new outpatient appointment, 12 weeks for an appointment for a procedure, and 10 days for diagnostics as outlined in the Sláintecare.[54] In reality, waiting times are steadily getting worse, with the HSE unable to indicate when these targets are ever likely to be met.[55]

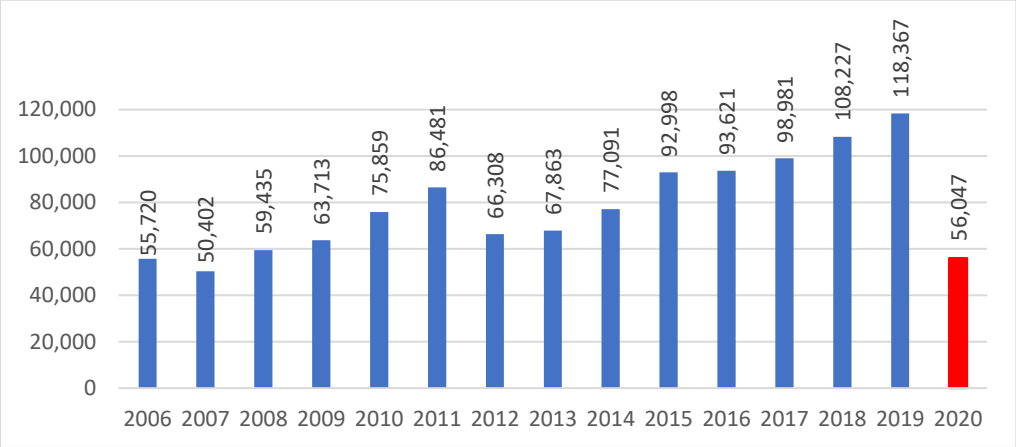
The Government needs to introduce and resource more ambitious waiting lists targets including a **maximum waiting time of 18 weeks instead of the current targets of 52 weeks following a GP referral for a consultant outpatient appointment and 64 weeks for inpatient/day-case public hospital treatment.**

The Government's long-promised multi-annual waiting list reduction plan must be released without delay and provide realistic targets and timescales for the reduction of Ireland's shocking waiting lists.

2.5 Emergency Department Overcrowding and Physical Distancing Requirements

National daily trolley counts declined significantly last year due to Covid-19 fears (**Figure 13**). Despite this, the total number of patients treated on trolleys and waiting admission to a hospital bed in 2020 was still more than the corresponding number in 2006, when the Emergency Department overcrowding crisis was described as a 'national emergency'.[56]

Figure 13: Number of Patients Treated on Trolleys Annually (2006-2020)



Source: Trolley Watch

The number of admitted patients waiting for a hospital bed has started to increase again, with activity in Emergency Departments in August running as high as 20% above 2019 levels.[57] This increase in attendances and admissions is set to continue and highlights the backlog of patients who deferred treatment during the pandemic and who are awaiting care. The increased numbers are having a significant impact on the delivery of essential care to patients, with elective and outpatient clinics recently cancelled at a number of hospitals, most notably at University Hospital Limerick.[58]

More than 37,400 patients were treated on trolleys in the first eight months of 2021. This is over 12,000 more compared with the first eight months of the pandemic from March to October last year.[59] On 13th September 2021, a total of **464 patients were on trolleys in acute hospitals in Ireland**. This is **80 more than** the 384 that were awaiting a hospital bed on 28th March 2006, when former Minister for Health Mary Harney described the Emergency Department overcrowding crisis as a '**national emergency'**. Having hundreds of patients treated on trolleys on a daily basis increases the risk of the cross-transmission of infection and is contrary to the national standards for the prevention and control of healthcare-associated infections. It was unacceptable pre-Covid and even more so since the pandemic. **The continued risk of Covid-19 infection means that overcrowding in our Emergency Departments is unacceptable and cannot be tolerated**.

The ongoing challenges posed by poor physical infrastructure and constrained service capacity continue to be highlighted as a significant concern by HIQA, which has indicated these issues have been worsened by the Covid pandemic.[60] A recent report from HIQA found that six of 10 inspected hospitals were 'non-compliant' with infection-control procedures.[61]

There were 13,564 inpatient and day-case public beds open in our acute hospitals in March 2021.[62] Physical distancing requirements will reduce this significantly unless appropriate measures to mitigate its effects are introduced.[63] This is against the backdrop of an acute hospital system that is already experiencing severe overcrowding and excessive occupancy levels due to a shortage of acute hospital beds. Physical distancing requirements also continue to create major problems for Consultant outpatient clinics and Emergency Department care as well as inpatient and day case care. **Increased capacity, physical infrastructure and facilities must be commissioned and funded by the HSE to ensure that public hospital services can be maintained.**

Section 2 Recommendations:

The IHCA recommends that a minimum of 6,000 additional public hospital beds must be funded in the revised National Development Plan (NDP) by 2030 and that at least half of these are delivered within the first three years of the plan.

It is essential all planned additional hospital beds are prioritised for completion and a programme of new builds commissioned without delay as the IHCA is concerned the promised additional 1,146 inpatient beds by end 2021 will not be delivered.

At a minimum, the Government must urgently double the ICU capacity to 579 beds as recommended in an HSE commissioned report a decade ago, and ultimately increase capacity further to over 640 ICU beds to bring the number up to the EU average. The existing public hospital ICU capacity of 300 beds is far too low.

Dedicated theatre and bed capacity to deliver essential scheduled care must be expanded across our acute hospital base, not just in three locations as currently proposed.

The Government must fund and commission the expansion of public hospital capacity, including the appointment of additional Consultants and the delivery of increased physical capacity, as this represents the most effective, sustainable mechanism for reducing waiting lists.

The Government needs to introduce and resource more ambitious waiting time targets including a maximum waiting time of 18 weeks in place of the current targets of 52 weeks following a GP referral for a consultant outpatient appointment and 64 weeks for inpatient/day-case public hospital treatment.

The Government's long-promised multi-annual waiting list reduction plan must be released without delay and provide realistic targets and timescales for the reduction of Ireland's shocking waiting lists.

The Government must be transparent with the public and frontline staff about the size of the backlog of deferred care and set out how – in practical terms – it will be managed, as well as providing realistic targets and related timescales for the delivery of such care.

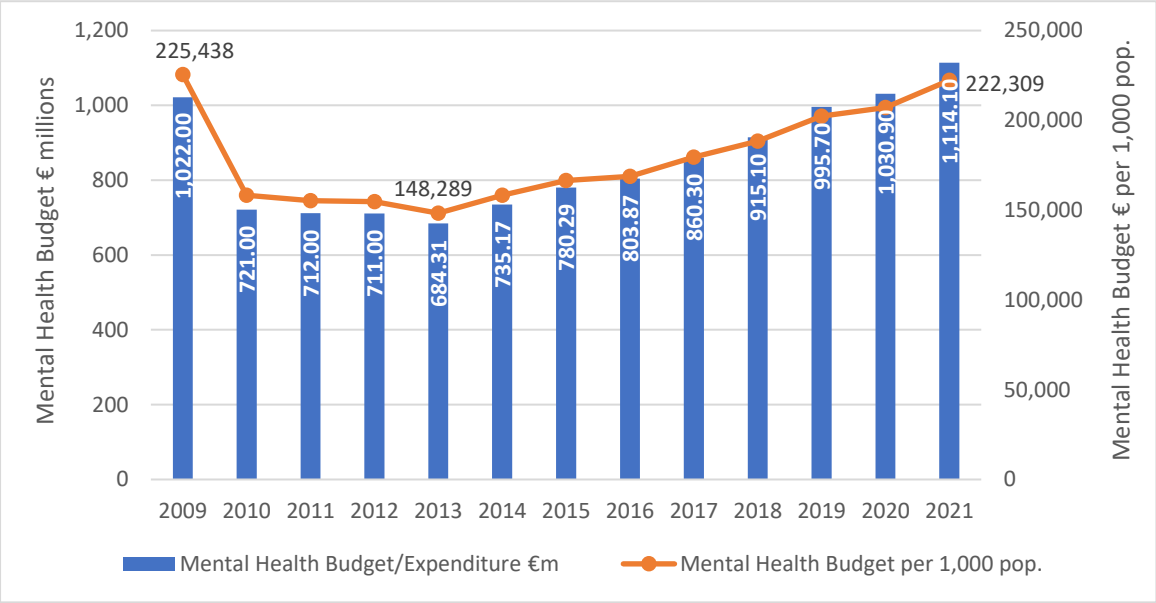
3. Mental Health Services

3.1 Mental Health Budget

The Association has submitted a separate comprehensive Mental Health Pre-Budget Submission to the Department of Health (available here).[64]

In summary, the 2021 Mental Health Budget of €1,114.1m is 9% above the corresponding 2009 expenditure level.[65] However, given the population has grown by 478,100 (10.5%) since 2009, the current budget allocation of €223,309 per 1,000 population is still below the corresponding €225,832 spend in 2009, which was too low to start with (Figure 14).[66] Current mental health spending on a population basis has therefore failed to reach the previous inadequate level set 13 years ago.

Figure 14: Mental Health Budgets and spend per 1,000 population, 2009-2021



Sources: HSE Service Plans and Performance Reports; CSO Census data in 2011 and 2016 and CSO Estimated Populations, PxStat.

At 5.4% of the Health Budget,[67] the mental health budget in 2021 is at its lowest level as a proportion of the overall HSE budget since 2012.[68] The percentage is low by international standards and approximately half that of most Northern European Countries.[69] In the UK, spending on mental health in NHS England was 10.8% in 2017/18, with calls for this to increase to over 13% by 2028/29.[70] The last time Ireland allocated 13% of total health expenditure to mental health services was in 1984.[71] Mental health services in Ireland continue to operate under severe pressure as a result of the funding shortfalls.

Significant disparities in the allocation of funding and resources persists, with CHOs of similar population size allocated different budget allocations and staffing. For example, there is a **25% difference in funding for mental health services in CHO 7 compared with CHO 4 on a population basis**.[72]

Section 3 Recommendations:

The 2022 Mental Health Budget needs to be set at a realistic level given the historic deficits in the service and the impact of the pandemic on the population's mental health.

The services available to patients and the per capita budgets for Mental Health Services across the different CHOs should be streamlined so they are broadly similar and at a sufficiently high level in all areas of the country.

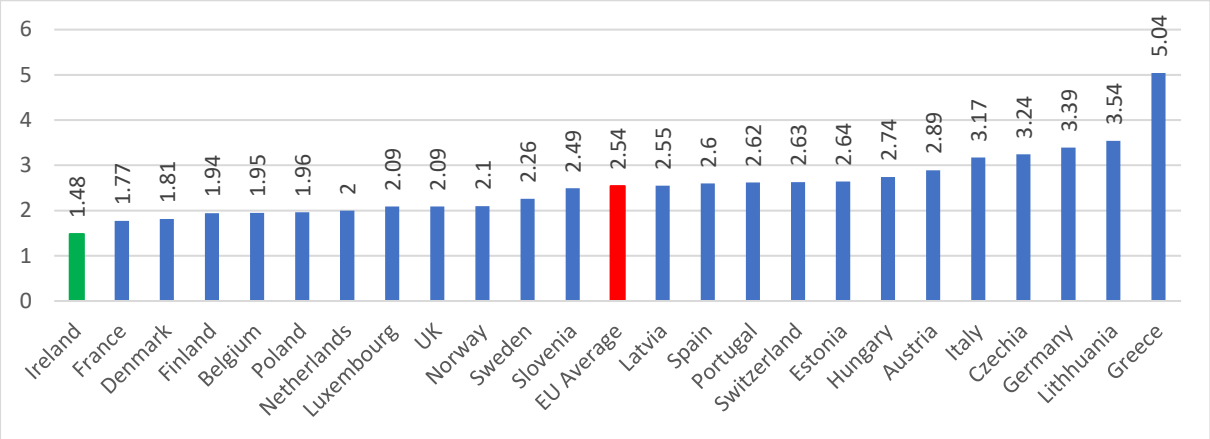
4. Consultant Vacancies & the Recruitment and Retention Crisis

4.1 Consultant Numbers and Vacancies

Ireland has the **lowest number of medical specialists per 1,000 population in Europe at 1.48, 42% below the EU average** of 2.54 (**Figure 15**).[73] In addition, around 1 in 5 permanent Consultant posts in Ireland are either vacant or filled on a temporary or agency basis, some of which are not specialist registered.

