Pre-Budget Submission 2017

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Submission by:

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Foreword

As the newly elected President of the IHCA it is glaringly obvious to me and to my fellow consultants that after years of austerity there is a need for urgent and significant investment in our acute hospital and mental health services. To ensure the delivery of high quality safe service for patients, a fully funded programme is required to upgrade the physical condition of hospitals, replace obsolete equipment, increase bed and other capacities and significantly increase consultant numbers.

The Government must address these significant capacity and equipment deficits in the health budget by ensuring that it allocates substantially increased funding for capital and current budget expenditure to reverse the cuts of recent years.

Our population is increasing and progressively ageing with growing expectations for higher quality healthcare. Acute hospitals have responded by treating more patients than ever before and now have one of the shortest average lengths of stay and one of the highest bed occupancy rates in the OECD. This has arisen in the circumstances where Ireland has one of the lowest numbers of acute beds and one of the lowest numbers of doctors in the OECD.

The 'trolley crisis', which is directly related to the shortage of hospital beds, is no longer an issue for the winter months. It is a year-round capacity problem with hundreds of patients being treated on trolleys daily. Yet research has proven that mortality rates for patients who are treated on trolleys are higher than those treated in beds. In addition, waiting lists are at record high levels. In June of this year there were 76,000 patients awaiting essential surgery.

At any given time, there are a significant number of clinically discharged patients in acute hospitals which impacts adversely on the optimal use of the existing inadequate bed capacity. In April an average of 617 acute hospital beds were occupied every day by clinically discharged patients and therefore unavailable to new admissions. This is the equivalent of closing a large teaching hospital while there is an obvious shortage of hospital beds.

When the deficit in acute hospital beds is combined with insufficient theatre capacity, growing inpatient and day-case patient waiting lists are the inevitable consequence. Aside from cancelled surgeries, the lack of beds has other knock-on effects including overcrowding in emergency departments. This overcrowding is due to the lack of acute hospital beds and will only be resolved by an investment programme to expand capacity.

Ireland's patients deserve better. They need more beds, they need more consultants and they need modern infrastructure and functioning equipment.

Dr Tom Ryan

President, IHCA

Executive Summary

1. Cumulative Budget Reductions, Demographic Pressures and Increased Demand

Health service budgets have been under increasing pressure for some considerable years. The public health service is expected to deliver higher levels of activity against a backdrop of cumulative budget reductions, repeated annual budget deficits and the increasing demographic pressures associated with our growing and ageing population. Acute hospital and mental health services have been underfunded year after year due to the failure to adequately provide for predictable demand and growth in demand. While it is acknowledged that some of the deficits have been addressed on a delayed basis by way of supplementary budgets, this has not been sufficient to address the increases in demand as evidenced by growing waiting lists.

The HSE 2015 "Planning for Health" document projects a cumulative reduction in the total healthcare budget of 31.7% by 2017 compared with 2009 including demographic pressure of 11.8% and budget reductions of 19.9%. This figure does not take account of medical and other inflation.

Increased demand for care is partly attributable to demographic changes. Between 2006 and 2015, there has been an increase of 143,600 (31%) in the population aged 65 and over. By 2021 it is projected that there will be a further increase of 107,600 aged 65 years and over, representing an increase of 17% compared with 2016. This cohort is associated with medical needs that are especially complex, time consuming and resource intensive.

The population growth of 3.7% between 2011 and 2016, as confirmed in the 2016 census results, further highlights the increased demand which must be taken into account in deciding on the 2017 health budget levels.

The effects of these demographic changes are already evident. Between 2008 and 2015, inpatient, daycase and ED attendances increased by 40,751 (6.7%), 241,683 (37.9%) and 43,339 (3.76%) respectively. This confirms the signficant and sustained upward trend in patient demand for acute hospital care arising largely from demographic pressure and advances in medical treatment.

The IHCA recommends that unfunded patient care needs and projected future increases in the demand for care are provided for in the 2017 Health Budget. This requires realistic, verifiable projections which take account of the increased numbers of patients awaiting care, the rising rate of chronic disease, an ageing population and other demographic pressures.

2. Under-resourcing and Acute Hospital Funding Deficits

In parallel with increasing demand and demographic pressure, under-resourcing and acute hospital funding deficits have had an adverse impact on the ability of acute services to deliver timely care to patients and have created serious and critical capacity constraints.

Years of significant underfunding of acute hospitals, with an average annual deficit of €215m between 2012 and 2015, have resulted in gaping capacity deficits undermining the basic resources and physical

infrastructure required to meet the increasing demand for care. OECD data demonstrates that Ireland experienced the third largest percentage health expenditure cut *per capita* in real terms compared with other countries between 2009 and 2013.

The funding of acute hospitals in recent years has been inadequate to meet patient acute care needs. Hospital funding deficits for the first four months of 2016 totalled €112m. The April 2016 HSE Performance Report confirms that acute hospitals were 8.28% over budget at the end of April. Only two of the country's 49 acute hospitals did not report budget overspends to the end of April.The April 2016 HSE Performance Report confirms that acute hospitals were 8.28% over budget at the end of April.

Based on current trends, the year-end deficit in the overall health budget would have been in the region of €500m, equivalent to the revised health estimate agreed by the Government in June. The revised estimate increases will be allocated to address expected shortfalls in funding for current day to day spending but will not address the significant infrastructure and capacity deficits which have accumulated during years of austerity.

The annual public capital health budget has been cut from €598m to €414m between 2008 and 2016. The acute hospital capital budget was cut from €273m to €235m over the same period. These cuts accumulate to €1,700m and €530m respectively in the overall health budget and the acute hospital capital budget resulting in overwhelming restrictions on essential infrastructure and equipment investment.

The IHCA strongly recommends that the 2017 acute hospital budget includes a significant increase in frontline funding to end the under-resourcing and the annual acute hospital budget deficits that are undermining the delivery of timely care to patients. In addition, we recommend that the acute hospital capital budget be substantially increased to reverse the cumulative cuts in recent years and address the growing physical infrastructure and equipment deficits.

3. Critical Capacity Constraints

At a time when the Irish health service has been subject to sustained underfunding and budget deficits, medical science has continued to advance and there have been significant developments in terms of new medications and treatments. Given the lack of resources available in acute hospitals, the public health system cannot keep pace with what is now regarded as contemporary best medical practice.

International comparisons confirm that Ireland's acute hospitals have one of the lowest numbers of practising doctors, a relatively low number of acute hospital beds and an excessively high bed occupancy rate. Consultants who attempt to deliver safe care to their patients are continuously aware of the mismatch between the available physical and human resources and the actual needs of their patients. There are deficits throughout the hospital system in terms of acute hospital beds, ICU beds, access to endoscopy and diagnostic imaging, and access to operating theatres and outpatient clinics.

Between 2007 and 2014, the number of acute hospital beds was cut by 1,643 (14%) from 12,123 to 10,480. In 2009, the HSE's commissioned Prospectus Report recommended an immediate increase of 45% in ICU beds from 289 to 418 in 2010 alone, to be followed by a further increase to 579 by 2020. The report has not been acted upon and instead the number of ICU beds has actually declined.

When the bed deficit is combined with insufficient theatre capacity generally, growing inpatient and day-case patient waiting lists are the inevitable consequence. Aside from cancelled surgeries, the lack of beds has other knock-on effects including overcrowding in emergency departments.

Ireland's bed occupancy rate at 94% compares unfavourably with the OECD average (77%) and the UK (84%). This occupancy rate is far in excess of the recommended 85% occupancy rate. It jeopardises the safe and effective delivery of high quality care.

The treatment of large numbers of patients on trolleys is no longer a seasonal problem but a year round capacity problem which highlights the extreme nature of the acute hospital capacity shortage.

At any given time, there is a significant number of clinically discharged patients residing in acute hospitals which impacts adversely on the optimal use of the existing inadequate bed capacity. In April on average 617 acute hospital beds per day were occupied by clinically discharged patients and unavailable to new admissions. This is the equivalent of a large teaching hospital being closed throughout the year.

Acute hospitals are not only attempting to treat patients with inadequate capacity but they are invariably doing so with equipment which is increasingly obsolete.

In addition, the rehabilitation services are substantially underfunded. There is a significant deficit of rehabilitation beds in general and rehabilitation services for young and previously healthy patients who have experienced trauma injuries. Recuperation for such patients is delayed and compromised as a result.

The IHCA strongly recommends that the 2017 acute hospital budget is resourced fully to address the capacity constraints that are preventing the timely provision of care to patients. In particular, we recommend that the budget must include provision for:

- **An immediate increase in the number of acute, ICU and rehabilitation beds required to treat patients awaiting care on time, relieve emergency department overcrowding, reduce bed occupancy levels and address the growing waiting lists.**
- **An immediate increase in the availability of step down care and other facilities to support timely discharge of patients from acute hospitals.**

4. Growing Waiting Lists

Hospital consultants and doctors are struggling to treat an increasing number of acutely ill patients due to the severe capacity constraints outlined above and the effects of the continuing Consultant recruitment and retention crisis.

NTPF data confirms the sustained upward trend in inpatient, daycase, outpatient and GI endoscopy waiting lists despite the significant increases in the past decade in the number of patients being treated. In the 12 months to June 2016, the number of patients awaiting inpatient and daycase treatment and essential surgical care increased by 14%, the number awaiting GI endoscopies by 25% and outpatient waiting lists by 50%.

The IHCA strongly recommends an increase in the level of frontline resources and capital expenditure to tackle the root causes of rising waiting lists. This includes measures to address the lack of acute and ICU beds, insufficient operating theatre time, and diagnostics and other facilities

which require significant investment. Given the ongoing failure to provide adequate capacity in public hospitals to treat the increased number of patients presenting for care, any short term solutions in terms of NTPF outsourcing must incorporate 'whole care' packages which ensure assessment, treatment and follow-up care for patients.

5. Consultant Recruitment and Retention Crisis.

It is essential that the health service recruits and retains the number and calibre of Consultants that are needed to deliver safe high quality care to patients. There is a continuing failure to fill Consultant posts due to the State's blatant and repeated breaches of contract terms. Combined with frontline under-resourcing, the failure to honour contract terms has undermined the attractiveness of the Irish health service to highly trained internationally mobile specialists. Ireland is suffering a damaging medical brain drain because the terms and conditions on offer here are not competitive with other English speaking countries which include North America, Australia and the UK.

The State's refusal to provide parity for new entrant consultants in terms of salary and the failure to restore basic trust risks the loss of a generation of highly trained specialists and consultants who are emigrating to pursue their careers in other countries.

One in four advertised hospital Consultant posts received no applicants in 2015 and a significant percentage of posts received only one eligible applicant. There are now hundreds of approved Consultant posts which cannot be filled on a permanent basis. Under these circumstances the public health system will fail to provide the high quality safe care that the public deserves.