Ireland would need an additional 5,000 medical specialists to achieve the EU average number of specialists on a population basis.[74]

Figure 15: Specialist medical practitioners per 1,000 population in EU in 2019 (or nearest year)



Source: Eurostat, 2021

Comparing consultant staffing in Ireland with the UK and Australia confirms we have **27% fewer Consultants on a population basis compared with the UK and a third (32%) fewer compared with Scotland or Northern Ireland**.[75] **Ireland has only half the number of Consultants compared with Australia on a population basis** (**Appendix 1, Table 2**).

This shortage in Consultant numbers is a key workforce capacity deficit that is resulting in longer delays for patients awaiting treatment. **The Consultant salary inequity applying since 2012 is the root cause of Ireland's consultant recruitment and retention crisis and the unacceptable numbers of people on record waiting lists and needs to be reversed.**

4.2 New Consultant Salary Inequity and Vacancies

Ireland's lack of competitiveness in international recruitment terms is attributable to the new Consultant salary inequity, with more attractive salaries on offer to Consultants in other English-speaking countries. **In Australia, Canada, and the United States, average salaries are around 50% above those being paid to Consultants in Ireland appointed prior to 2012 and double those paid to those contracted post October 2012.**[76]

The Public Service Pay Commission reported to Minister Paschal Donohoe in September 2018 confirming that there is a general difficulty in recruiting Consultants and that the Settlement of the 2008 Consultant Contract High Court case had exacerbated the inequitable pay differential.[77] Despite the report recommending that the Government should resolve the pay inequity issue for all Consultants contracted since 2012, the Government has yet to end the discrimination.

Based on the HSE data, the number of permanent Consultants in post is around one fifth below that recommended in the Hanly Report in 2003. The number is around 50% below that recommended when adjusted for population growth and demographic changes in the interim.[78] An international comparison of Consultant staffing confirms that the shortfalls are significant in practically all specialties and across all hospital types.[79]

HSE data confirms that there were **618 permanent Hospital Consultant posts vacant or filled on a temporary/agency basis as at 1st February 2021.** This includes 255 permanent consultant posts that were vacant, with five of unknown status and likely vacant. A further 290 posts were filled by temporary and locum consultants, with an additional 68 posts filled on an agency basis. **This figure of 618 has increased further in recent months, given that the number of Consultant vacancies increased by 54 over a two month period, from 260 at the start of February to 314 (+54, 21%) at the end of March.**[80]

The Public Appointments Service (PAS) advertised 130 Consultant posts between 1 February and the end of August. As these posts remain to be filled or have failed to attract a suitable candidate and remain vacant, **the number of Consultant posts vacant or filled on a temporary/agency basis is estimated at 748**.[81]

The specialties with the largest percentage of permanent consultant posts that are either vacant or filled on a temporary/locum or agency basis are those advertised as Type A contacts in Psychiatry and Emergency Medicine. Of the 68 approved consultant posts filled by agency staff in February, more than half (40, 59%) were in psychiatry.

The consequence of the 2012 government induced consultant recruitment and retention crisis is that our public hospital and mental health services are simply unable to provide the level of care patients need. The increased demand on acute services due to Covid-19 infections and the backlog of deferred care due to the pandemic adds further urgency for the Government to restore pay parity and end the discrimination immediately.

4.3 Consultant Recruitment Crisis

Evidence of the recruitment crisis includes the fact that 26% of the 174 hospital consultant posts that were advertised by the PAS over a 20-month period in 2019/20 received either none or just one single applicant per post.[82]

In an **advertisement for three Consultant Child & Adolescent Psychiatry posts in the Laois/Offaly and Longford/Westmeath MHS, not a single doctor applied for any of the posts**.[83] A similar competition for **two Consultant Physicians in Geriatric Medicine at Letterkenny University Hospital also saw zero applicants for the posts**. Similar difficulties have been experienced in filling **three Consultant Radiology post the Kerry University Hospital** which failed to attract eligible applicants in early 2021 and in filling a Consultant Histopathology and Cytology post in a Dublin Maternity hospital which has been advertised a number of times.

Analysis of the posts advertised by the PAS so far in 2021 reveals that many hospitals and mental health services continue to struggle to fill their posts. **Attempts to hire a Consultant Microbiologist at Letterkenny University Hospital have proved unsuccessful, with the original deadline for the competition of 25th February extended four times to 23rd September**. [84] Similarly, a Child & Adolescent Psychiatry replacement post in MHS Kerry has had its closing date extended four times already in 2021, as have two recruitment campaigns for replacement CAMHS Psychiatry posts in CHO 8 (Laois/Offaly and Longford/Westmeath).

This recruitment crisis has also manifested itself in the **appointment of 109 doctors who are not on the Medical Council Specialist Register to Hospital Consultant posts as at end April.**[85] This is a serious indictment of government policy and is gravely damaging the delivery of timely, quality care to patients, as outlined by the former President of the High Court, Justice Peter Kelly, in a letter to Minister Simon Harris and the health service management in May 2018.[86] The issue has more recently been described as "very serious" by the HSE in terms of the risk it poses to patient safety and quality of care.[87]

4.4 Consultant Agency Costs

Ending pay discrimination and restoring pay parity for Consultants contracted since 2012 has the potential to result in an outcome that is better than cost neutral, when account is taken of the resultant patient benefits, shorter lengths of stay in hospital and other savings including reduced agency costs.

The loss of our highly trained specialists has resulted in the employment of agency staff at often twice the cost of retaining such staff through direct employment. **Overall Medical/Dental Agency spend has**

increased from €37m in 2012 to €94m in 2020. [88] **This is an increase of €59m per annum, to more than two-and-a-half times the 2012 costs. This does not include additional agency spend in the voluntary services.**

Information obtained by the IHCA through the Freedom of Information Act confirms (see Appendix 3): [89]

- **An agency psychiatrist was employed in the MHS Limerick for a short period last year at the equivalent WTE rate of €390,000 p.a.;**
- **The services of an agency consultant surgeon in the Midlands Regional Hospital, Portlaoise has been procured since 2016 at a cost of €350,000 in 2020; an Emergency Medicine Agency Consultant at MRH Tullamore cost €297,581;**
- **Five agency Consultants at University Hospital Kerry have been hired in Obstetrics & Gynaecology, Radiology and Rheumatology (3 posts) at an average annual cost of €300,555 WTE for each agency consultant - or €1.5m per annum;**
- **The total cost to cover Consultant Psychiatrist Agency Posts in the three Mental Health Services for Laois/Offaly, Longford/Westmeath and Louth/Meath in 2020 totalled €2.5m.**

This false economy highlights the importance of restoring pay parity for Consultants contracted since October 2012, so that our health service is repositioned to be more competitive and better equipped to fill the increasing number of vacant permanent posts with doctors on the Medical Council Specialist Register.

The **'unambiguous commitment' made by Minister for Health Stephen Donnelly in October 2020 to remedy the salary inequity in full for all Consultants must be honoured** to restore trust between the consultant body and the health service management and tackle the deteriorating consultant recruitment and retention crisis.

These are significant factors which are undermining the safety and quality of patient care and the provision of acute hospital and mental health services. It should be noted that the current difficulties are contributing to increased clinical indemnity claims. **The State Claims Agency year end liability for active clinical claims has nearly tripled from €1.04bn to €3.03bn over the period 2013 to 2020** (**Appendix 1, Table 3**).[90]

The cost of resolving the two-tier consultant pay inequity has been calculated by the National Pay Unit of the HSE National Finance Division at €25.7m.[91] **In budgetary terms, this is approximately 4% of the €604 Winter Plan 2020-2021 and less than 1.4% of the €1.881bn additional allocation to Covid-19 health measures in 2021.**[92]

4.5 Demand for Consultants to 2028

An increase of 1,653 (53%) in the number of Consultants working in acute hospital-based specialties is required by 2028 to address current shortfalls and meet increased patient demand.[93] The number of Medical specialists overall needs to increase by 583 (68%), from 854 to 1,437, with a required increase in the number of surgical specialists of 213 (31%), from 678 to 891.

The Government must rectify and match the pay of Consultants appointed since October 2012 to that of their colleagues and provide for it in full in the 2022 Health Budget. This is essential to fill the 1 in 5 vacant permanent consultant posts with doctors on the Specialist Register, and deliver timely, high-quality hospital and mental health services now and in the future.

4.6 Consultant Vacancies and Burnout

Even before the pandemic there were not enough Consultants to provide timely care to patients, which led to a system that is overstretched and understaffed with decreasing levels of general well-being and

morale. The pandemic, followed by the added stress of the cyber-attack on the HSE, has placed even more extreme work demands on Consultants and other front-line staff.

The effects of this are clear. **Almost four in five Hospital Consultants (77%) are experiencing burnout due to the combined pressures of Covid-19 and the pre-existing extremely overstretched nature of the acute services they work in.**[94] The pandemic has exacerbated the pre-existing strain related to low baseline staffing and a high number of vacant posts throughout our acute hospitals and mental health services. On the frontline, our younger consultants, who are being discriminated against, have carried an extremely heavy burden of work during the past 18 months and will continue to do so. To decrease the dependency on consultants working beyond their contract hours and **to reduce the serious risk of burnout, the Government must immediately fill the 1 in 5 vacant consultant posts** by addressing the consultant recruitment and retention crisis.

Section 4 Recommendations:

The Government must fill the 1 in 5 permanent posts vacant or temporarily filled and appoint additional Hospital Consultants to increase the number of Consultants in line with international norms and to establish a consultant-provided health service and to reduce the serious risk of burnout.

The loss of our highly trained specialists has resulted in the employment of agency staff at often twice the cost of retaining such staff through direct employment. This false economy highlights the importance of restoring pay parity for Consultants contracted after October 2012, so that the Irish health service is more competitive in international recruitment terms and better equipped to fill the increasing number of vacant permanent posts with doctors who are on the Medical Council Specialist Register.

The cost of ending the pay inequity has been calculated at 4% of the Winter Plan 2020-2021 and less than 1.4% of the additional allocation to Covid-19 health measures in 2021.

The 'unambiguous commitment' made by Minister for Health Stephen Donnelly in October 2020 to remedy the salary inequity in full for all Consultants must be honoured to restore trust between the consultant body and the health service management and tackle the deteriorating recruitment crisis.

5. Capital Investment Requirements

5.1 Capital Budget

The recent HSE Capital Plan 2021 allocated €983.17m to capital projects, which includes €130m for Covid-19 actions.[95] The core allocation of €853 is increased to €880m with additional funding from the National Development Plan.[96] A total of €783m has been made available for building and equipping health facilities. Acute hospitals have been allocated €670m, which does not include the above Covid-19 spend.[97] This is only the third year since 2008 that there has been a net increase in the level of capital funding compared with 2008 levels (**Table 4, Appendix 1**).[98]

The Irish health system is only now recovering from historic long-term underfunding of capital projects. **A sustained, multi-annual programme of additional capital spending in public acute hospitals and mental health services, is required to mitigate against the €1.34bn of underinvestment that has pertained over the past decade.**

5.2 National Children's Hospital, Replacement Equipment & ICT

The current cost of the National Children's Hospital (NCH) project was estimated at €1.73bn, but the final bill could be closer to €2.7bn.[99] This does not take into account the impact of the pandemic on the

construction sector, which could increase the cost further by between 10%-40%.[100] The National Paediatric Hospital Development Board (NPHDB) confirmed in July that the contractor had submitted more than 906 claims for extra costs totalling €446m. The NPHDB still cannot provide cost projections for the delivery of the project, citing ongoing commercially sensitive engagement with the contractor, and uncertainly remains over the revised opening date of 2024.[101]

In addition, funds anticipated to be drawn down for the NCH in 2020 were instead used as part of the €220m capital funding in response to the pandemic.[102] **A commitment is needed from Government that all overruns with the NCH development will be funded separately to avoid the cancellation or delay of other essential capital projects in Health.**

Currently acute hospitals are not only attempting to treat patients with inadequate capacity, but they are invariably doing so with equipment that is increasingly obsolete and which must be replaced. The HSE has indicated that between 2017 and 2021, €3.64bn will be required for priority replacements.[103] **This capital funding has clearly not been provided,** with just €66.28m allocated for medical equipment replacement in the HSE Capital Plan 2021.[104]

Significant increased capital funding is required to bring operating theatre capacity, equipment and other facilities up to acceptable standards.

A further concern is that the HSE does not know the end of life for hundreds of its MRI, CT and ultrasound scanners, while others with an end-of-life date of 2013 are still in use.[105] **A full audit of MRIs and other diagnostic equipment should be carried out to inform a new capital replacement programme.**

A national Electronic Health Record is a vital part of the health infrastructure for patients and healthcare professionals and needs to be properly resourced and implemented without delay. This need was again highlighted in the roll-out of the Covid-19 vaccines. Furthermore, a national EHR system needs to be in place in order to capture and share data relating to episodes of care, which will facilitate a fit-for-purpose activity based funding model that can effectively link activity and cost and identify opportunities for improved efficiency.[106]

It is estimated that the cyber-attack on the HSE on 14 May will cost at least €100m to rectify, with some reports putting the cost as high as €500m.[107] **It is essential the HSE invests intelligently in new IT systems, replacing legacy IT equipment and upgrading its cybersecurity following the recent cyber-attack.**

Section 5 Recommendations:

Additional capital spending in Health over many years is required to catch-up on the €1.34bn of underinvestment seen over the past decade.

All overruns with the National Children's Hospital development must be funded separately to avoid the cancellation or delay of other essential capital projects.

Significant increased capital funding is required to bring operating theatre capacity, equipment and other facilities up to acceptable standards. A full audit of MRIs and other diagnostic equipment should be carried out to inform a new capital replacement programme.

A national Electronic Health Record is a vital part of the health infrastructure for patients and healthcare professionals and needs to be properly resourced and implemented without delay.

It is essential the HSE invests intelligently in new IT systems, replacing legacy IT equipment and upgrading its cybersecurity following the recent cyber-attack.

6. Governance and Restructuring

The Association supports the restructuring of healthcare services to ensure greater alignment between community and hospital healthcare services, based on common geographic areas with the full integration of these services. For this realignment to work effectively **all hospital and community health services should be merged into one organisation within specific geographic areas**.

The **empowerment of local medical and management teams** to plan, recruit, invest, respond, and adapt during the pandemic resulted in better organised care over the past 18 months and needs to continue long-term. Locally empowered, bottom-up decision making has been proven time and again to work—in healthcare and elsewhere.

Section 6 Recommendations:

The Association supports the restructuring of healthcare services to ensure greater alignment between community and hospital services, based on common geographic areas with the full integration of these services. For this realignment to work effectively all hospital and community health services should be merged into one organisation within specific geographic areas.

7. Conclusion

Our ability to respond to meet increasing levels of patient demand and the backlog of deferred care that has accrued due to the pandemic will require increased acute hospital capacity and a resolution of the Consultant recruitment and retention crisis. Without addressing these twin deficits, the structural mismatch between capacity and demand in our public health services will continue to increase rather than decrease waiting lists and waiting times.

Public hospital and mental health services in Ireland do not currently have the capacity to provide timely, safe care to patients. This is evident from:

- The record number of people on hospital waiting lists;
- The return of unacceptably high numbers of patients being treated on trolleys;
- Excessively high and unsafe bed occupancy rates;
- The lowest number of medical specialists and hospital beds per 1,000 of population in the EU;
- The 1 in 5 permanent Consultant posts vacant or filled on a temporary basis;
- The number of doctors employed as Consultants by the HSE who are not on the Medical Council Specialist Register;
- The dramatic increase in Medical agency costs and adverse outcome claims.

The Government must take immediate action to address these problems. **The 2022 Health Budget needs to ensure that public hospital and mental health services have sufficient levels of current and capital funding to provide timely, high quality care to patients.**

In particular, **immediate action is required to end the Consultant salary inequity imposed unilaterally by the government in 2012** as it is the root cause of Ireland's Consultant recruitment and retention crisis and, by extension, the unacceptable numbers of people on record waiting lists. **The low number of Consultant posts in Ireland combined with the 1 in 5 approved posts that are vacant** is impacting on patient care and contributing significantly to the unacceptable delays that patients experience when they need to access care.

The solution is obvious: we must recruit and appoint additional Consultants without delay. Addressing the Consultant recruitment and retention crisis, halting the medical brain drain and making Ireland an

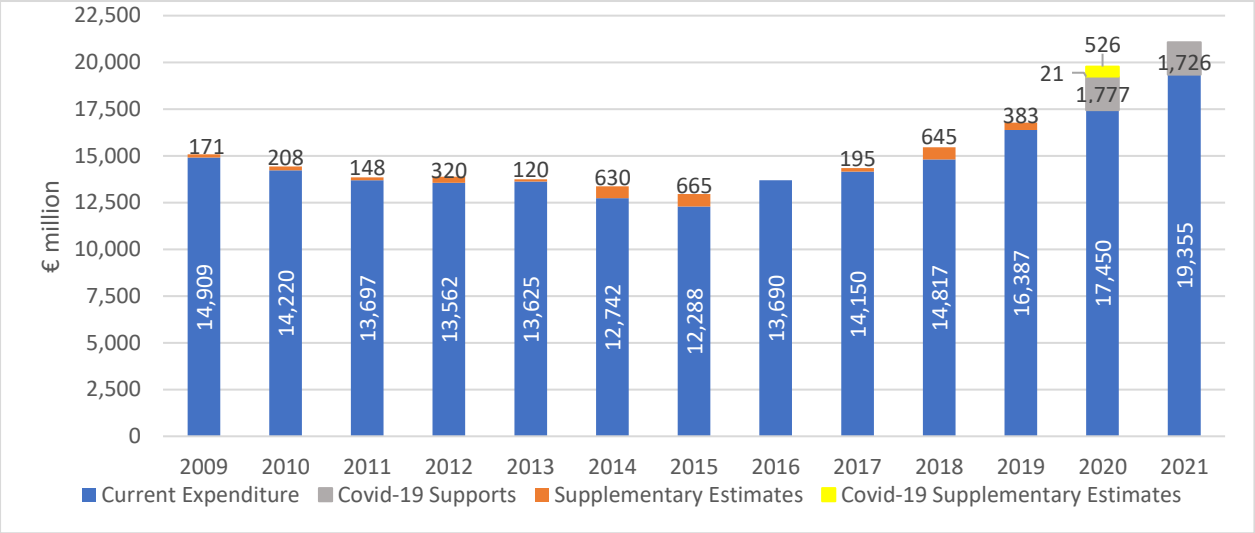
attractive place to pursue a medical career can be achieved if the Government restores pay parity for Hospital Consultants contracted since October 2012. All of the evidence confirms that it would be better than cost neutral and it would lead to the more efficient and effective delivery of more timely, higher quality care.

Immediate Government action is required now to arrest the current deteriorating situation in our acute hospitals and mental health services and to ensure that the obvious capacity deficits are addressed.

Appendices

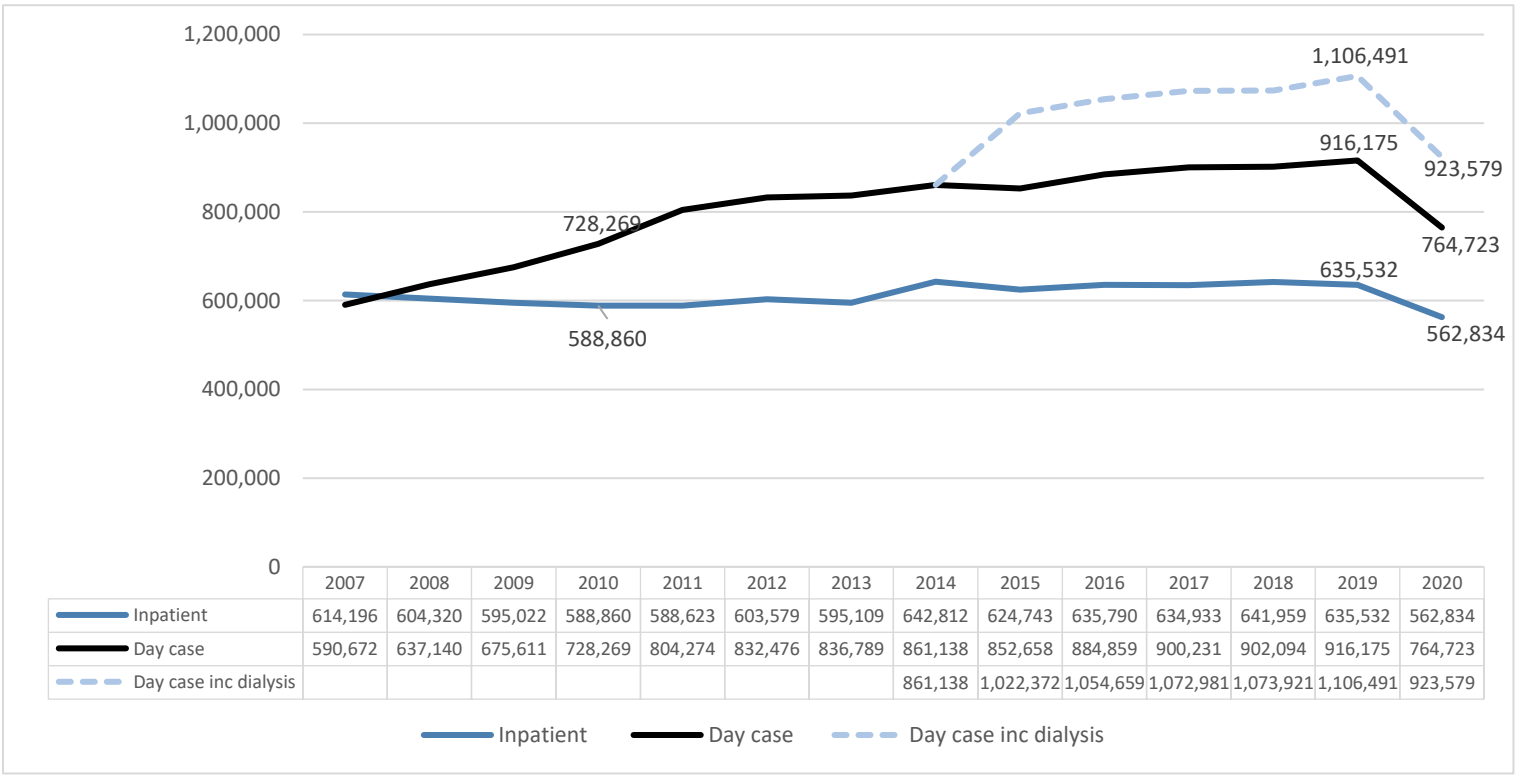
Appendix 1: Tables and Figures

Figure 1: Health Budgets 2008-2021: Current Expenditure, Covid-19 Supports, Supplementary Estimates and Covid-19 Supplementary Estimates



Sources: DPER databank, Appropriations Accounts 2009-2019 and 2020 Supplementary Estimates for Public Services.

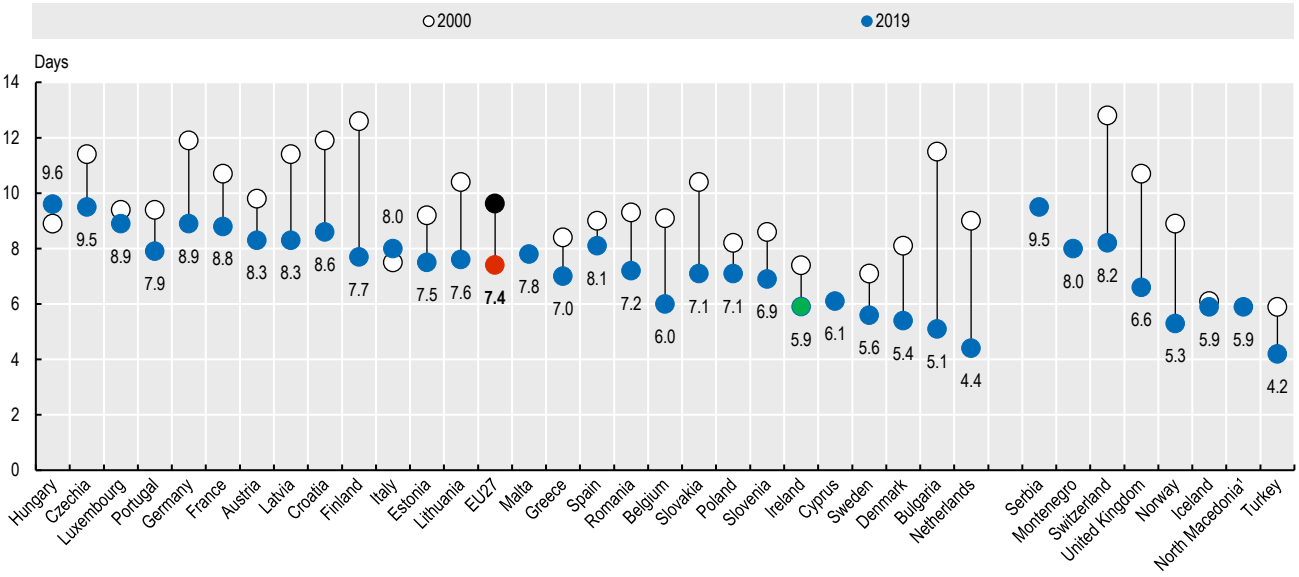
Figure 4: Inpatient and Day Case Totals including and excluding Dialysis Cases (2007 – 2020)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Inpatient	614,196	604,320	595,022	588,860	588,623	603,579	595,109	642,812	624,743	635,790	634,933	641,959	635,532	562,834
Day case	590,672	637,140	675,611	728,269	804,274	832,476	836,789	861,138	852,658	884,859	900,231	902,094	916,175	764,723
Day case inc dialysis								861,138	1,022,372	1,054,659	1,072,981	1,073,921	1,106,491	923,579