There is a real opportunity for the State and the Minister for Health to end the discrimination against new entrant consultants and honour the 2008 Consultant Contract. Both actions are necessary to restore the trust of the medical profession in the State and employers and improve the country's international competiveness in recruiting consultants.

The IHCA strongly recommends that the State ends the discrimination against new entrant Consultants and honours the 2008 Consultant Contract in order to restore trust and improve our international competitiveness in recruiting Consultants.

6. Mental Health Services

The 2016 Mental Health budget is €215m (21%) below 2009 expenditure even allowing for increases in 2014 and 2015. At €791.6m, it equates to 5.8% of the total health budget, which is low by international standards and in comparison with the NHS which spends 11% of its total health budget on mental health services.

The lack of resources for mental health services has led to ongoing delays in the implementation of the Vision for Change Report first published a decade ago.

Compared with 2008, staffing levels in mental health services have been cut by 1,072 (10%) to 9,404 WTEs in 2015. There are 427 approved Consultant Psychiatrist posts in the service, some 373 below that recommended by the College of Psychiatrists of Ireland.

At present it is not possible to provide appropriate inpatient care to children and adolescents due to a severe lack of CAMHS beds. Approximately 30% of CAMHS admissions in April were to age inappropriate Psychiatric Inpatient Units. This is in breach of Ireland's obligations under the UN

Convention of Human Rights which requires the separation of adults and children into age appropriate units.

The IHCA strongly recommends a significant increase mental health funding in the 2017 budget. This is essential for the provision of improved and timely care and to ensure that children and adolescents are admitted to age appropriate units.

It is essential that the €35 million annual ring-fenced funding is utilised without the delays experienced in recent years in filling priority posts identified. This requires urgent action to address deficiencies in the recruitment services.

7. Clinical Indemnity

Escalating clinical indemnity costs are driving up the cost of providing care in public hospitals and are jeopardising private practice in surgical and other specialities, forcing consultants to cease practice and emigrate. The cost of clinical indemnity more than doubled for most specialties in the two year period commencing 2013 and ending 2014. In 2015 and 2016, there were additional increases including substantial increases for some specialties and sub-specialities.

The IHCA welcomes steps taken by the Minister for Justice and Equality in 2014 and the enactment of legislation to introduce Pre-Action Protocols to speed up the processing of clinical indemnity claims and reduce legal and other costs. There continues to be an urgent need to implement without delay the Pre-Action Protocols together with other essential changes including the reform of Tort Law.

The IHCA strongly recommends that proposals on the lowering of the indemnity caps and the provision of indemnity on a commercial basis by the SCA should be brought to Cabinet for consideration as a matter of priority.

There is a pressing need to urgently adopt Regulations and Rules of Court to give effect to the newly enacted legislation on Pre-Action Protocols to ensure more intensive case management of medical negligence cases thereby resolving claims more efficiently. This must include a requirement for the exchange of information within defined time periods, with significant penalties where exceeded, to reduce delays and costs.

It is essential that recently announced initiatives concerning reform of Tort Law and a separate review of court sittings are expedited without further delay.

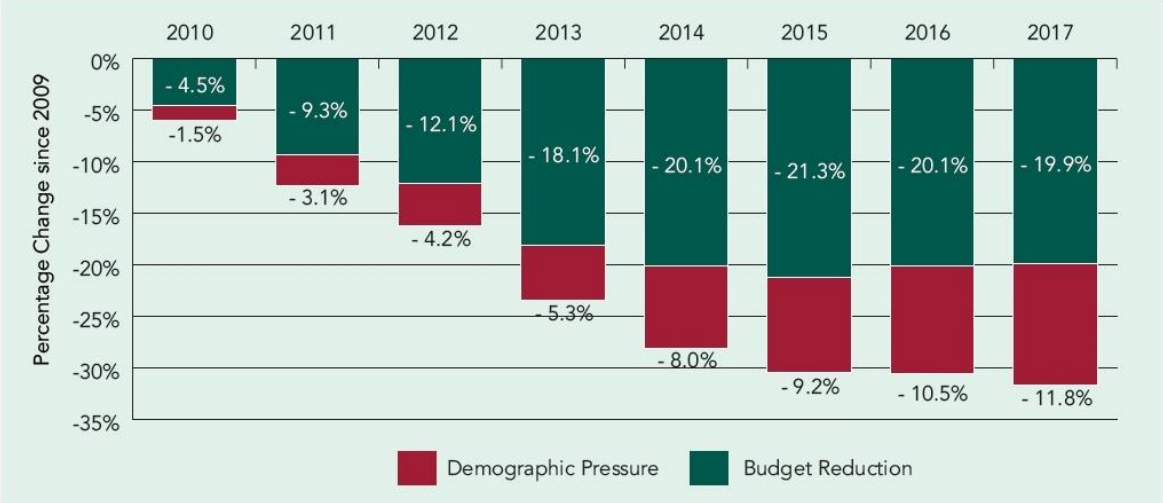
1. Cumulative Budget Reductions, Demographic Pressures and Increased Demand

Health service budgets have been under increasing pressure for some considerable years. The public health service is expected to deliver higher levels of activity against a backdrop of cumulative budget reductions, repeated annual budget deficits and the increasing demographic pressures associated with the country's growing and ageing population. Acute hospital and mental health services have been underfunded year after year due to the failure to adequately provide for predictable demand and growth in demand. While it is acknowledged that some of the deficits have been addressed on a delayed basis by way of supplementary budgets, this has not been sufficient to address the increases in demand as evidenced by growing waiting lists (see Section 4).

1.1 Cumulative Budget Reductions

The HSE Report, "*Planning for Health: Trends and Priorities to inform Health Service Planning 2016*", documents the cumulative decreases in the overall health budget including demographic pressures (Figure 1). If the projection for 2017 is maintained, the cumulative reduction in the healthcare budget would be 31.7% compared with 2009. This includes demographic pressure of 11.8% and a cumulative budget reduction of 19.9%.[1] This figure does not take account of the effects of medical and other inflation.

Figure 1: *Cumulative budget reductions and demographic pressure combined (2010 – 2017)*



Source: HSE Report: "Planning for Health: Trends and Priorities to inform Health Service Planning 2016" based on Finance Unit, Dept of Health for budget data, CSO and EC Ageing report for 2012 for demographic effect

While there were nominal increases in the acute hospital and mental health service budgets in 2015 and 2016, the *Planning for Health* report acknowledges that funding levels "*already contain a cumulative shortfall and are sub-optimal*". It is noted that that any additional funding designed only to address the "*pure-demographic effect*" will not be sufficient.[2]

[1]HSE Report: "*Planning for Health: Trends and Priorities to inform Health Service Planning 2016*"
[2]HSE Report: "*Planning for Health: Trends and Priorities to inform Health Service Planning 2016*"

1.2 Demographic Pressure

The increase in the demand for care is partly attributable to demographic changes in society. Between 2006 and 2015, there has been an increase of 143,600 (31%) in the population aged 65 and over(Figure 2). This cohort is associated with medical needs that are especially complex, time consuming and resource intensive. It is worth noting that patients aged 65 and over[3]:

- Account for 91% of delayed discharges.
- Have an average length of stay of 12.3 days compared with 6.0 in general.
- Account for over 50% of all in-patient bed days despite making up 12.7% of the overall population.
- Approximately 90% of our total healthcare costs are expended on 30% of the population with chronic disease and this demographic is expanding.
- By 2021 it is projected that there will be another 107,600 people aged 65 years and over, representing an increase of 17% compared with 2016.
- In the same period there will be an additional 15,200 people aged 85 years and over.

***Figure 2**: Population aged over 65 (2006 – 2015)*

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Pop. 85 and over	47,800	49,400	51,900	54,000	56,100	58,200	60,500	62,100	63,800	66,000
Pop. 80 – 84	64,400	65,600	65,900	66,900	68,400	69,800	71,000	72,600	74,900	76,900
Pop. 65 - 79	350,200	356,000	365,900	378,000	390,600	403,600	417,900	433,400	447,900	463,100

Source: CSO statbank population aged 65 and over by age group (2006 – 2015)

The population growth of 3.7% between 2011 and 2016, as confirmed in the 2016 census results, further highlights the increased demand which must be taken into account in deciding on the 2017 health budget levels.

1.3 Increase in number of patients treated in acute hospitals

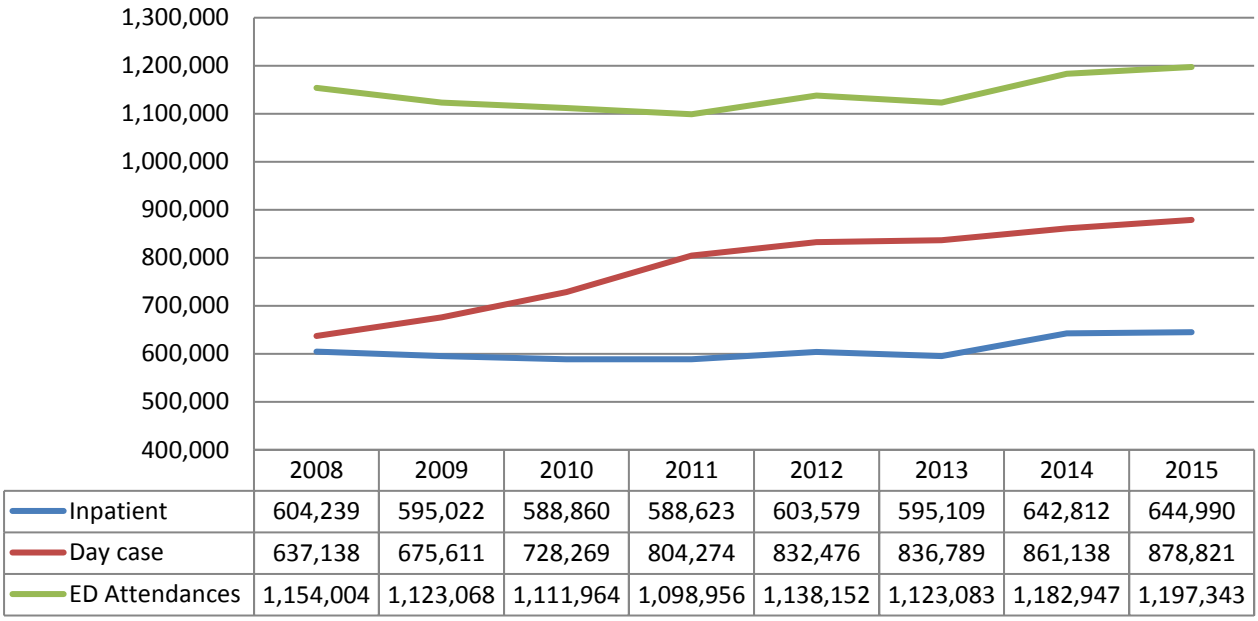
The effects of these demographic changes are already evident. Between 2008 and 2015 annual inpatient, daycase and ED attendances increased by 40,751 (6.7%), 241,693 (37.9%) and 43,339 (3.76%) respectively (Figure 3). There is a sustained upward trend in demand for acute hospital care due to demographic pressure and advances in medical treatment.