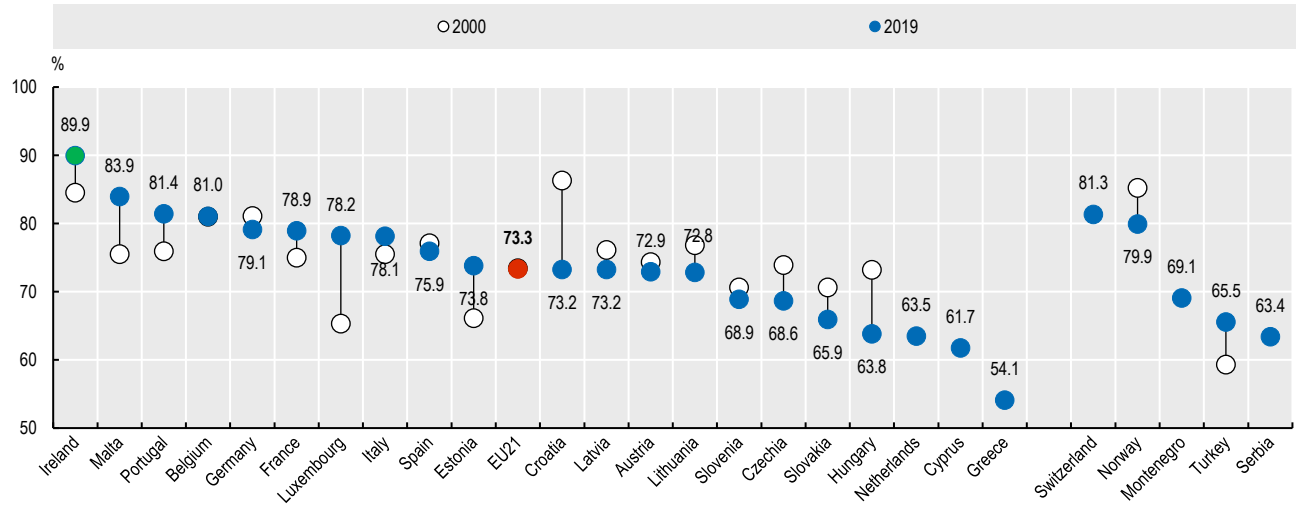
Sources: HSE Performance Reports (2007 – 2020); HSE Annual Report and Financial Statements 2020

Figure 5: Average length of stay in hospital in OECD, 2000 and 2019 (or nearest year)



Sources: OECD Health Statistics 2020; Eurostat Database.

Figure 7: Occupancy rate of curative (acute) care beds, 2000 and 2019 (or nearest year)



Sources: OECD Health Statistics 2020; Eurostat Database.

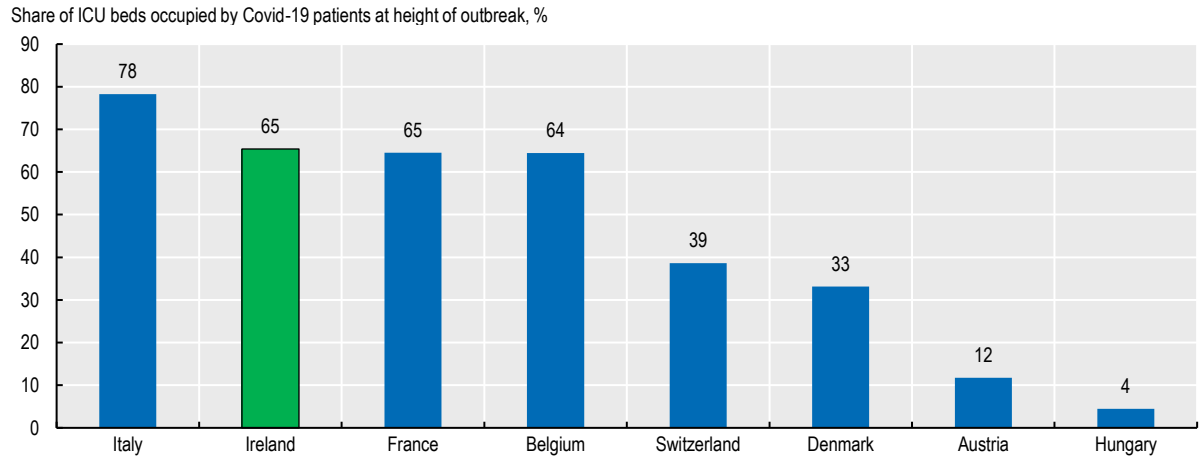
Table 1: Available General Beds at 8am (excluding Critical Care) over 14-day period in August 2021

Date	Number of Available General Beds (excluding Critical Care)	% Available (based on 13,564 inpatient/day case beds open in March 2021)	% Available (based on 11,285 inpatient only beds open in March 2021)
Tues 03/08/21	162	1.2	1.4
Mon 02/08/21	376	2.8	3.3
Sun 01/08/21	412	3	3.7
Sat 31/07/21	No data		
Fri 30/07/21	211	1.6	1.9
Thurs 29/07/21	169	1.2	1.5
Wed 28/07/21	149	1.1	1.3

Tues 27/07/21	177	1.3	1.6
Mon 26/07/21	193	1.4	1.7
Sun 25/07/21	361	2.7	3.2
Sat 24/07/21	518	3.8	4.6
Fri 23/07/21	261	1.9	2.3
Thurs 22/07/21	230	1.7	2
Wed 21/07/21	204	1.5	1.8
14-day average	**263**	**1.9**	**2.3**

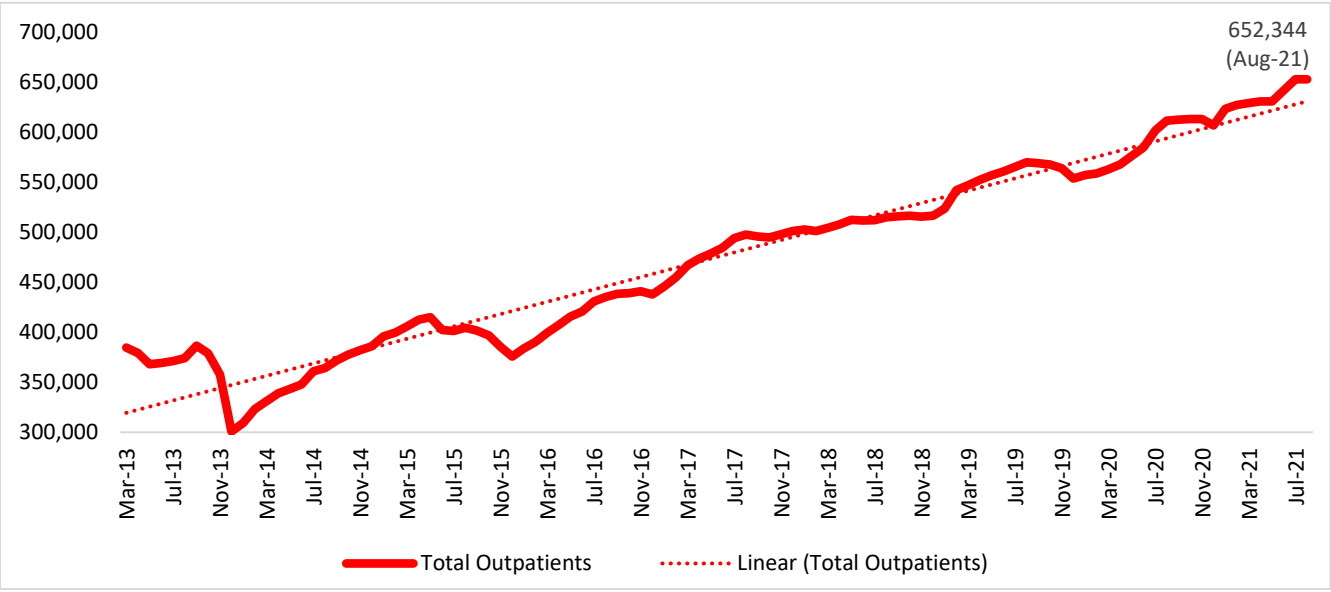
Sources: HSE COVID-19 Daily Operations Update Acute Hospitals, 21 July to 3 August 2021; Latest available Department of Health Open Beds Report - March 2021, 12 July 2021.

Figure 9: Estimated ICU Capacity to Cope with Surge in Covid-19 Patients during First Wave of Pandemic



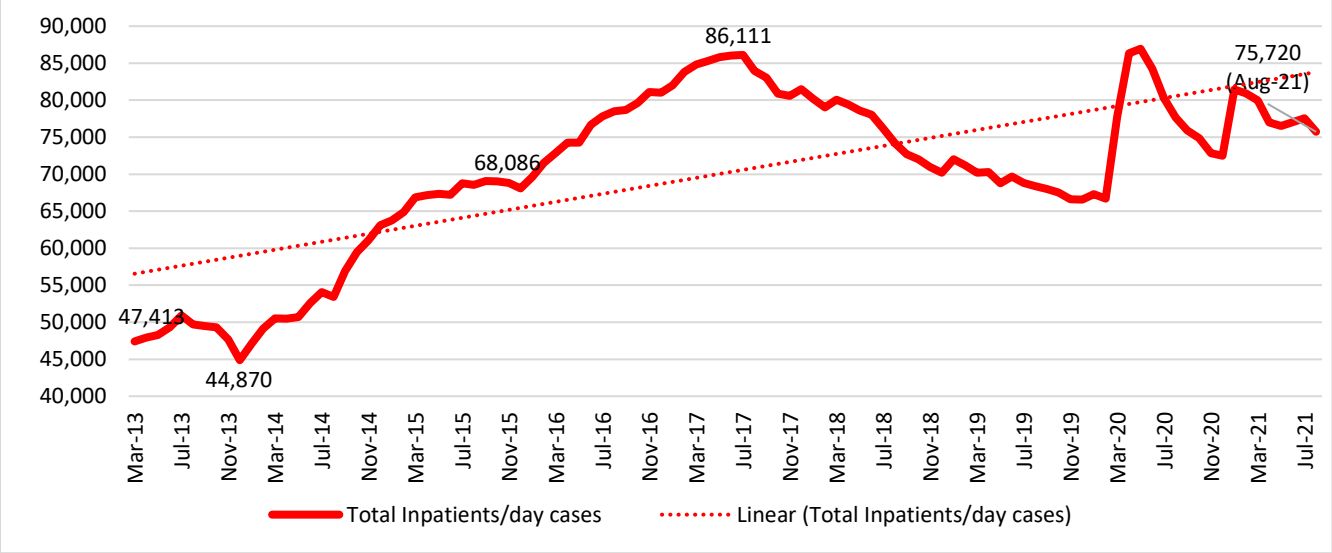
Source: Health at a Glance: Europe 2020.

Figure 10: Outpatient Waiting List (March 2013 – August 2021)



Source: NTPF

Figure 11: Inpatient and Day Case Waiting Lists (March 2013 – August 2021)



Source: NTPF

Table 2: Comparison of Ireland's Publicly Funded Medical Workforce with UK and Australia (2019/20)

Country	Population m	Total NCHDs	Total NCHDs per 100,000 pop.	Total Consultants	Consultants per 100,000 pop.	Ratio of NCHDs to Consultants
Ireland	4.98	7,426	149	3425	69	2.16:1
England	56.29	69,960	124	52,212	93	1.33:1
Scotland	5.46	6,985	128	5,522	101	1.26:1
Wales	3.15	4,338	138	2,822	90	1.54:1
N. Ireland	1.9	2,686	141	1,919	101	1.39:1
Total UK	66.8	83,969	126	62,475	94	1.34:1
Australia	25.7	27,675	108	34,170	133	0.8:1

Source: HSE, January 2021.