[3] HSE Report: "*Planning for Health: Trends and Priorities to inform Health Service Planning 2016*"

Despite the significant increase in the number of patients being treated in acute hospitals, waiting list numbers continue to increase. These unmet medical needs can only be fulfilled by effectively addressing the underlying capacity deficits in terms of acute and ICU beds, theatre facilities, and the Consultant recruitment and retention problems. Continued failure to invest in physical capacity and human resources as the population increases and ages will lead to increasing inefficiency, poorer patient outcomes and unnecessary costs.

Overall, the number of inpatients and daycase patients treated in acute hospitals has increased by 282,434 in the seven year period to 2015, an increase of 22.8% during a time of steep budget cuts and reductions in acute hospital staff numbers.

Figure 3: *Inpatient and Daycase totals (2008 to 2015)*



	2008	2009	2010	2011	2012	2013	2014	2015
Inpatient	604,239	595,022	588,860	588,623	603,579	595,109	642,812	644,990
Day case	637,138	675,611	728,269	804,274	832,476	836,789	861,138	878,821
ED Attendances	1,154,004	1,123,068	1,111,964	1,098,956	1,138,152	1,123,083	1,182,947	1,197,343

Source: HSE Performance Reports (2008 – 2015)

The Association also notes the intention of the Minister for Health to work on a collaborative basis in developing a 10-year Health Service Plan. However, this should not delay the immediate investment that is needed to address the capacity constraints that adversely impact on the delivery of care to patients. In addition, any long term plan must be realistic and supported by the necessary resources and funding.

The IHCA recommends that unfunded patient care needs and projected future increases in the demand for care are provided for in the 2017 Health Budget. This requires realistic, verifiable projections which take account of the increased numbers of patients awaiting care, the rising rate of chronic disease, an ageing population and other demographic pressures.

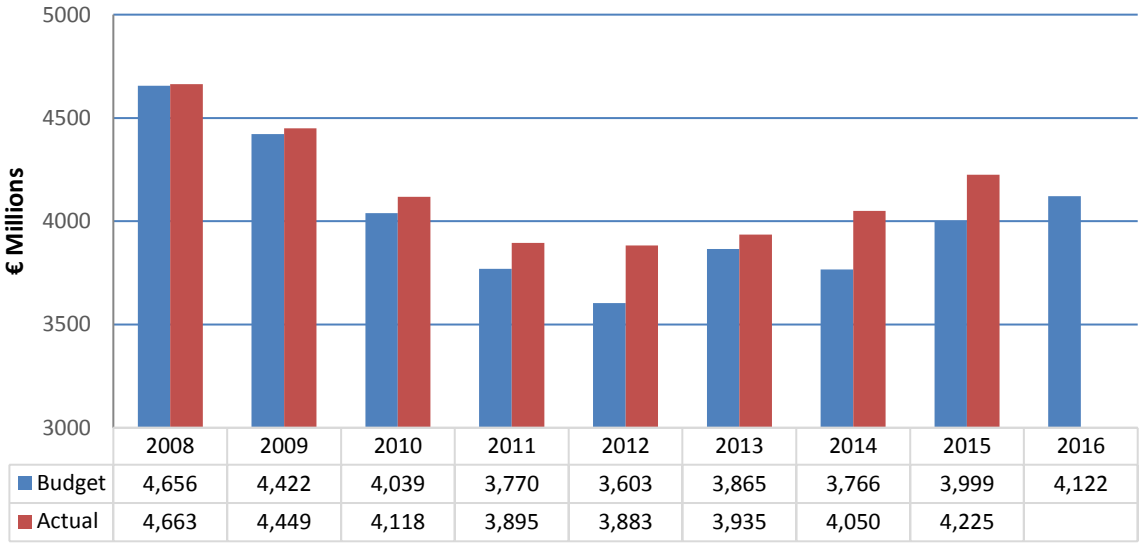
2. Under-resourcing and Acute Hospital Funding Deficits

In parallel with increasing demand and demographic pressure, under-resourcing and acute hospital funding deficits have had an adverse impact on the ability of acute services to deliver timely care to patients and have created serious and critical capacity constraints (see Section 3).

2.1 Under-resourcing

Years of significant underfunding of acute hospitals, with an average annual deficit of €215m between 2012 and 2015 have resulted in gaping capacity deficits undermining the basic resources and physical infrastructure required to meet the increasing demand for care. Frontline resources in acute hospitals were cut steeply under austerity measures and sufficient funding has not been provided to cater for the country's increasing and ageing population. There needs to be a significant increase in frontline funding to address the existing capacity constraints. Having regard to this year's revised health estimate of €500m, it is understood that a small proportion of these funds have been assigned to the acute hospital sector. Accordingly, the revised acute hospital budget for 2016 will remain substantially below 2008 (Figure 4). The difference between the 2008 and 2016 budget figures must be viewed against a backdrop of growing demand, an increase in the number of patients treated and an increase in the number of patients awaiting care.

Figure 4: *Acute Hospital funding 2008 – 2016 (€millions)*



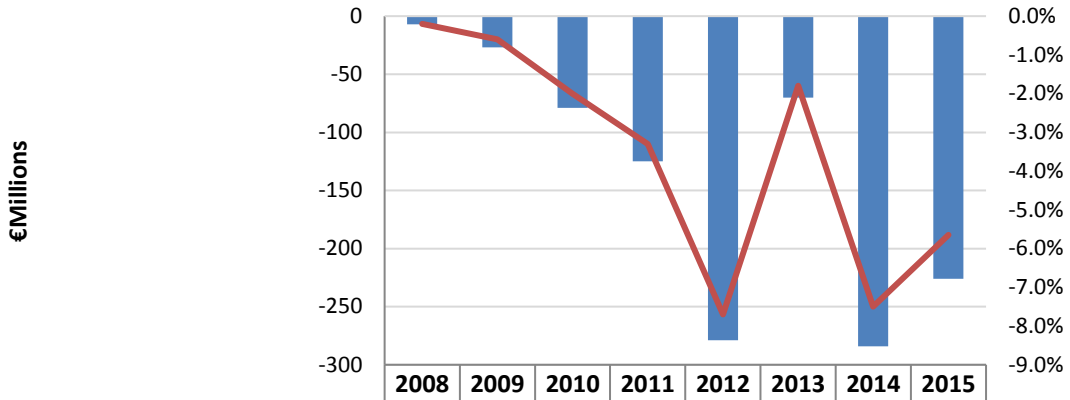
	2008	2009	2010	2011	2012	2013	2014	2015	2016
Budget	4,656	4,422	4,039	3,770	3,603	3,865	3,766	3,999	4,122
Actual	4,663	4,449	4,118	3,895	3,883	3,935	4,050	4,225	

Source: HSE Performance Reports and HSE Annual Reports and Accounts (2007 -2016)

2.2 Acute hospital funding deficits

There have been significant deficits in the acute hospital budget since 2008 (Figure 5) and these have restricted the basic resources and physical infrastructure required to treat the increasing numbers of patients who present for care.

Figure 5: *Acute Hospital funding deficits (2008 to 2015) before the inclusion of supplementary budget allocations*

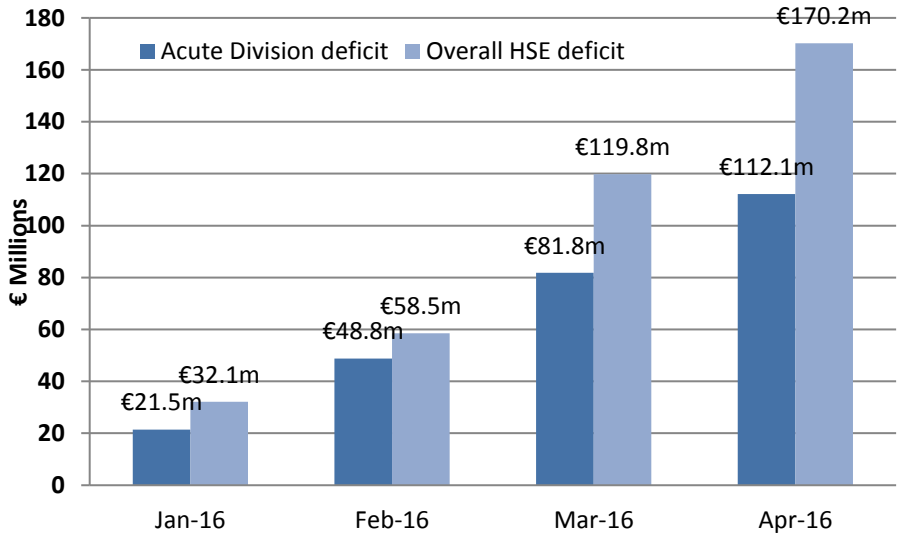


	2008	2009	2010	2011	2012	2013	2014	2015
Deficit €m	-7	-27	-79	-125	-279	-70	-284	-226
% Change	-0.2%	-0.6%	-2.0%	-3.3%	-7.7%	-1.8%	-7.5%	-5.65%
Supplementary estimates €m	255	236	80	595	148	360	219	680

Source: HSE Performance Reports and HSE Annual Report and Financial Statements (2007 – 2014)

It is clear that increases in the frontline acute hospital budgets in recent years were inadequate to fund patient demand for care. The acute hospital funding deficit for the first four months of 2016 was €112.1m (Figure 6)[4]. The April 2016 HSE Performance Report confirms that acute hospitals were 8.28% over budget at the end of April as detailed in Appendix 5. All but two of the country's 49 acute hospitals reported budget overspends at the end of April 2016. Fifteen acute hospitals were over budget by between 10% and 27%.[5]

Figure 6: *HSE and Acute Hospital funding (January to April of 2016)*



Source: HSE Performance Reports (January – April 2016)

[4]April 2016 HSE Data document
[5]April 2016 HSE Data document

Based on current trends, the year-end deficit in the overall health budget would have been in the region of €500m, equivalent to the revised health estimate agreed by the Government in June. The revised estimate increases will be allocated to address the expected shortfalls in funding for current day to day spending. It does not address the significant deficits in capacity which have accumulated during years of austerity. In addition, it is worth noting that the revised estimate is intended to address shortfalls throughout the entire health service for 2016. It is understood that a relatively small proportion of these funds have been assigned to the acute hospital sector.[6]

The annual public capital health budget (Figure 7) has been cut from €598m to €414m between 2008 and 2016. The acute hospital capital budget was cut from €273m to €235m over the same period. These cuts accumulate to €1,700m and €530m respectively in the overall health budget and the acute hospital capital budget resulting in overwhelming restrictions on essential infrastructure and equipment investment.