Table 3: Active Clinical Claims and year end liability (2013 – 2020)

	2013	2014	2015	2016	2017	2018	2019	2020
No. of Active Clinical	3,061	2,844	3,000	3,021	2,976	3,196	3,370	3,498
Outstanding Liability	€1.04bn	€1.16bn	€1.35bn	€1.67bn	€1.98bn	€2.33bn	€2.72bn	€3.031bn
Average liability per clinical claim	€339.8k	€407.9k	€450.0k	€552.8k	€665.3k	€729.0k	€807.1k	€866.5k

Source: NTMA Annual Report and Accounts 2013 – 2020

Table 4: Investment in health infrastructure, € million (2008 - 2021)

Exchequer Capital Plan Funding (2008 - 2021)		
	Total Health	**Total Acute Hospitals**
2008	€598m	€273m
2009	€447m **(€151m cut)**	€209m **(€64m cut)**
2010	€366m **(€232m cut)**	€220m **(€53m cut)**

2011	€347m **(€251m cut)**	€202m **(€71m cut)**
2012	€350m **(€248m cut)**	€208m **(€65m cut)**
2013	€347m **(€251m cut)**	€203m **(€70m cut)**
2014	€386m **(€212m cut)**	€197m **(€76m cut)**
2015	€398m **(€200m cut)**	€185m **(€88m cut)**
2016	€423m **(€175m cut)**	€237m **(€36m cut)**
2017	€454m **(€144m cut)**	€229m **(€44m cut)**
2018	€513m **(€85m cut)**	€221m **(€52m cut)**
2019	€667m **(€69m increase)**	€325m **(€52m increase)**
2020	€854m **(€256m increase)**	€587m **(€314m increase)**
2021	€880m **(€282m increase)**	€670m **(€397m increase)**
Cumulative Cut or Increase between 2008 and 2020	**€1,342m cut**	**€144m increase**

Sources: Revised Estimates for Public Services (2008 - 2021); HSE Reports on Capital Programme cited in DOH Health in Ireland Key Trends 2017; 'Building on Recovery: Infrastructure and Capital Investment 2016 – 2021' Capital Plan; HSE Capital Plan 2021. The capital budgets of €854m for 2020 and €853m for 2021 exclude €220m and €130m respectively for Covid 19 actions in those years. The HSE Capital Plan 2021 published on 4 August put the capital allocation at €983.17m, but does not separate out Covid spending or allocate a specific total to Acute Hospitals.

Appendix 2: Consultant Posts Vacant, Permanently Filled and Filled on a Temporary/Agency Basis as at 1 February 2021.

Source: HSE NDTP PQ Response 8669/21 to Deputy David Cullinane, 24 February 2021.

National Doctors Training and Planning
Health Service Executive
Sancton Wood Building, Heuston South Quarter
St John's Road West, Dublin 8

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Feidhmeannacht na Seirbhíse Sláinte
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24th February 2021

Deputy Cullinane
Dáil Eireann,
Leinster House,
Kildare Street,
Dublin 2

Ref: PQ 8669/21

To ask the Minister for Health the number of approved consultant posts by hospital group and hospital respectively filled by tenure, permanent, temporary, locum, agency and vacant consultant posts by discipline and specialty in tabular form; the length of time the vacant posts have remained vacant; and if he will make a statement on the matter.

Dear Deputy Cullinane

National Doctors Training and Planning (NDTP) Response
The data contained in this response is extracted from DIME (Doctors Integrated Management E-system) as at 01.02.2021. DIME is dependent on clinical sites inputting details on their consultant workforce and therefore there may be variances and gaps in the data supplied to that held within clinical sites. As DIME is a live system it must be noted that there can be variances in the figures published dependent on the run date of the report as entries can be made with a retrospective date

The consultant figures relate to CAAC (Consultant Applications Advisory Committee) approved consultant posts.

- **Filled** - The clinical site has verified that a consultant currently occupies this post
- **Status unknown** - The clinical site has not yet assigned a consultant to the post or marked the post as vacant
- **Vacant** - The clinical site has verified on DIME that this is a vacant post, however, it should be noted that recruitment for the post may be underway and in some cases appointments may have already been made with a prospective start date.

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Table 1 Filled and vacant consultant posts by medical discipline and tenure

Medical Discipline	Filled Agency	Filled Temporary	Filled Permanent	Filled Total	Status Unknown Total	Vacant Total	Total
Anaesthesiology	1	32	358	**391**	1	11	**403**
Emergency Medicine	2	19	84	**105**		9	**114**
Intensive Care Medicine		1	28	**29**		5	**34**
Medicine	10	62	688	**760**	2	77	**839**
Obstetrics & Gynaecology	7	7	157	**171**		11	**182**
Paediatrics		19	193	**212**		20	**232**
Pathology		25	248	**273**		34	**307**
Psychiatry	40	64	349	**453**	2	30	**485**
Radiology	5	13	267	**285**		35	**320**
Surgery	3	48	476	**527**		23	**550**
Total	**68**	**290**	**2848**	**3206**	**5**	**255**	**3466**

Table 2 Filled and vacant consultant posts by hospital group and tenure							
Hospital group/CHO	Filled Agency	Filled Temporary	Filled Permanent	Filled Total	Status Unknown Total	Vacant Total	Total
BreastCheck			36	**36**		**7**	**43**
Children's Health Ireland		2	197	**199**		**21**	**220**
CHO 1	2	9	29	**40**		**4**	**44**
CHO 2	1	4	35	**40**		**5**	**45**
CHO 3	3	2	26	**31**		**4**	**35**
CHO 4	2	17	36	**55**		**5**	**60**
CHO 5	12	6	25	**43**			**43**
CHO 6		3	39	**42**	**2**	**8**	**52**
CHO 7	4	12	52	**68**		**5**	**73**
CHO 8	9	2	34	**45**		**4**	**49**
CHO 9	7	6	59	**72**		**5**	**77**
Dublin Midlands Hospitals Group	3	28	458	**489**		**26**	**515**
Ireland East Hospitals Group	2	28	474	**504**	**2**	**31**	**537**
Mental Health Services		3	11	**14**		**5**	**19**
Other*		1	15	**16**		**2**	**18**
RCSI Hospitals Group	7	29	416	**452**		**31**	**483**
Saolta Hospitals Group	4	58	357	**419**	**1**	**30**	**450**
South / South West Hospitals Group	8	51	420	**479**		**44**	**523**
University of Limerick Hospitals Group	4	29	129	**162**		**18**	**180**
Total	**68**	**290**	**2848**	**3206**	**5**	**255**	**3466**

* Those not within a CHO or HG e.g. Health Protection Surveillance.

The following should be noted in relation to the tenures provided above:

- **Permanent** includes consultants appointed on a permanent basis and consultants who have obtained a contract of indefinite duration.
- **Temporary** incudes fixed term contract holders and specified purposes contract holders.
- **Agency** includes consultants engaged via an agency.

Temp/Agency includes those who are appointed for reasons such as maternity leave, career break, sick leave etc. or to backfill permanent consultants who may be seconded to another role e.g. clinical lead, clinical director etc., as well as to fill vacancies.

In some instances, there may be more than one consultant assigned to a consultant post for a variety of reasons (job-sharing, locums etc.). The tenure is determined by the consultant that was most recently assigned to the post.

National Doctors Training and Planning
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Table 3 Length of time posts have been vacant		
Vacant Total	Vacant greater than 12 months	Vacant less than 12 months
255	94	161

It should be noted that recruitment for the post may be underway and in some cases appointments may have already been made with a prospective start date. DIME does not have the facility to capture the stages of recruitment.

Table 4 Vacant consultant posts by hospital group and principal clinical site

Hospital group/CHO	Principal Clinical Site	Medical Discipline	Vacant Total
BreastCheck	Breastcheck - Eccles Unit	Radiology	**1**
	Breastcheck - Merrion Unit	Pathology	**1**
	Breastcheck - Southern Unit	Pathology	**1**
		Radiology	**1**
		Surgery	**1**
	Breastcheck - Western Unit	Pathology	**1**
		Radiology	**1**
Children's Health Ireland	CHI at Connolly	Paediatrics	**1**
	CHI at Crumlin	Anaesthesiology	**3**
		Intensive Care Medicine	**1**
		Medicine	**3**
		Paediatrics	**4**
		Pathology	**1**
		Radiology	**2**
		Surgery	**1**
	CHI at Tallaght	Paediatrics	**1**
	CHI at Temple St	Pathology	**1**
		Radiology	**1**
		Surgery	**1**
	Childrens Hospital Group	Pathology	**1**
CHO 1	Donegal Hospice	Medicine	**1**
	MHS Cavan / Monaghan	Psychiatry	**1**
	MHS Sligo / Leitrim	Psychiatry	**1**
	OPS Sligo / Leitrim	Medicine	**1**
CHO 2	CAMHS Galway Roscommon Mayo	Psychiatry	**2**
	CHO 2	Medicine	**2**
	MHS Galway / Roscommon	Psychiatry	**1**
CHO 3	MHS Limerick	Psychiatry	**2**
	MHS Tipperary North	Psychiatry	**2**
CHO 4	CAMHS Cork	Psychiatry	**2**
	CHO 4	Psychiatry	**1**

Table 4 Vacant consultant posts by hospital group and principal clinical site			
Hospital group/CHO	**Principal Clinical Site**	**Medical Discipline**	**Vacant Total**
	MHS Cork North Lee	Psychiatry	**1**
	MHS Cork South Lee	Psychiatry	**1**
CHO 6	CHO 6	Medicine	**1**
	National Rehabilitation Hospital	Medicine	**5**
		Paediatrics	**1**
		Pathology	**1**
CHO 7	CHO 7	Medicine	**1**
	MHS Dublin South Central	Psychiatry	**1**
	Our Lady's Hospice & Care Services	Medicine	**3**
CHO 8	MHS Louth / Meath	Psychiatry	**2**
	MHS Midlands	Psychiatry	**2**
CHO 9	CAMHS Dublin North City	Psychiatry	**2**
	MHS Dublin North City	Psychiatry	**1**
	St Michael's House, Dublin	Psychiatry	**1**
	St Vincent's, Fairview	Psychiatry	**1**
Dublin Midlands Hospitals Group	Coombe Women & Infants University Hospital	Obstetrics & Gynaecology	**1**
		Pathology	**3**
	Midlands Regional Hospital, Tullamore	Medicine	**1**
	Naas General Hospital	Radiology	**2**
	St James's Hospital	Anaesthesiology	**1**
		Emergency Medicine	**1**
		Intensive Care Medicine	**1**
		Medicine	**8**
		Pathology	**1**
		Radiology	**1**
		Surgery	**1**
	Tallaght University Hospital	Emergency Medicine	**1**
		Intensive Care Medicine	**1**
		Radiology	**1**
		Surgery	**2**
Ireland East Hospitals Group	Cappagh National Orthopaedic Hospital	Radiology	**1**
		Surgery	**1**
	Mater Misericordiae University Hospital	Intensive Care Medicine	**1**
		Medicine	**3**
		Pathology	**1**
		Radiology	**2**
		Surgery	**2**
	Midlands Regional Hospital, Mullingar	Obstetrics & Gynaecology	**1**
		Paediatrics	**2**
		Radiology	**1**
	National Maternity Hospital	Obstetrics & Gynaecology	**1**
	Our Lady's Hospital, Navan	Radiology	**1**
		Surgery	**2**
	St Columcille's Hospital	Anaesthesiology	**1**

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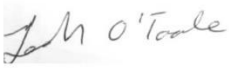
Table 4 Vacant consultant posts by hospital group and principal clinical site