Figure 7: *Health and Acute Hospitals Capital Expenditure/ Budgets*

	Health Capital Expenditure /Budget Totals (€m)	**Acute Hospital Capital Expenditure/ Budget Totals (€m)**
2008	598	273
2009	447	209
2010	366	220
2011	347	202
2012	350	208
2013	347	203
2014	386	197
2015*	382	178.3
2016*	414	234.7
Cumulative reduction in Capital Expenditure	1,745	532

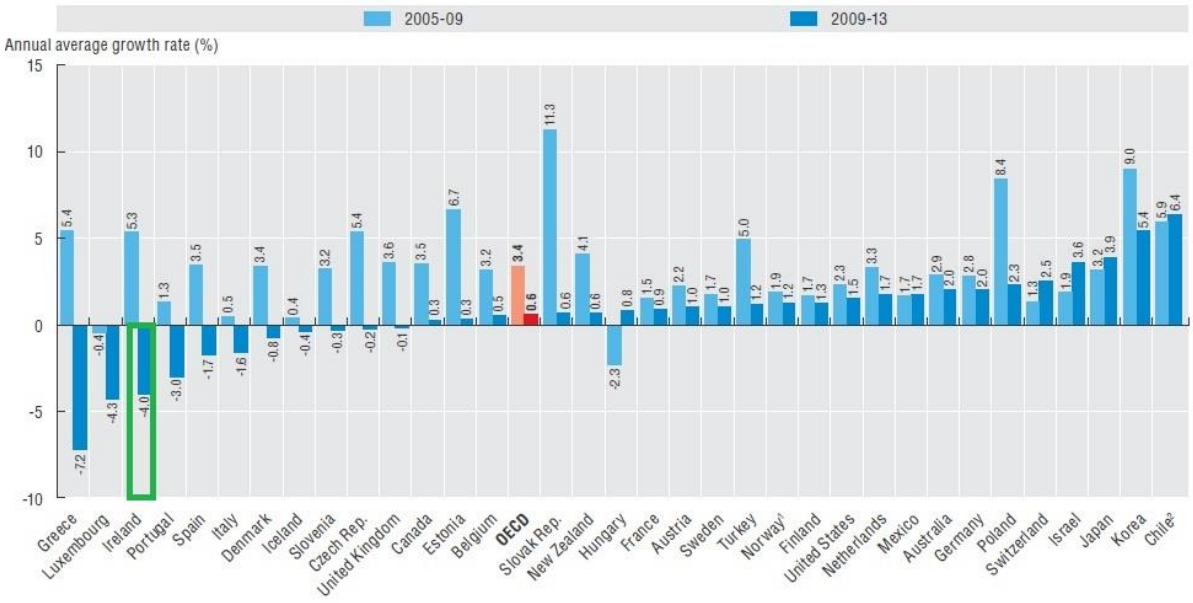
Source: Revised Estimates for Public Services (2008 – 2014) and HSE Reports on Capital Programme cited in DOH Key Trends 2015 and Revised Estimates for Public Services (2015 – 2016).
**Figures for 2015 and 2016 refer to budgeted capital amounts rather than expenditure data.*

2.3 Health expenditure and funding: Comparisons with other countries

OECD data demonstrates that Ireland experienced the third largest percentage health expenditure cut *per capita* in real terms compared with other countries between 2009 and 2013 (Figure 8). Ireland's Health expenditure as a share of GDP was considerably lower than other comparable developed countries (see Appendix 2).

[6] Statement by the Minister for Health, Simon Harris TD to the Dail on Health Estimate for 2016 on 16 June 2016

Figure 8: *Annual average growth in per capita health expenditure, real terms, 2005 to 2013 (or nearest years)*



Source: OECD Health at a Glance 2015

The IHCA strongly recommends that the 2017 acute hospital budget includes a significant increase in frontline funding to end the under-resourcing and the annual acute hospital budget deficits that impact adversely on the delivery of timely care to patients. In addition, the IHCA recommends that the acute hospital capital budget be increased to reverse the cumulative cuts in recent years and address the growing physical infrastructure and equipment deficits.

3. Critical Capacity Constraints

At a time when the Irish health service has been subjected to sustained underfunding and budget deficits, medical science has continued to advance and there have been significant developments in terms of new medications and treatments. Given the lack of resources available in acute hospitals, the public health system cannot keep pace with what is now regarded as contemporary best medical practice.

International comparisons confirm that acute hospitals have one of the lowest numbers of practising doctors, a relatively low number of acute hospital beds and an excessively high bed occupancy rate. Consultants who attempt to deliver safe care to their patients are continuously aware of the mismatch between the available physical and human resources and the actual needs of their patients. There are deficits throughout the hospital system in terms of acute hospital beds, ICU beds, access to endoscopy and diagnostic imaging, and access to operating theatres and outpatient clinics.

The unacceptable consequence of these capacity constraints is that hundreds of patients are being treated on trolleys every day. Over 76,000 patients were awaiting essential surgery in June and the cancellation of surgical appointments is a regular occurrence because of the shortage of acute hospital beds. In addition, hospitals continue to be affected adversely by the continuing consultant recruitment and retention crisis.

Access to diagnostic imaging is a perennial problem in the acute health system. At a very basic level, the inadequacy of essential hospital equipment impedes access to diagnostic investigations.

The average number of MRI Units per million of population in Ireland was 13.4 compared with an OECD average of 14.9 in 2014. The equivalent average for CT scanners was 16.7 compared with an OECD average of 25.3.[7]

These capacity constraints are serious and they are substantive in terms of their effects. Specific examples include:

- **Inadequate MRI facilities at Our Lady's Hospital Crumlin**: It is understood the demand for children's MRI services exceeds capacity by nearly 200%. This translates on a weekly basis to 74 referrals with capacity for 39 MRI consultations[8].
- **Ageing radiology equipment at Sligo Regional Hospital**: The fluoroscopy unit is over 15 years old and equipment used in the unit regularly breaks down, sometimes mid-procedure. The equipment has had to be maintained using parts from a decommissioned unit imported from Japan.
- **Acute hospitals are not only attempting to treat patients with inadequate capacity but they are invariably doing so with equipment which is increasingly obsolete.**

[7]OECD Health Statistics 2016

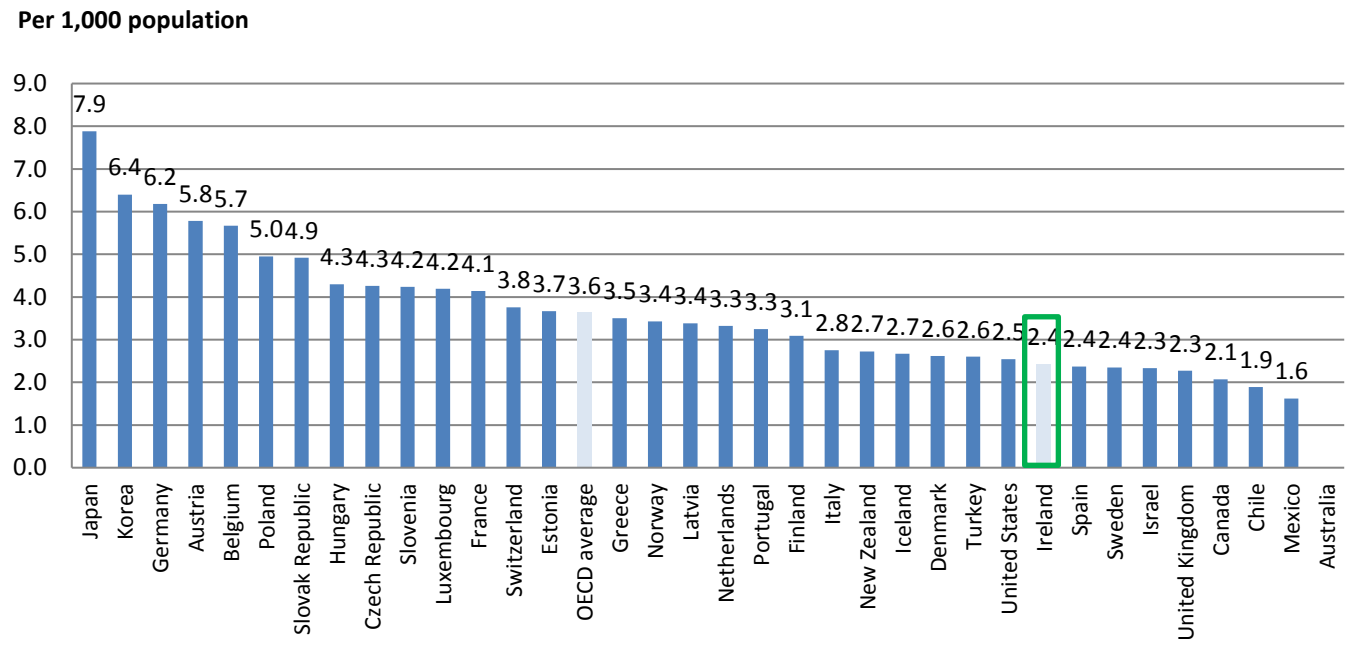
[8]Figures obtained under a freedom of information by website mummypages.ie cited in Noel Baker, "20,000 children on hospital waiting lists", Irish Examiner (23 February 2016)

3.1 Acute Hospital and ICU Bed Stock

Deficits in acute hospital and ICU bed stock are confirmed by the following:

- Ireland has one of the lowest numbers of acute hospital beds in the OECD at 2.4 beds per 1,000 population, which is 33% below the OECD average of 3.6 (Figure 9)
- Between 2007 and 2014, the number of acute hospital beds was cut by 1,643 (14%) from 12,123 to 10,480.
- In 2009, the HSE commissioned Prospectus Report recommended an immediate increase of 45% in ICU beds from 289 to 418 commissioned in 2010 alone, to be followed by a further increase to 579 by 2020.
- The report has not been acted upon and instead the number of ICU beds has declined 12%.[9]

Figure 9: *Hospital beds per 1000 of population (2014 or nearest year)*

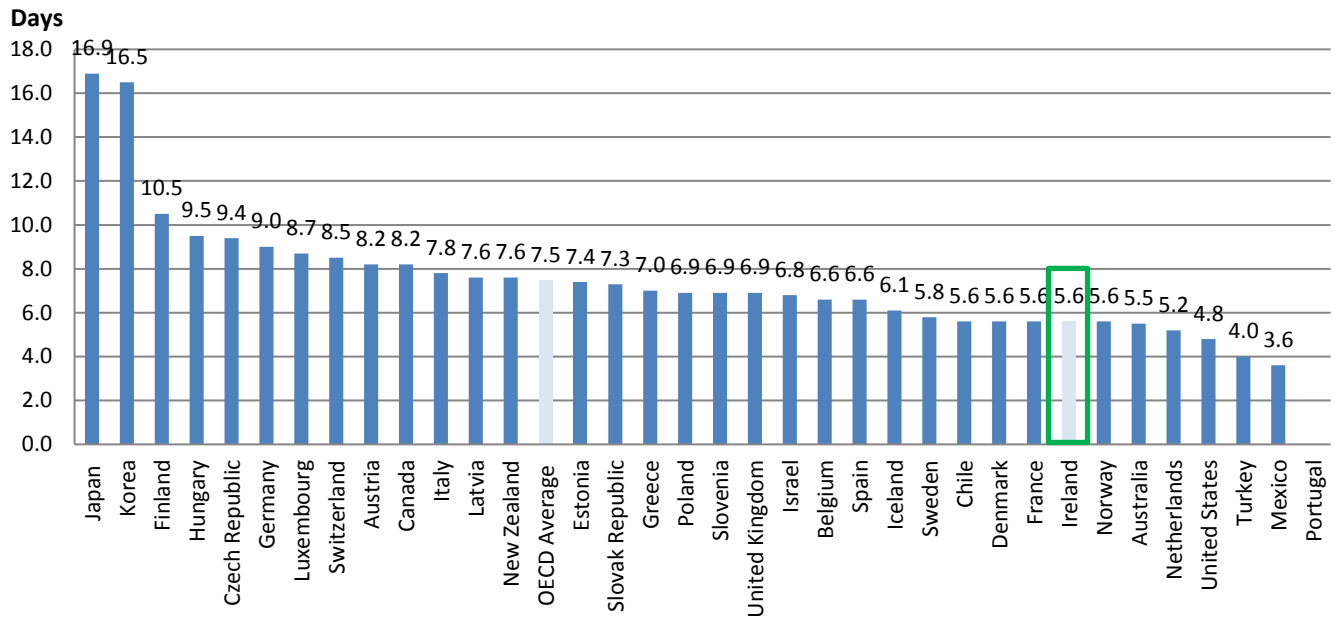


Source: OECD Health Statistics 2016

The average length of stay in Ireland's acute hospitals is 5.6 days, which is 25% below the OECD average of 7.5 (See Figure 10). This is being achieved despite the fact that Ireland has one of the lowest numbers of practising doctors at 2.8 per 1,000 of population which is 18% below the OECD average of 3.4 (Figure 18)[10].

[9]National Adult Critical Care Capacity and Activity Census 2015, Acute Hospitals Division HSE (September 2015)
[10]OECD Health Statistics 2016

Figure 10: *Average Length of stay in hospital (2014 or nearest year)*



The lack of acute beds and other frontline resources is leading to the cancellation of scheduled essential surgery and adding to inpatient and daycase patient waiting lists. In the 12 month period to June 2016, there has been a 14% increase in the number of inpatients and daycase patients awaiting essential surgery.[11]

In addition to the cancellation of surgical operations, the lack of sufficient bed stock has other knock-on effects including overcrowding in emergency departments. US studies confirm that 30-day and 7-day mortality increases significantly due to emergency department overcrowding. Applying the population metrics to Ireland, there is some basis to conclude that some 300-350 Irish patients a year are dying prematurely as a result of emergency department overcrowding.[12]

It is clear a significant increase in the number of acute and ICU beds is required to address these problems. The HSE projected that, in order to stay at current levels of service, the Irish health system will require 330 additional acute hospital beds between 2014 to 2016 and a further 1,020 by 2021 if current utilisation rates and models of care remain static.[13] This is a conservative estimate as it is based on maintenance of existing levels of service. It is unlikely to be sufficient to address waiting lists and ED overcrowding, even if implemented in full.

In addition, the rehabilitation services are substantially underfunded. There is a significant deficit of rehabilitation beds in general and rehabilitation services for young and previously healthy patients who have experienced trauma injuries. Recuperation for such patients is delayed and compromised as a result.

[11]NTPF waiting list data

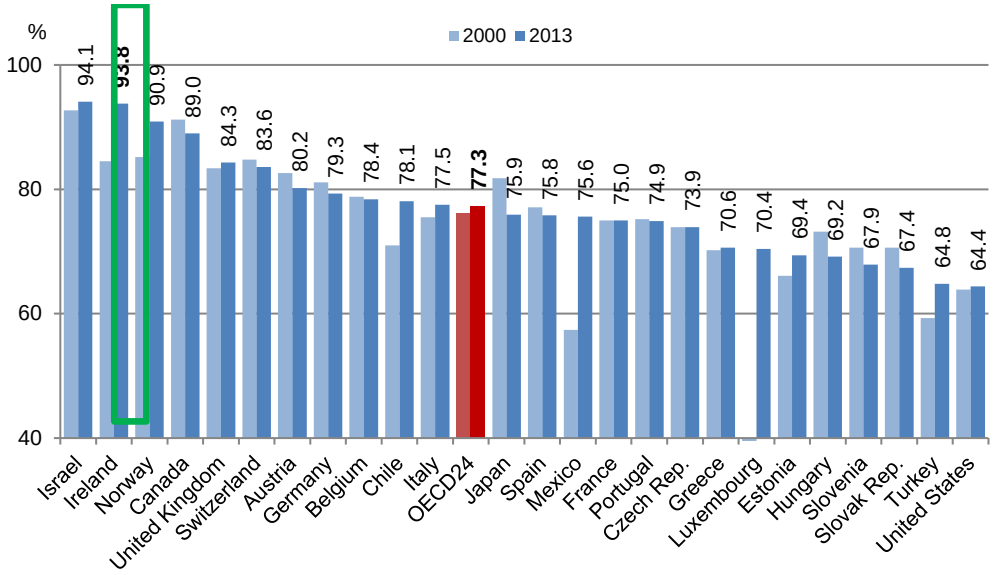
[12]Sprivulis PC, Da Silva J-A, Jacobs IG, et al. The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments. *Med J Aust*2006; 184: 208-212, Richardson DB. Increase in patient mortality at 10 days associated with emergency department overcrowding. *Med J Aust*2006; 184: 213-216

[13]HSE, Planning for Health 2016, Page 21

3.2 Bed Occupancy

Ireland's bed occupancy rate at 94% compares unfavourably with the OECD average (77%) and the UK rate (84%). This occupancy rate is far in excess of the recommended 85% occupancy rate. It jeopardises the safe and efficient delivery of high quality care.The vast majority of OECD countries have rates that are significantly lower than the recommended rate (Figure 11). In contrast, Ireland is close to the top of the scale. Between 2000 and 2013 Ireland's bed occupancy has increased 9.3% compared with increases in the UK rate and OECD24 average rate of just 0.9% and 1.2% respectively over the same period.

Figure 11: *Bed occupancy rate of curative (acute) care beds, 2000 and 2013*



Source: OECD Health at a Glance 2015

Research has confirmed that bed occupancy rates significantly above 85% are associated with poorer outcomes, increased rates of hospital associated infection, negative impact on staff health, and poorer performance as assessed by Emergency Department admission and discharge targets[14].

For example, in a study of a large UK District General Hospital, where bed occupancy was reduced from 93.7% to 90.2% there was an associated reduction in all markers of mortality and an improved ability of the acute trust to achieve the ED 95% 4-hour target for seeing, treating, admitting or discharging patients.[15]

Additionally in a New South Wales study, based on published hospital performance data, a significant negative correlation was observed between high bed occupancy rates and ED admission performance in the 20 largest general public hospitals with Emergency Departments in New South Wales.[16]

[14]Keegan, AD, (2010), "Hospital bed occupancy: more than queuing for a bed", *Medical Journal of Australia,* Volume 193, Number 5, 6 September 2010

[15]Boden et al, (2016), "Lowering levels of bed occupancy is associated with decreased in hospital performance on the 4-hour target in a UK District General Hospital", *Emergency Medicine Journal 2016,* Volume 33, Issue 2

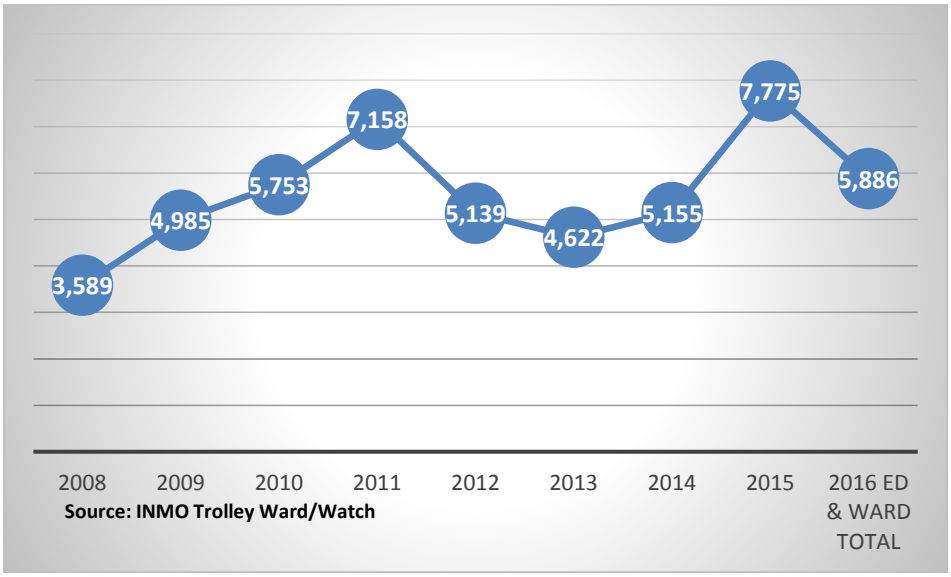
[16]Keegan, AD, (2010), "Hospital bed occupancy: more than queuing for a bed", *Medical Journal of Australia,* Volume 193, Number 5, 6 September 2010

3.3 Patients on Trolleys

The treatment of large numbers of patients on trolleys is no longer a seasonal problem but a year round capacity problem which highlights the extreme nature of the acute hospital capacity shortage.

The lack of sufficient bed stock has led to hundreds of patients being treated on trolleys every day. In June 5,886 patients were treated on trolleys, 14% and 64% above the June 2014 and June 2008 levels respectively (Figure 12).