Hospital group/CHO	Principal Clinical Site	Medical Discipline	Vacant Total
		Medicine	1
		Radiology	1
		Surgery	1
	St Luke's General Hospital, Carlow/Kilkenny	Medicine	1
		Obstetrics & Gynaecology	1
		Radiology	1
	St Vincent's University Hospital	Intensive Care Medicine	1
		Medicine	2
	Wexford General Hospital	Medicine	1
		Paediatrics	1
Mental Health Services	Central Mental Hospital, Dundrum	Psychiatry	5
Other*	Health Protection Surveillance	Pathology	1
	Sexual Health Crisis Pregnancy Programme	Medicine	1
RCSI Hospitals Group	Beaumont Hospital	Anaesthesiology	1
		Emergency Medicine	1
		Medicine	5
		Pathology	4
		Psychiatry	1
		Radiology	3
		Surgery	4
	Cavan General Hospital	Pathology	1
		Radiology	2
	Connolly Hospital, Blanchardstown	Medicine	1
	Monaghan Hospital	Medicine	1
	Our Lady of Lourdes Hospital, Drogheda	Emergency Medicine	1
		Medicine	2
		Pathology	1
	Rotunda Hospital	Obstetrics & Gynaecology	3
Saolta Hospitals Group	Letterkenny University Hospital	Anaesthesiology	1
		Medicine	2
		Obstetrics & Gynaecology	1
		Pathology	2
		Radiology	2
		Surgery	2

Table 4 Vacant consultant posts by hospital group and principal clinical site			
Hospital group/CHO	**Principal Clinical Site**	**Medical Discipline**	**Vacant Total**
	Mayo University Hospital	Emergency Medicine	**1**
		Medicine	**1**
	Portiuncula Hospital, Ballinasloe	Obstetrics & Gynaecology	**1**
	Roscommon University Hospital	Medicine	**1**
	Sligo University Hospital	Medicine	**2**
		Surgery	**1**
	University Hospital Galway	Anaesthesiology	**1**
		Emergency Medicine	**3**
		Medicine	**2**
		Paediatrics	**3**
		Pathology	**1**
		Radiology	**1**
		Surgery	**2**
South / South West Hospitals Group	Bantry General Hospital	Medicine	**1**
	Cork University Hospital	Emergency Medicine	**1**
		Medicine	**11**
		Paediatrics	**1**
		Pathology	**7**
		Radiology	**3**
		Surgery	**1**
	Cork University Maternity Hospital	Obstetrics & Gynaecology	**2**
	South Infirmary Victoria University Hospital	Surgery	**1**
	South Tipperary General Hospital	Medicine	**1**
	University Hospital Kerry	Medicine	**1**
		Paediatrics	**1**
		Pathology	**1**
	University Hospital Waterford	Medicine	**6**
		Paediatrics	**2**
		Pathology	**2**
		Radiology	**2**
University of Limerick Hospitals Group	University Hospital Limerick	Anaesthesiology	**2**
		Medicine	**3**
		Paediatrics	**3**
		Pathology	**2**
	University of Limerick Hospitals Group	Anaesthesiology	**1**
		Medicine	**2**
		Radiology	**5**
Total			**255**

* Those not within a CHO or HG e.g. Health Protection Surveillance.



Leah O'Toole
Assistant National Director

Appendix 3: FOI Responses to the IHCA in December 2020, January/February 2021 on Cost of Agency Consultants

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Seirbhís Meabhairshláinte Luimnigh
FSS Mheán Iarthair
Elmhurst
Ospidéal Naomh Iosaef
Sráid Mulgrave
Luimneach

Teil: 00353 (0) 61 461242
Facs: 00353 (0) 61 416774
Website: www.hse.ie

Limerick Mental Health Services
HSE Mid - West
Elmhurst
St. Joseph's Hospital
Mulgrave St
Limerick

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Website: www.hse.ie

13/01/21

Private & Confidential
Mr. Martin Varley,
Secretary General,
Irish Hospital Consultants Association,
Heritage House, Dundrum Office Park,
Dublin 14

Re: Request for information under the Freedom of Information Act - CHO3 FOI-2020-1319

Dear Mr. Varley,

I refer to your correspondence dated the 20th November 2020 in respect of Consultant posts currently filled by doctors on an agency basis under the Freedom of Information Act 2014. My apologies for the delay in replying to your request. Please find below a breakdown of Consultant Psychiatrists posts in Limerick, Clare and North Tipperary filled by agency doctors.

Location	Specialty	Start Date	Cessation Date	Continued Service	Total Cost by Consultant Post to date	WTE Value based on hours worked	Other related costs – payroll & agency & VAT where applicable
Limerick	Psychiatry	18.07.2016	21.02.2020	HSE staff	€51,193.78	0.27	€13,183.78
Limerick Clare	Psychiatry Psychiatry	16.03.2020 17.07.2020	10.07.2020 N/A	No Yes	*€154,337.05	0.82	€39,272.05
Tipperary	Psychiatry	13.08.2018	N/A	Yes*	€198,909.35	1.08	€50,334.35
Limerick	Psychiatry	03.02.2020	N/A	Yes	€211,535.79	0.99	€53,660.79
Tipperary	Psychiatry	04.09.2017	N/A	Yes	€183,340.05	0.98	€47,215.05
Limerick	Psychiatry	28.09.2020	20.11.2020	No	€43,681.00	0.15	€14,801.00
Tipperary	Child & Adult Mental Health Services	27.10.2020	N/A	Yes	*€17,006.08	0.05	€1,133.60

* This figure is the total cost for Limerick and Clare
* This figure was given in sterling (£15,600) and not yet paid at time of request – so exchange rate as of 22/12/20.

1. Rights to appeal: You may appeal this decision in writing to **FOI Internal Reviewer, Consume Affairs Department, Block A-Clinical and Administration Building, Merlin Park Hospital, Galway.** You shoul make your appeal in writing to the above named officer within four weeks of receiving this letter. The appea will involve a complete reconsideration of the matter by a more senior member of the staff of the HSE.

Yours sincerely,

Aisling Guihan
Senior Executive Officer
Limerick Mental Health Services
Freedom of Information – Decision Maker

Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt

Grúpa Ospidéal Bhaile Átha Cliath Lár Tíre FSS
Dublin Midlands Hospital Group HSE
Páirtnéir Acadúil Coláiste na Tríonóide Baile Átha Cliath
Academic Partner Trinity College Dublin

Dublin Midlands Hospital Group
Bridgewater House
Bridgewater Business Centre
Conyngham Road
Islandbridge
Dublin D08 T9NH

Tel: (01) 795 9280

Mr Martin Varley,
Secretary General,
Irish Hospitals Consultants Association,
Heritage House
Dun drum Office Park
Dun drum
Dublin 14 D14 C2R2

8th February 2021

Re: Non Personal Freedom of Information Request

Dear Mr Varley,

I refer to your request for a review under Freedom of Information which was received by the consumer affairs area office and forwarded to this office for a response on the 24th November 2020.` Your request was acknowledged by this office on 14th December 2020.
As was relayed to your organisation on the 13th January 2021 There was a delay from one of the hospitals in confirming there information due to the significant pressures experienced by the hospital from the Covid- 19 pandemic. I wish to apologise for this delay.

Scope of Review
The scope of your request contained in your correspondence dated 20th November 2020 was;
I am requesting under the Freedom of Information Act 2014 that you provide the IHCA with full details, excluding doctors' names, of all consultant posts filled by doctors on an Agency basis at the hospitals and Mental Health Services in your area of responsibility as per the below list. The information requested includes the location, specialty and the durations for which individual Agency doctors have been in these consultant posts, including start dates to cessation dates, as applicable, or if their services continue to be procured.
In addition, I am requesting confirmation under the FOI Act, on an anonymised basis, the total cost by consultant post of employing the individual doctors who are being employed on an Agency basis, confirming the annual equivalent (WTE) total salary plus other related contract costs including agency costs and VAT where applicable for each calendar year of their employment and part year where appropriate.

Decision
I have decided today, after careful consideration of the matter to release information supplied by the hospitals in question which meets the scope of your request. However I have decided to refuse the individual names, start dates to cessation dates, as applicable as is personal to the post holder and the fact that they continue to be employed. The total cost by consultant post of the employment of these individual doctors on an agency basis would also be deemed personal information and is exempted by Section 37(1) of the Freedom of Information Act 2014.
Information Access
Please find the following information released from the two hospitals referred by you in the scope of your request.

Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt

Grúpa Ospidéal Bhaile Átha Cliath Lár Tíre FSS
Dublin Midlands Hospital Group HSE
Páirtnéir Acadúil Coláiste na Tríonóide Baile Átha Cliath
Academic Partner Trinity College Dublin

Dublin Midlands Hospital Group
Bridgewater House
Bridgewater Business Centre
Conyngham Road
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Information re FOI request 141220.xlsx

LOCATION	SPECIALITY	AGENCY COSTS 2020
MHR TULLAMORE	General Medicine/ Neprology	€282,346
MHR TULLAMORE	Emergency Department	€297,581
MHR PORTLAOISE	Consultant General Surgery	€350,000

Findings, particulars and reasons for decisions to deny access

As stated I am applying Section 37(1) of the FOI Act to deny access to what is deemed personal information. The start dates and cessation dates and in this case as the doctors services continue to be procured is personal to that individual and post holder.
Section 37(1) states;

A head shall refuse to grant an FOI request if, in the opinion of the head access to the record concerned would involve the disclosure of personal information
As part of this decision to refuse access to this information I had due consideration for Section 37(5) that on balance that the right to privacy of the individual to whom the information relates should be upheld in relation to the public interest that the request should be granted.
Similarly the total cost by consultant post of the employment of these individual doctors on an agency basis would also be deemed personal information and is exempted by Section 37(1) of the Freedom of Information Act 2014. However the overall agency costs are provided.
Again as part of this decision to refuse access to this information I had due consideration for Section 37(5) that on balance that the right to privacy of the individual to whom the information relates should be upheld in relation to the public interest that the request should be granted.

Section 37(5) of the Act states:

> *"Where , as respects an FOI request the grant of which would, but for this subsection, fall to be refused under subsection (1), in the opinion of the head concerned, on balance- the public interest that the request should be granted outweighs the public interest that the right to privacy of the individual to whom the information relates should be*

I must also consider if Section 37(5)(b) is of relevance. The effect of Section 37(5)(b) is that a record, which has been found to be exempt under Section 37(1), may still be released if it can be demonstrated that the grant of the request would benefit the individual to who the record relates. I do not consider this to be the case and am therefore satisfied that Section 37(5)(b) does not apply.

Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt

Grúpa Ospidéal Bhaile Átha Cliath Lár Tíre FSS
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Academic Partner Trinity College Dublin

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Bridgewater Business Centre
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Tel: (01) 795 9280

Right of Appeal

In the event that you need to make such an appeal, you can do so by writing to the HSE Freedom of Information Office, 3rd Floor, Scott Building, Midland Regional Hospital, Tullamore, Co. Offaly. Your correspondence should include a fee of €30 for processing the appeal. Payment should be made by way of bank draft, money order, postal order or personal cheque made payable to the Health Service Executive.

If you are unhappy with my decision, you can make an appeal. You can also do so by writing to the Information Commissioner at 18 Lower Leeson Street, Dublin 2. If you wish to appeal, you must usually do so not later than 6 months from the date of this notification. Should you write to the Information Commissioner making an appeal, please refer to this letter. If you make an appeal, the Information Commissioner will issue a fresh decision after fully investigating and considering the matter.

Yours sincerely,

Mr. James Conway,
Assistant National Director FOI Reviewer/Decision Maker,
Dublin Midland Hospital Group,
Midland Regional Hospital @ Tullamore,
Co. Offaly.

UNIVERSITY HOSPITAL KERRY

OSPIDÉAL NA hOLLSCOILE, CIARRAÍ • A UNIVERSITY AFFILIATED ACUTE HOSPITAL

Health Service Executive
Southern Area
University Hospital Kerry.
Tralee, Co. Kerry.
0667124259

14th January 2021

Mr. Martin Varley,
Secretary General,
Irish Hospital Consultants Association,
Heritage House,
Dundrum Office Park,
Dublin 14.

RE: Agency Consutlant Posts UHK. FOI: 26561

Dear Mr. Varley,
I refer to your request under the Freedom of information Act 1997 for information pertaining to Agency Consultant Posts in University Hospital Kerry; held in University Hospital Kerry received on the 20th November 2020.

Location	Speciality	WTE	Start Date	Finish Date
UHK	Obs/Gynae	1.0	27.11.2017	N/A
UHK	Rheumatology	1.0	11.10.2018	01.01.2021
UHK	Radiology	1.0	24.9.2018	N/A
UHK	Radiology	1.0	02.12.2019	N/A
UHK	Radiology	1.0	22.6.2020	N/A

Weekly Cost	Annual Cost
€ 5,779.91	€ 300,555.08
Note: Based on Std Basic hours @ 39 per week (Inc agency fee & VAT)	

This is based on a standard 39 hour week @ €5,779.91 (Annual cost €300,555).
Although all the information available has been released, under the terms of the Freedom of Information Act, I am obliged to advise you of your rights. These are as follows:

You may appeal this decision by writing to the Freedom of Information Office, Consumer Affairs, HSE South, HSE Offices, Ground Floor East, Model Business Park, Model Farm Road Cork, within four weeks of receipt of this letter. Please refer to this decision in any correspondence. The appeal will involve a complete reconsideration of the matter by a more senior member of staff of this body.