Figure 12: *Monthly Trolley Analysis (June 2008 – June 2016)*



Source: INMO Trolley Ward/ Watch (June 2008 – June 2016)

The implications of having such high numbers of patients accommodated on trolleys are considerable and include increased mortality, longer lengths of stay and poorer patient outcomes in general. Studies have confirmed poorer mortality rates for all patients admitted during periods of Emergency Department overcrowding.[17]

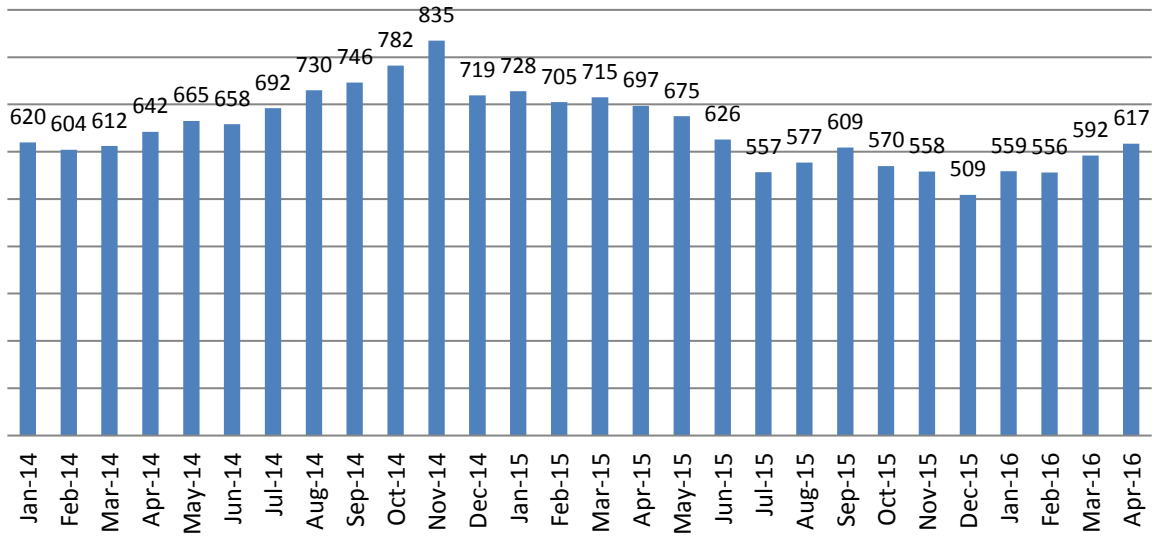
3.4 Clinically discharged patients

At any given time, there is a significant number of clinically discharged patients residing in acute hospitals which impacts adversely on the optimal use of the existing inadequate bed capacity.

The number of clinically discharged patients has remained at levels of between 500 and 800 in recent years (Figure 13). Despite sustained efforts in recent years to reduce this number, it remains unacceptably high.

[17]Sprivulis PC, Da Silva J-A, Jacobs IG, et al. The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments. *Med J Aust*2006; 184: 208-212, Richardson DB. Increase in patient mortality at 10 days associated with emergency department overcrowding. *Med J Aust*2006; 184: 213-216

Figure 13: *Clinically discharged patients by month (Jan 2014 – Apr 2016)*



Source: HSE Performance reports (January 2014 – February 2016)

In April 2016, on average 617 acute hospital beds per day were occupied by clinically discharged patients and unavailable to new admissions (Figure 13). This is the equivalent of a large teaching hospital being closed throughout the year.

The current target, included in the 2015 ED Task Force Report is to reduce the number of clinically discharged patients on a continuous basis such that it does not exceed 500. This target is not sufficiently ambitious and will not address the problem.

The IHCA strongly recommends that the 2017 acute hospital budget is resourced fully to address the capacity constraints that are preventing the timely provision of care to patients. In particular we recommend that the budget must include provision for:

- **An immediate increase in the number of acute, ICU and rehabilitation beds required to treat patients awaiting care on time, relieve emergency department overcrowding, reduce bed occupancy levels and address the growing waiting lists.**
- **An immediate increase in the availability of step down care and other facilities to support timely discharge of patients from acute hospitals.**

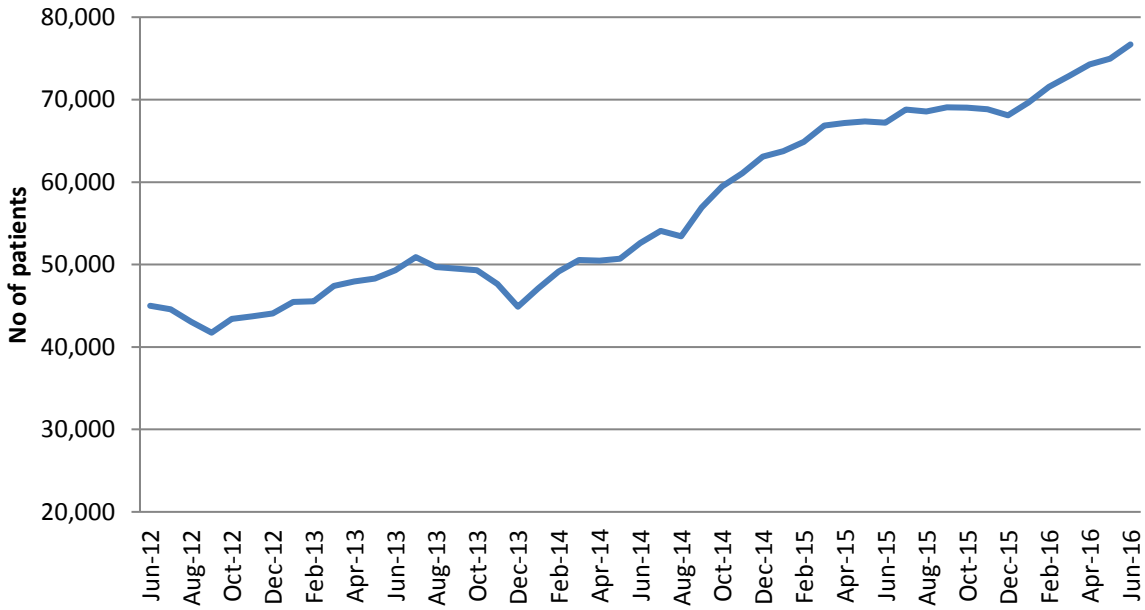
4. Growing Waiting Lists

Hospital consultants and doctors are struggling to treat an increasing number of acutely ill patients due to the severe capacity constraints outlined above and the effects of the continuing consultant recruitment and retention crisis.

Figures 14, 15 and 16 below confirm the sustained upward trend in inpatient, daycase, outpatient, and GI endoscopy waiting lists despite the significant increases in the past decade in the number of patients being treated.

In the 12 months to June 2016, the number of patients awaiting inpatient and daycase treatment and essential surgical care increased to 76,696 (14%) (Figure 14). Over the same period the number of patients waiting over 15 months for inpatient or daycase treatment increased significantly from 3,078 to 6,579 and from 57 to 3,038 for those waiting over 18 months.

Figure 14: *Total Inpatient and Daycase waiting list figures (June 2012 – June 2016)*

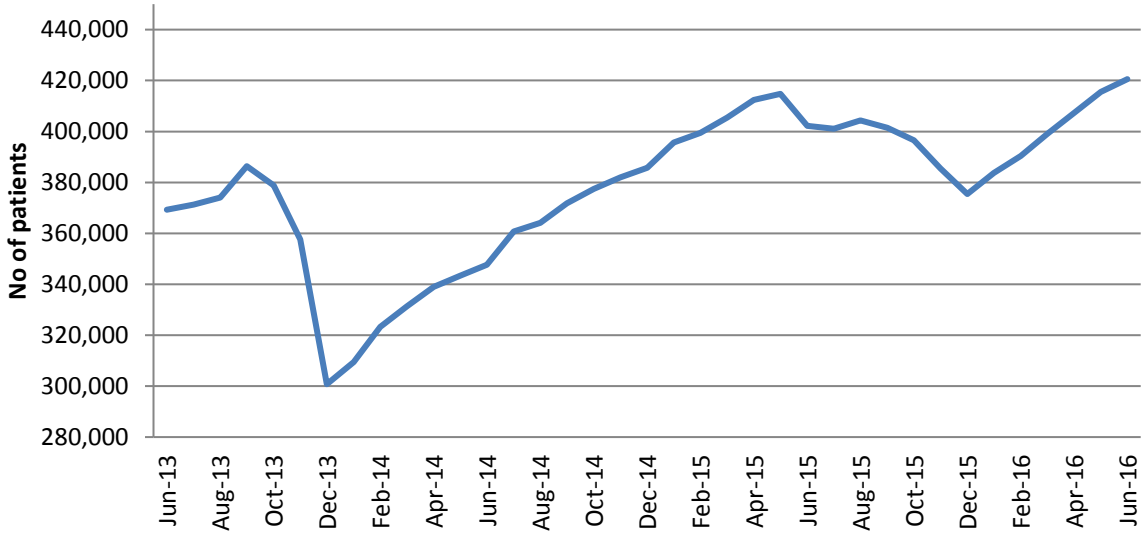


Source: NTPF (2012 -2016)

Waiting lists are increasing because the number of patients requiring acute care far exceeds the existing capacity which is driving up waiting times considerably.

The number of patients on outpatient waiting lists increased from 402,156 to 420,545 (50%) in the 12 months to June 2016 (Figure 15).

Figure 15: *Outpatient Waiting List (June 2013 – June 2016)*

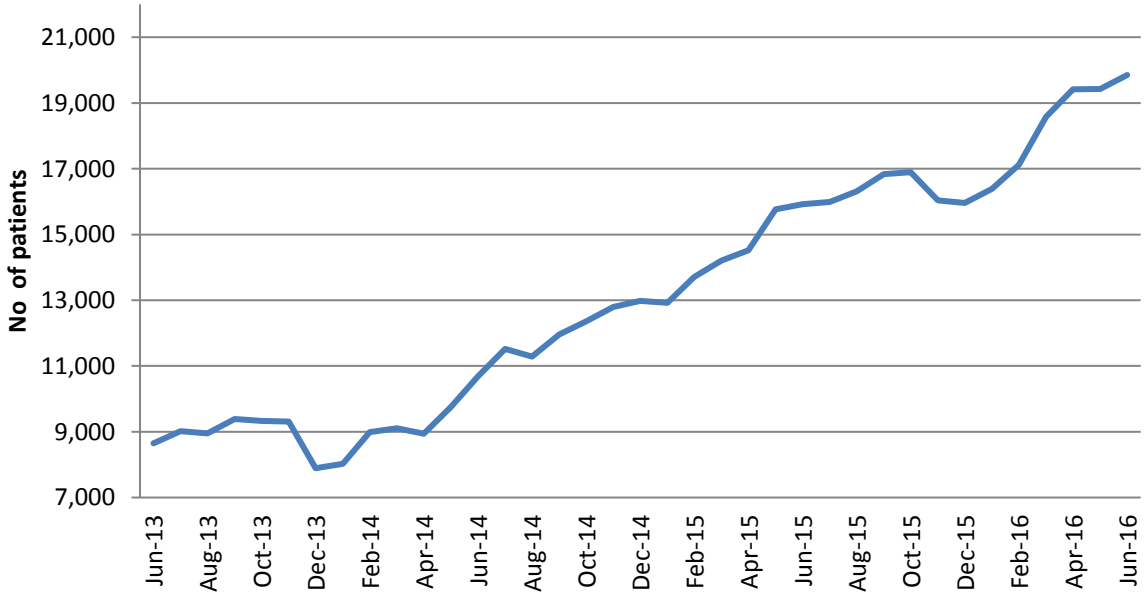


Source: NTPF (2013 -2016)

The growth in outpatient waiting lists is due to a failure to recruit and retain a sufficient number of Consultants across different specialties and the failure to resource outpatient clinics appropriately.

The number of patients awaiting GI endoscopies has increased by 25% in the twelve months to June 2016 (Figure 16). The longest waiting lists are concentrated in those hospitals with the biggest capacity constraint issues. In February 2015, 74% of those waiting more than three months for endoscopies were concentrated in four hospitals with specific capacity issues - Beaumont, Tallaght/Naas, Galway University Hospital and Mercy University Hospital. This trend has continued as confirmed in the June 2016 NTPF data.

Figure* 16*: *Total GI endoscopy waiting list numbers (June 2013 – June 2016)*



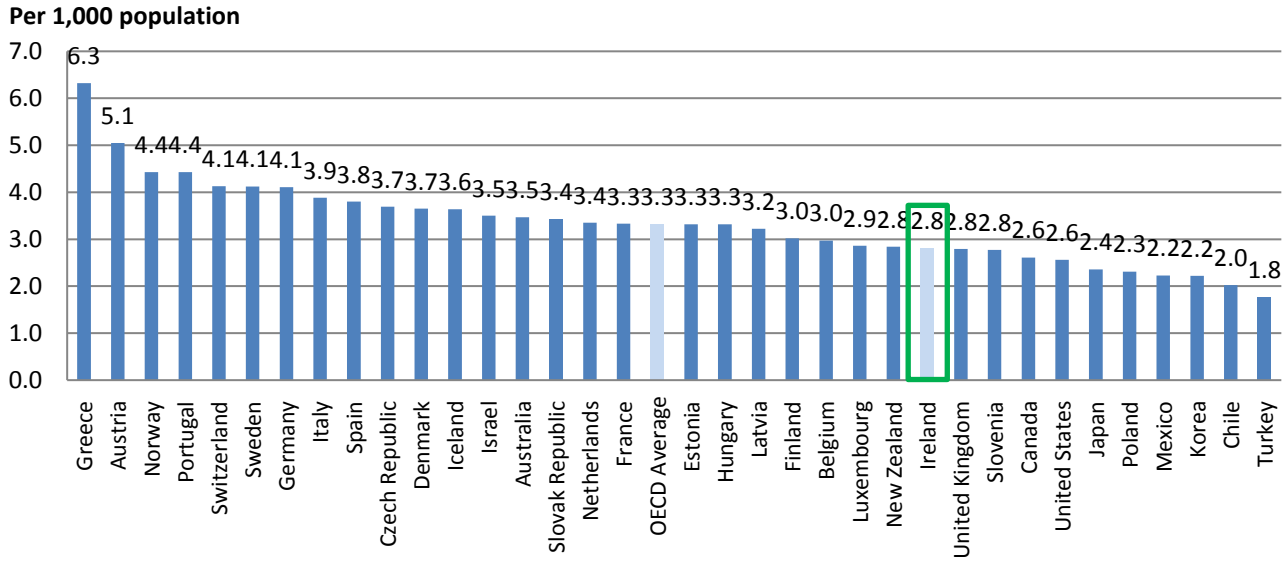
Source: NTPF (2013 -2016)

The IHCA strongly recommends an increase in the level of frontline resources and capital expenditure to tackle the root causes of rising waiting lists. This includes measures to address the lack of acute and ICU beds, insufficient operating theatre time and diagnostics and other facilities which require significant investment. Given the ongoing failure to provide adequate capacity in public hospitals to treat the increased number of patients presenting for care, any short term solutions in terms of NTPF outsourcing must incorporate 'whole care' packages which ensure assessment, treatment and follow-up care for patients.

5. Consultant Recruitment and Retention Crisis.

It is imperative that the consultant recruitment and retention crisis is addressed as a matter of urgency. Ireland has one of the lowest numbers of practising doctors per 1,000 of population at 2.8 which is 18% below the OECD average of 3.4.[18]

Figure 17: Practising doctors per 1 000 population (2014 or nearest year)



Source: OECD Health Statistics 2016

Acute hospitals have around two thirds the number of Consultants recommended in the Hanly Report over 13 years ago. In the interim, the demand for care has grown substantially due to the country's increasing and ageing population. In some specialties, the country has around one third to half the number of hospital consultants compared with the recommended international norms. Under these circumstances the public health system will fail to provide the high quality safe care that the public deserves.

Some examples of Consultant shortfalls include:

- 146 approved Obstetrician and Gynaecologist posts compared with 191 recommended in the Hanly Report and over 200 recommended by the Institute of Obstetrics and Gynaecology.
- 96 approved Orthopaedic surgery posts compared with 189 surgeons recommended in the 2013 National Clinical Programme for Surgery.
- 176 approved Consultant Paediatrician posts compared with 320 recommended by the Faculty of Paediatrics.
- Insufficient oncology and other specialties required to provide timely care to cancer patients.
- Shortage of Consultants in radiology and pathology diagnostic services not just in cancer centres but also in other acute hospitals which screen and refer patients to the cancer centres for treatment.

[18]OECD Health at a Glance 2015

There is an increasing requirement for many other specialities which can be confirmed separately. It is essential that the health service recruits and retains the number and calibre of Consultants that are needed to deliver safe high quality care to patients. There is a continuing failure to fill Consultant posts due to the State's blatant and repeated breaches of contract terms. Combined with frontline under-resourcing, the failure to honour contract terms has undermined the attractiveness of the Irish health service to highly trained internationally mobile specialists. Ireland is suffering a damaging medical brain drain. It is not competitive in recruiting and retaining Consultants because the terms and conditions on offer in Ireland are not competitive with the other English speaking countries which include North America, Australia and the UK.

The State's refusal to provide parity for new entrant consultants in terms of salary, and the failure to restore basic trust risks the loss of a generation of highly trained specialists and consultants who are emigrating to pursue their careers in other countries.

The continued failure to take corrective action along these lines is having serious consequences. One in four advertised hospital consultant posts received no applicants in 2015 and in addition a significant number had only one applicant per post. There are now hundreds of approved consultant posts which cannot be filled on a permanent basis. These vacancies are exacerbating the delays in treating patients and impacting adversely on patient outcomes. It is clear that the health service is no longer competitive in attracting and recruiting the number of high calibre consultants required to deal with current service levels let alone the significant unmet needs of Irish patients.

There is a real opportunity for the State and the Minister for Health to end the discrimination against new entrant consultants and honour the 2008 Consultant Contract. Both actions are necessary to restore the trust of the medical profession in the State and employers and improve the country's international competiveness in recruiting consultants.

Finally, the implementation of new recruitment controls by the HSE in February of this year is a retrograde step. If the recruitment of frontline staff is impeded, patient care will be affected and the number of patients on trolleys and waiting lists will increase further.

The IHCA strongly recommends that the State ends the discrimination against new entrant Consultants and honours the 2008 Consultant Contract in order to restore trust and improve our international competitiveness in recruiting Consultants.

6. Mental Health Services

6.1 Cumulative Mental Health Budget Cuts

The 2016 Mental Health Budget is €215m (21%) below 2009 expenditure even allowing for increases in 2014 and 2015 (Figure 18). At €791.6m, it equates to 5.8% of the total health budget which is low by international standards and in comparison with the NHS which spends 11% of its total health budget on mental health services.

The lack of resources for mental health services has led to ongoing delays in the implementation of the Vision for Change Report first published a decade ago. The table below details significant cuts in the mental health services budget for the three year period 2009 to 2011 of approximately 30%. Mental health services have not as yet recovered from these dramatic cuts.

Figure 18: *Current expenditure on Mental Health (2009 – 2015)*

Year	**Provisional Outturn** €'000
2009	1,006,682
2010	963,324
2011	712,000
2012	711,000
2013	758,200*
2014	754,800*
2015	794,400*
2016 (Budget)	791,600**
Decrease between 2009 – 2016 (% change)	***-215,082 (-21%)***

Source: Provisional outturn figures sourced from revised estimates for public services
**Includes ring fenced funding under Programme for Government*
***Budget figure for 2016 rather than provisional outturn from 2016*

It is noted that the 2016 mental health budget includes ring-fenced funding of €35m allocated to Mental Health Services. This funding must be used to increase clinical and allied health professional staffing levels and other frontline supports to deliver improved mental health services. Similar funding in previous years had not been fully spent due to difficulties attracting eligible candidates for approved posts and securing their recruitment.

6.2 Staffing levels and serious deficits in the number of Consultant Psychiatrist posts

Compared with 2008, staffing levels in mental health services have been cut by 1,072 (10%) to 9,404 WTEs in 2015.[19]

There are 427 approved Consultant Psychiatrist posts in the service[20], some 373 below that recommended by the College of Psychiatrists of Ireland.[21]

Of 34 Consultant Psychiatrist posts advertised in 2015, 65% were unfilled including CAMHS (10), Adult (9), Old Age (2) and Learning Disability (1).

The failure to attract Consultant Psychiatrists in the numbers required has resulted in significant staffing and resource shortfalls across key Consultant sub-specialties. Some examples are provided below:

- In 2013, the Irish College of Psychiatrists recommended a minimum of 86 Consultants in Psychiatry of Old Age compared with 46 approved posts.[22] [23]
- While Vision for Change recommended 138 Consultant Child and Adolescent Psychiatrist posts, there are 111 such approved posts.[24] [25]
- Vision for Change also recommended 15 Consultant Forensic Psychiatric posts which compares with 11 approved posts.[26] [27]

6.3 Increasing demand for community based care and lack of community resources

The population growth of 3.7% in period 2011 to 2016 has placed increased demands on what is already a poorly resourced service in international terms. This increased demand on the service must be taken into account in deciding on the 2017 budget. In addition the subsequent increase in population since Vision for Change along with increasing levels of deprivation has led to a lack of capacity in acute units with levels of bed occupancy in excess of 90%.