Yours sincerely,

Betty Murphy

Ms. Betty Murphy
Decision Maker

Cc Freedom of Information Office, Consumer Affairs, HSE South, HSE Offices, Ground Floor East, Model Business Park, Model Farm Rood, Cork

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Ospidéal N. Bríd
Bóthar Cheanannais
Baile Átha Fhirdia, Co. Lú

Telephone: 041 6853264 Fax: 041 6853503

St. Brigid's Hospital
Kells Road,
Ardee, Co. Louth A92 DRN0

MP/nk/163.20

16th December 2020

Private & Confidential
Mr Martin Varley
Secretary General
Irish Hospital Consultants Association
Heritage House
Dundrum Office Park
Dublin 14

Re: Request for information under the Freedom of Information Acts re Agency Consultants Employed by CHO8.

Dear Mr Varley

I refer to your request under the Freedom of Information Act 2014, for information regarding Consultant posts filled by doctors on an agency basis for:

- Mental Health Services for Laois/Offaly
- Mental Health Services for Longford/Westmeath
- Mental Health Services for Louth/Meath

I have now made a final decision to part grant your request on the 15th December 2020.

I am responding on behalf of the statutory Mental Health Services operated by the CHO8 for Louth/Meath, Longford/ Westmeath and Laois/Offaly and detail the information as follows:

Laois Offaly and Longford Westmeath CAMHS and YAMHS 2020

Location	Speciality	Agency Cost
Young Adult Mental Health Services Laois Offaly	Consultant Psychiatrist YAMHS	
Young Adult Mental Health Services Longford Westmeath	Consultant Psychiatrist YAMHS	
Child and Adolescent Mental Health Services Longford Westmeath	Consultant Psychiatrist CAMHS	
Child and Adolescent Mental Health Services Laois Offaly	Consultant Psychiatrist CAMHS	
		Total:

Louth Meath Mental Health Services 2020

Location	Speciality	Agency Cost
Drogheda Department of Psychiatry	Consultant Psychiatrist Mental Health Adult	
Ashbourne	Consultant Psychiatrist Mental Health Adult	
Dundalk	Consultant Psychiatrist Mental Health Adult	
		Total:

Laois/Offaly 2020

Location	Speciality	Agency Cost
Laois/Offaly	Consultant Psychiatrist Old Age Psychiatry	
Laois/Offaly	Consultant Psychiatrist Old Age Psychiatry	
Laois/Offaly	Consultant Psychiatrist General Adult	
		Total:

Longford/Westmeath Adult Mental Health Services 2020

Location	Speciality	Agency Cost
Longford/Westmeath	Consultant Psychiatrist Adult	
Longford/Westmeath	Consultant Psychiatrist Adult	
		Total:

Total Cost for Consultant Psychiatrist Agency Posts for 2020: €2,509,046.42

2. Findings, particulars and reasons for decisions to deny access
The sections of the Act which can apply to deny access to documents are known as its exemption provisions.

Under Section 37.(1) of the act I am withholding the individual cost of each separate location, under the rationale that due to the small number of individuals that form part of the request, Section 37.(1), applies regarding an identifiable individual. Where information may not on the face of it, be about an identifiable individual, it may still be personal information if it allows that individual to be identified. I have taken into consideration that release under the Freedom of Information Act is release to the world at large. I have however considered the public interest in the use of public funds and I am therefore agreeable to releasing the total agency expenditure for Consultant Psychiatrist posts for CHO8 to date for 2020, which amounts to €2,509,046.42.

Should you have any questions or concerns regarding the above, please contact me on 041 6850630 or at maria.peel@hse.ie

Right of Appeal
You may appeal this decision. In the event that you need to make such an appeal, you can do so by writing to the Internal Reviewer, Ms Dervila Eyres, Head of Mental Health Services, Midlands Louth Meath Community Healthcare Organisation CHO8, Health Services Executive, St Brigid's Complex, Kells Road, Ardee, Co Louth. You should make your appeal within 4 weeks from the date of this notification; however, the making of a late appeal may be permitted in appropriate circumstances. A week is defined in the Acts to mean 5 consecutive weekdays, excluding Saturdays and public holidays (Sundays are also excluded, as they are not weekdays). The appeal will involve a complete reconsideration of the matter by a more senior member of the Staff of the Health Executive.

Yours sincerely,

Maria Peel

Maria Peel
Interim Business Manager & FOI Decision Maker
Louth Meath Mental Health Services

Encl: 1 copy of Sec 37.(1)

[1] HSE National Service Plan 2021.
[2] HSE Annual Report and Financial Statements 2020.
[3] HSE National Service Plan 2021.
[4] Government's proposal to Dáil Eireann for spending on Health in 2021, Parliamentary Budget Office, 12 February 2021.
[5] Parliamentary Budget Office Economic and Fiscal Commentary Spring 2021, 11 March 2021.
[6] ESRI Research Series Number 114, October 2020: How Does Irish Healthcare Expenditure Compare Internationally? The majority of EU countries exclude social care from their healthcare-related expenditure accounts returned to the OECD. In contrast, Ireland includes virtually all social care expenditure under its health spend. In total over one-fifth of the Irish health budget in 2017 at €4.6bn was comprised of expenditure on Services for Older People, Disability Services, related HSE corporate costs and Department of Employment Affairs and Social Protection payments to carers that is excluded in other countries. (Source: ESRI, October 2020.)
[7] OECD.Stat. NECG consists of 10 EU Member States (Austria, Belgium, Denmark, Finland, France, Germany, Ireland, Netherlands, Sweden, and the UK) that share a number of features such as income per capita and overall size of GDP.
[8] Exchange rate 1USD = 0.84266879 EUR, accessed 6 September 2021, www.xe.com. Estimated population of 5,011,500 in April 2021, CSO statistical release, 31 August 2021.
[9] CSO statistical release, 31 August 2021. The population increased from 4,485,100 in 2008 to an estimated 5,011,500 in 2021.
[10] Open Beds Report – December 2019, Department of Health, 3 March 2020.
[11] Those aged 65 years and over increased from 483,800 in 2008 to an estimated 742,300 in April 2021. Health in Ireland: Key Trends 2017, 2018 and 2019, Department of Health; CSO Statistical release, 31 August 2021.
[12] Eurostat.
[13] HSE National Service Plan 2021.
[14] IGEES Spending Review 2021: Impact of Demographic Change on Health Expenditure 2022-2025, Department of Health, 30 July 2021. Note: Of that €324m, €117 (36%) will be required next year to meet demographic cost pressures in Acute Hospitals, with this rising to €140m by 2025. (Source: IGEES Spending Review 2021) The €324m required for health demographics next year is almost twice the previously underestimated figure of €175m calculated by the Department of Health in 2019. (Source: IGEES Spending Review 2019: Budgetary Impact of Changing Demographics from 2020-2030, Department of Health, 2 October 2019.)
[15] Expenditure Report 2021 – Part II Expenditure Allocations 2021. Department of Public Expenditure and Reform, 13 October 2020.
[16] See Figure 4, Appendix 1. The large increase in day case attendances since 2014 is attributable to the inclusion of dialysis cases previously excluded. HIPE data confirms that day patients with a principal diagnosis requiring dialysis accounted for 16.6%, 16.1%, 16%, 15.7%, and 17.2% of day patient discharges in 2015, 2016, 2017, 2018 and 2019 respectively. The inpatient figure for 2020 excluding dialysis uses the 17.2% rate for 2019. Source: Activity in Acute Public Hospitals in Ireland, 2017, 2018 and 2019 Annual Reports, Healthcare Pricing Office, September 2018, September 2019 and September 2020.
[17] The number of inpatients treated in 2019 decreased by 5,409 (-0.1%) compared with 2018. See Figure 4, Appendix 1.
[18] See Figure 5, Appendix 1. OECD Health Statistics 2020; Eurostat Database
[19] See Figure 6. Eurostat.
[20] Ireland's pre-Covid hospital bed occupancy rates was the highest in the EU at 89.9%.
[21] The overall population increased by 1,132,000 between 2000 and 2019 or by 30%; CSO PxStat. The number of those aged over 65 increased by 271,600 (64%), from 424,700 in 2000 to an estimated 696,300 in 2019; CSO PxStat.
[22] OECD.Stat.
[23] OECD Health Statistics 2020; Eurostat Database.
[24] An IHCA analysis of the general acute hospital beds available over a 14-day period in August shows on average just 263 beds were available for newly admitted patients on any given morning - approximately 2% of the total number of public acute hospital beds. See Table 1, Appendix 1. HSE Covid-19 Daily Operations Update Acute Hospitals, 21 July to 3 August 2021; Latest available Department of Health Open Beds Report - March 2021, 12 July 2021.
[25] National Development Plan 2018-2027, 16 February 2018. It should be noted that this is at the lower end of the range of 2,590 to 7,150 additional beds recommended by 2031 on a scenario basis in the Capacity Review published the previous month. (Source: Health Service Capacity Review 2018, 23 January 2018.)
[26] HSE Capital Plan 2019, 2 September 2019.
[27] National Development Plan 2018-2027, 16 February 2018.
[28] HSE Capital Plan 2021, 4 August 2021.
[29] This is calculated from a base figure at the start of 2020 of 10,733 acute inpatient beds open (excluding Critical Care Beds n=255]. Department of Health press release on Budget 2021, 14 October 2020.
[30] HSE Winter Plan 2020/2021, 24 September 2020.
[31] The Minister for Health told the Dáil on 13 July (Priority Question No 33) that 834 acute beds had been delivered "through the winter plan and this year so far, with another 229 expected this year", which covers the period October 2020

(Winter Plan Oct 2020-April 2021) to July 2021, but takes bed capacity at the start of 2020 as its baseline. However, the Minister did not give an overall figure of the number of inpatient beds delivered.

[32] However, this figure deviates significantly from the latest official Department of Health Open Beds Report for March 2021, published on 12 July, which indicates that there were 11,285 inpatient beds open in March 2021. (Source: Department of Health Open Beds Report - March 2021, 12 July 2020). This is an increase of just 261 inpatient beds in the first three months of 2021 (11,024 inpatient beds were open in Dec 2020) (Source: Department of Health Open Beds Report - December 2020, Open, 10 March 2021) and an increase of just 552 inpatient beds compared with the base figure in December 2019 of 10,733 inpatient beds. This is less than half (48%) the target number of 1,146 additional inpatient beds operational by end 2021. Furthermore, the March 2021 open beds total includes 104 inpatient beds at the National Rehabilitation Hospital, Dun Laoghaire which have only been included from 2021 onwards. This reflects a change in the governance of NRH beds from community to acute hospitals rather than any actual increase in overall beds in the health system. Whatever statistics are used, it is clear the Government is highly unlikely to deliver on the promised additional 1,146 inpatient beds by the end 2021.

[33] Sláintecare Progress Report January - June 2021, Department of Health, 10 September 2021.

[34] HSE National Adult Critical Care Capacity - Census Report 2020, March 2021.

[35] Health at a Glance: Europe 2020, 19 November 2020.

[36] Health at a Glance: Europe 2020, 19 November 2020.

[37] HSE National Adult Critical Care Capacity - Census Report 2020, March 2021. The number of deaths in critical care would likely have been higher if this additional surge capacity had not been in place. However, the redeployment of staff to open these temporary beds had a negative impact on essential scheduled care, resulting in likely delayed patient diagnoses and poorer outcomes.

[38] Multi-annual National Adult Critical Care Capacity Planning 2019, 2020 and subsequent years – Memorandum, HSE Critical Care Programme, 24 April 2019.

[39] Covid-19 Daily Operations Update Acute Hospitals, Performance Management and Improvement Unit, HSE, confirmed there were 297 adult critical care beds open and staffed on 9 August, 299 on 8 August, 302 on 7 August, 300 on 6 August, 299 on 5 August 2021, and 296 on 4 August 2021. Budget 2021 uses a base of 255 ICU beds open at start of 2020.

[40] Irish National ICU Audit Annual Report 2018, National Office of Clinical Audit, 12 February 2020.

[41] The Minister for Health confirmed in the Dáil in July that 42 of the planned additional 66 ICU beds funded in Budget 2021 were now open, bringing the baseline ICU capacity to 297 beds. Budget 2021 anticipated that this figure of 297 ICU beds would be reached in Q1 2021, not by the end of Q2, with the remaining 24 planned by the end of 2021. (Source: Department of Health press release on Budget 2021, 14 October 2020). Therefore it is uncertain whether the target of 321 ICU beds open by the end of year will be met. When eventually delivered, the number of ICU beds open will be just 21 more than currently available and staffed, and still a significant 258 ICU beds short of the number recommended more than a decade ago.

[42] Department of Health press statement, 18 December 2020. The five prioritised sites for the additional 117 ICU beds are: Beaumont Hospital, St James's, the Mater, St Vincent's University Hospital and Cork University Hospital.

[43] Based on an estimated population of 5,011,500 in April 2021.

[44] See NOCA ICU Audit, p6.

[45] NTPF Waiting Lists.

[46] There were 203,976 people awaiting diagnostic scans at the end of Q1 2021; Ministerial response to PQs 2344-2385 from Deputy John Lahart, 21 April 2021.

[47] Minister Stephen Donnelly at Select Committee on Health, 2 December 2020.

[48] NTFP data; Posts advertised by the Public Appointments Service (PAS) between 1 February 2021 and 30 August 2021; HSE NDTP Response to PQ 8669/21 to Deputy David Cullinane, 24 February 2021; HSE NDTP data obtained by the IHCA, 4 November 2020; HSE NDTP Consultant Post Matching Report to 31 December 2019; Medical Workforce Report 2020-2021, HSE NDTP; PQ response 32037 from HSE to Deputy Louise O'Reilly, 19 July 2018; NDTP Consultant Workforce 2018; Response to Parliamentary Question raised by Deputy Billy Kelleher and provided to the Oireachtas Joint Health Committee on 28 June 2017; Public Service Pay Commission 'Recruitment and Retention - Module 1', August 2018; HSE response to Senator Colm Burke – Questions received 17 October 2016; HSE response to Senator Colm Burke, Spring 2015, App 1 - Consultant posts (Excluding Psychiatry) 18th Dec 2014. The HSE NDTP Consultant Post Matching Module was only rolled out nationally in 2017. *2021 NTPF Outpatient Waiting Lists as at 26 August 2021.

[49] Based on an estimated waiting list and backlog for hospital treatment of 337,735, comprising the current inpatient/day case waiting list of 75,720 and the 260,198 fewer hospital treatments that will have occurred over 2020 (255,610) and 2021 (4,588) compared with 2019 outturn; HSE Annual Report and Financial Statements 2020 and HSE National Service Plan 2021.

[50] Based on 1,742,023 inpatient/day cases in 2019 - 5% = 87,101. Backlog of 260,198 procedures could take 3 years from the end of 2021 to clear; HSE Annual Report and Financial Statements 2020 and HSE National Service Plan 2021.

[51] There were 362,903 fewer outpatient appointments in 2020 compared with 2019 and a further 189,756 less consultant appointments are expected to take place this year compared with pre-pandemic levels (HSE Annual Report and Financial Statements 2020 and HSE National Service Plan 2021). This amounts to an anticipated reduction of 552,659 outpatient appointments over two years. While the health service may not to have to catch up on all of these appointments, the fact

that almost 150,000 new outpatient appointments were cancelled in 2020 would suggest a backlog of around 300,000 new appointments could build up by the end of 2021 (HSE PQ response to Deputy Gino Kenny, 10 February 2021). Adding this to the 650,000 currently on the outpatient waiting list could mean a backlog of around 950,000 outpatient appointments. Based on 3,354,919 outpatient appointments in 2019 (5% = 167,746), a backlog of 300,000 new outpatients would take 1.79 years to clear; an outpatient waiting list and backlog of 950,000 patients would take 5.7 years to clear.

[52] This is based on 3,354,919 outpatient appointments in 2019, 2% = 67,098. A backlog of 300,000 new outpatients would take 4.5 years to clear; an outpatient waiting list and backlog of 950,000 would take over 14 years to clear.

[53] OECD Report - Waiting Times for Health Services, 28 May 2020. The official target for the percentage of people waiting less than a year for their first outpatient appointment was actually reduced by the HSE from 80% to 75% in 2021. Less than 6 in 10 people met the 80% target of waiting less than a year in 2020. (Source: HSE National Service Plan 2021.) Similar reductions in targets have been set for the percentage of women admitted for hospital treatment within three weeks of diagnosis of breast cancer (from 95% to 90%), access to community palliative care services within seven days (from 90% to 80%), and in the waiting times for assessments such as orthodontics (from 46% to 22% of patients seen within 6 months). (Source: HSE National Service Plan 2021.)

[54] HSE National Service Plan 2021.

[55] Liam Woods, HSE National Director, Acute Hospitals Division, on Drivetime, RTÉ Radio 1, 12 August 2021, https://www.rte.ie/radio/radio1/clips/21993118/.

[56] Minister for Health Mary Harney said on 28 March 2006 that the Emergency Department overcrowding crisis had to be treated as a national emergency, at a time when there were 384 patients on trolleys awaiting a hospital bed.

[57] HSE CEO Paul Reid at HSE Briefing, 5 August 2021. In the seven days up to 18th July 2021 there were 22,738 ED attendances, which was up 3,590 (19%) on the same period last year and an increase of 1,506 patients (7%) on pre-Covid levels in 2019. (Source: HSE Chief Operations Office Anne O'Connor at HSE Briefing, 22 July 2021.)

[58] UHL cancelled all elective activity and outpatient clinics from 28-30 July 28 due to exceptionally high emergency attendances and admissions.

[59] Monthly Trolley Watch Figures in 2021: Jan - 3,715; Feb - 3,456; Mar - 4,126; April - 4,637, May - 3,898; June - 5,179; July - 6,028; Aug - 6,367 (Total=37,406). This compares with 2020 trolley figures of 25,290 from March to October 2020 and 33,577 from March to Dec 2020.

[60] Overview Report: Monitoring and Regulation of Healthcare Services in 2020, HIQA, 10 August 2021.

[61] The six hospitals were: Naas General Hospital, Mayo University Hospital, South Tipperary General Hospital, Wexford General Hospital, Tallaght University Hospital and University Hospital Kerry. HIQA Overview Report: Monitoring and Regulation of Healthcare Services in 2020, HIQA, 10 August 2021.

[62] Open Beds Report March 2021, Department of Health, 12 July 2021.

[63] The HSE suggested in June 2020 that adhering to 2 metre physical distancing could reduce acute inpatient bed numbers by 25%, or approximately 2,700 beds; Service Continuity in a COVID Environment: A Strategic Framework for Delivery, HSE, 8 June 2020 – published 24 June 2020.

[64] A copy of the IHCA Mental Health Pre-Budget Submission 2022 is available at https://www.ihca.ie/_fileupload/IHCA%20Mental%20Health%20Pre-Budget%20Submission%2024082021.pdf.

[65] HSE Service Plans and Performance Reports.

[66] The population has increased from 4,533,400 in 2009 to an estimated 5,011,500 in 2021. This is an increase of 478,100 (10.5%).

[67] Total Health Budget for 2021 is €20,623m.

[68] In 2012 mental health funding accounted for 5.6% of overall HSE budget; HSE PQ response 38977/20 to Deputy Denis Naughten, 11 December 2020.

[69] Germany, the Netherlands and Sweden all spend approx. 11% of government health spending on mental health, with France allocating 13% of total government expenditure on health to mental health; WHO Global Health Observatory.

[70] 'Next steps for funding mental healthcare in England, Royal College of Psychiatrists, September 2020.

[71] Non-capital mental health expenditure totalled €184m in 1984, which was 13% of the total health budget of €1.413bn; *A Vision for Change*, p178.

[72] CHO7 had a mental health budget of €135,542 per 1,000 population in 2019 compared with €168,961 per 1,000 population in CHO4.

[73] Eurostat.

[74] Given a deficit of 1.06 medical specialists per 1,000 population, 5,276 specialists would be required to reach the EU average, based on the estimated population in April 2020 of 4,977,400. The definition of specialist medical practitioner includes medical interns and residents training as specialists.

[75] HSE Comparison of Ireland's Publicly Funder Medical Workforce with UK and Australia, January 2021.

[76] Spending Review 2019: Health Workforce Consultant Pay and Skills Mix, 2012-2017, Department of Public Expenditure and Reform, 15 August 2019.

[77] Report of the Public Service Pay Commission, Recruitment and Retention Module 1, September 2018.

[78] Report of the National Task Force on Medical Staffing, Department of Health, June 2003, p87.

[79] Demand for Medical Consultants and Specialists to 2028 and the Training Pipeline to Meet Demand: A High Level Stakeholder Informed Analysis, HSE NDTP, 2020.

[80] The number of vacant consultant posts (including those with unknown status, which are likely to be vacant), increased from 260 as at 1 February 2021 to 314 as at 31 March 2021; HSE NDTP Response to Deputy David Cullinane, 24 February 2021; HSE Consultant Post Matching Reports as at 31 March 2021.

[81] The 748 unfilled posts is derived from the 618 vacant or temporary filled posts as at 1 February plus the 130 posts advertised by the PAS between 1 Feb and 30 August 2021.

[82] PAS FOI response to Ken Foxe, *Irish Examiner*, 12 October 2020.

[83] PAS FOI response to Ken Foxe, *Irish Examiner*, 12 October 2020.

[84] Public Appointments Service website www.publicjob.ie.

[85] '109 consultants not on specialist register', *Medical Independent*, 15 July 2021, https://www.medicalindependent.ie/109-consultants-not-on-specialist-register/.

[86] Medical Council of Ireland -v- Bhatia, IEHC 246, 8 May 2018.

[87] Meeting minutes of HSE People and Culture Committee, 9 April 2021, https://www.hse.ie/eng/about/who/board-members/committees-of-the-board/people-and-culture-committee/minutes-hse-people-and-culture-committee-9th-april-2021.pdf.

[88] HSE PQ response 2457 19 to Deputy Louise O'Reilly, 5 February 2019; HSE Annual Report and Financial Statements 2020, 6 July 2021.

[89] FOI responses from the HSE to the IHCA in December 2020, January and February 2021 (Appendix 2).

[90] NTMA Annual Report and Accounts 2013 – 2020.

[91] HSE PQ response to PQs 21593/20 and 21342/20 from Deputy David Cullinane, 18 September 2020.

[92] HSE Winter Plan 2020/2021, 24 September 2020; Heath Section in 2021 Expenditure Report, 12 October 2020.

[93] Demand for Medical Consultants and Specialists to 2028, HSE NDTP, 2020.

[94] A pilot study of burnout and long covid in senior specialist doctors, *Ir J Med Sci*. 2021 Mar 13;1-5. doi: 10.1007/s11845-021-02594-3.

[95] HSE Capital Plan 2021, 4 August 2021.

[96] Expenditure Report 2021 – Part II Expenditure Allocations 2021. Department of Public Expenditure and Reform, 13 October 2020.

[97] Expenditure Allocations 2021.

[98] Revised Estimates for Public Services (2008 - 2021); HSE Reports on Capital Programme cited in DOH Health in Ireland Key Trends 2017; 'Building on Recovery: Infrastructure and Capital Investment 2016 – 2021' Capital Plan; HSE Capital Plan 2021.

[99] Deputy Seán Fleming, Chair, Public Accounts Committee, Dáil Debate on National Children's Hospital, 12 March 2019.

[100] Mr Tom Parlon, Director General, Construction Industry Federation, at the Oireachtas Special Committee on COVID-19 Response, 19 May 2020.

101 National Paediatric Hospital Development Board: 2019 Financial Statement, Public Accounts Committee, 13 July 2021.

[102] 'Funding expected to be used on Children's Hospital diverted to COVID-19 response', *Irish Independent*, 7 August 2020.

[103] Opening statement by former HSE Director General Tony O'Brien to Oireachtas Future of Healthcare Committee, 30 November 2016.

[104] HSE Capital Plan 2021.

[105] 'Health bodies accused of passing the buck as ageing equipment lingers in Irish hospitals', *Irish Examiner*, 24 August 2020.

[106] National Electronic Record Strategic Business Case, Office of the CIO, HSE, May 2016.

[107] 'Cyberattack: HSE faces final bill of at least €100m', *Irish Times*, 27 May 2021; 'HSE in 'ongoing battle' with cybercrime'. *Irish Mail on Sunday*, 14 August 2021.