The number of psychiatric unit and hospital admissions declined by 36% to 2,228 (36%) in the ten-year period to 2014. This is to be expected as Vision for Change recommends community-based care.[28]

The transition to community based care is dependent on the provision of adequately resourced multi-disciplinary teams and the development of specialist services and community supports. Under-resourcing and the failure to recruit Consultant Psychiatrists and allied health professionals have prevented the provision of the necessary community care services. To be effective, community

[19]HSE, Vision for Change Implementation Plan, 2009 -2013, cited at p26 of A Vision for Change – Nine years on an analysis of progress (2015) and December 2015 Management Data Report, Page 148
[20]HSE Consultant Establishment as at March 2016
[21]The College of Psychiatrists of Ireland – Workforce Planning Report 2013 – 2013 December 2013
[22]HSE Consultant Establishment as at 31st March 2016
[23]The College of Psychiatrists of Ireland – Workforce Planning Report 2013 – 2013 December 2013
[24]HSE Consultant Establishment as at 31st March 2016
[25]The College of Psychiatrists of Ireland – Workforce Planning Report 2013 – 2013 December 2013
[26]HSE Consultant Establishment as at 31st March 2016
[27]The College of Psychiatrists of Ireland – Workforce Planning Report 2013 – 2013 December 2013
[28]HRB Statistics Series 26 Activities of Psychiatric Units and Hospitals 2014

services must include strong well-resourced multi-disciplinary supports, home-based treatment and 24/7 crisis support. This lack of service development is reflected in the modest reduction in the re-admission rate to psychiatric units from 72% in 2006 to 67% in 2013.[29]

In addition acute beds are frequently not available for acute cases as longer term patients have no suitable services to move to due to the closure of staffed hostels and the failure to develop slow stream recovery units for those patients with significant serious illnesses and associated risks which cannot be managed in the community.

The number of child and adolescent in-patient admissions, increased by 13% to 415, between 2009 and 2013.[30]There are 66 operational inpatient beds in Child and Adolescent Mental Health Services (CAMHS), 49% below the 108 recommended in Vision for Change.[31]

At present it is not possible to provide appropriate inpatient care to children and adolescents due to a severe lack of CAMHS beds. In April 30% of CAMHS admissions were to age inappropriate Psychiatric Inpatient Units.[32] This is in breach of Ireland's obligations under the UN Convention of Human Rights which requires the separation of adults and children into age appropriate units.

The relatively low level of Child and Adolescent Psychiatrists and the general shortage of frontline resources has resulted in unacceptably high numbers of children on CAMHS waiting lists with waiting times that are too long. In April, 1,075 children were waiting over three months for their first appointment with 214 of those waiting over 12 months.[33]

Vision for Change also recommended that each mental health service should have access to its own dedicated and separate Old Age Psychiatry unit with eight beds for every 30,000 people over the age of 65, equivalent to 161 beds nationally.[34] Currently, there are only six acute units with a total of 62 acute designated assessment and treatment beds.[35] [36]

The IHCA recommends a significant increase mental health funding in the 2017 budget. This is essential for the provision of improved and timely care to all patients and to ensure that children and adolescents are admitted to age appropriate units.

It is essential that the €35 million annual ring-fenced funding is utilised without the delays experienced in recent years in filling the priority posts identified. This requires urgent action to address deficiencies in the recruitment services.

[29] A Vision for Change Nine Years on: a Coalition Analysis of Progress

[30]National Psychiatric In-Patient Reporting System (NPIRS) National Bulletin 2014 and HRB Statistics – Activities of Irish Psychiatric Units and Hospitals 2009 and 2014

[31]HSE, Vision for Change Implementation Plan, 2009 -2013, cited at p26 of A Vision for Change – Nine years on: a coalition analysis of progress (2015) and Mental Health Service Plan 2016

[32]Feb 2016 HSE Performance Data Report

[33] March/April HSE Performance Report 2016

[34] (606,000 people over 65 in 2015 divided by 30,000 = 20.2 multiplied by eight beds = 161 beds)

[35]See footnote 2

[36] "Half required psychiatry of old age teams in place", -June 11 2015 – Irish Medical Times - http://www.imt.ie/news/latest-news/2015/06/half-required-psychiatry-old-age-teams-place.html

7. Clinical Indemnity

7.1 Escalating Clinical Indemnity costs

The size and number of clinical negligence claims continues to increase.[37]The Medical Protection Society (MPS) acknowledges that this is not attributable to a deterioration in clinical standards but rather reflects a generally more active claims environment. The Joint Oireachtas Committee on Health and Children Report in June 2015 noted evidence that the number of Consultants and general resource levels play a contributory role in the incidence of errors.[38]This is particularly significant in the context of public hospitals which continue to experience deficits in funding, physical resources and medical manpower in part due to high levels of vacant posts and posts filled on a temporary basis.

The State Claims Agency (SCA) is reimbursed on a monthly basis from the Department of Health Vote for its pay-outs under the Clinical Indemnity Scheme (CIS). The total cost of all claims resolved has increased from €21.69m in 2008 to €69.2m in 2015 (219%) (Figure 19). It should be noted that the cost of claims resolved has been reduced due to the introduction of periodic payments for maternity service claims. However, this in effect is a deferral of payments as part of the compensation to be paid in such cases will be accounted for in future years.

The SCA had 3,000 active clinical claims under management, with an estimated liability of €1.35bn in respect of those claims at end of 2015[39]. This represents a significant cost burden for the State and acts as a drain on funds that are required for the delivery of frontline health services.

***Figure 19**: Total cost of CIS claims resolved (2008 – 2015)*

Cost Element	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
	€000	**€000**	**€000**	**€000**	**€000**	**€000**	**€000**	**€000**
Cost for all Claims Resolved								
Awards/Settlements	10,995	12,836	33,786	33,512	35,357	36,104	45,033	44,578
Legal Fees - SCA	4,385	4,327	7,848	7,086	8,607	9,571	8,989	8,438
Legal Fees - plaintiff	5,464	4,427	12,370	12,527	12,964	15,551	14,126	14,718
Other	844	355	897	849	959	1,251	1,244	1,455
Grand Total	21,688	21,945	54,901	53,974	57,887	62,477	69,392	69,178

	€000	**€000**	**€000**	**€000**	**€000**	**€000**	**€000**	**€000**
Average Cost per Claim Resolved								
Awards/Settlements	37	39	99	103	100	102	92	91
Legal Fees - SCA	15	13	23	22	24	27	18	17
Legal Fees - plaintiff	18	13	36	39	37	44	29	30
Other	3	1	3	3	3	4	3	3
Grand Total	73	66	161	166	164	176	142	141

Source: SCA (2015) Submission to the Joint Committee on Health and Children (2008 -2010) and NTMA Annual Report and Accounts 2015

[37] MPS Submission, "*Health Priorities for new Government",* published February 2016

[38]Houses of the Oireachtas, Joint Committee on Health and Children Report on the Cost of Medical Indemnity Insurance, June 2015, Page 16.

[39]State Claims Agency eZine, Spring 2016, Page 18 and NTMA Annual Report and Accounts 2015

Escalating clinical indemnity costs are driving up the cost of providing care in public hospitals and are jeopardising private practice in surgical and other specialities. If this trend continues, it will further increase the number of patients presenting for care in already crowded public hospitals.

The cost of indemnification for Consultants in Ireland is a multiple of that charged in the UK and other jurisdictions. This is primarily due to the fact that the UK reformed the law over a decade ago to address the issues which were driving up their costs. Similar actions have been taken in other jurisdictions. In contrast, significant reforms have not been implemented here as yet.

The cost of clinical indemnity has more than doubled for most specialties in the two year period commencing 2013 and ending 2014. In 2015 and 2016, there were additional increases including substantial increases for some specialties and sub-specialities.

The net effect of the escalating costs of indemnity charges is that an increasing number of Consultants have ceased private practice because the costs have become unsustainable. The ongoing uncertainty with regard to future indemnity costs is exacerbating the situation. The significant increases in indemnity costs are interfering with the health service's ability to attract and retain Consultants in Ireland. Many doctors are discouraged from entering surgical specialties and other specialties because of the prohibitive indemnity costs associated with them.

Independent hospitals account for about 40% of the total number of theatre procedures requiring anaesthesia in acute hospitals. Consultants in private practice also provide care for medical patients and are responsible for a significant proportion of outpatient consultations. There is a concern that as more private consultants restrict or close their practices, more patients will be forced to seek surgical and medical care in public hospitals which are already struggling to cope with existing patient numbers and growing waiting lists. An increase in the number of patients seeking care in the public system could also lead to an increase in the number of clinical claims falling under the remit of the SCA.

It is understood that the Department of Health has received a report assessing whether the indemnity caps should be lowered to reduce the cost of private practice clinical indemnity. In June 2015, the Joint Oireachtas Committee on Health supported such course of action. The Department has also received a report to assess the actuarial cost of the SCA providing indemnity cover on a ground up commercial basis to consultants practising in private hospitals and clinics.

The IHCA welcomes steps taken by the Minister for Justice and Equality in 2014 and the enactment of legislation to introduce Pre-Action Protocols to speed up the processing of clinical indemnity claims and reduce legal and other costs. However, there continues to be an urgent need to implement without delay the Pre-Action Protocols together with other essential changes including the reform of Tort Law.

The IHCA welcomes commitments in the Programme for Government to establish an expert group to report within six months on options for reforming Tort law and existing claims processes. The Association also welcomes the decision to commission an annual study of court efficiency and sitting times and the proposals to introduce legislation to reduce excessive delays to trials and court proceedings including pre-trial hearings. Actions following these reviews could, if implemented, reduce future costs for the State and release funds to be redirected towards the provision of high quality healthcare services.

The IHCA strongly recommends that proposals on the lowering of the indemnity caps and the provision of indemnity on a commercial basis by the SCA should be brought to Cabinet for consideration as a matter of priority.

There is a pressing need to urgently adopt Regulations and Rules of Court to give effect to the newly enacted legislation on Pre-Action Protocols to ensure more intensive case management of medical negligence cases thereby resolving claims more efficiently. This must include a requirement for the exchange of information within defined time periods, with significant penalties where exceeded, to reduce delays and costs.

It is essential that recently announced initiatives concerning reform of Tort law and a separate review of court sittings are expedited without further delay.

Conclusions

The Association is highlighting the need for substantially increased frontline acute hospital and mental health funding so that the challenges set out in this submission are effectively addressed.

The cumulative net cuts in the acute hospital and mental health budgets since 2008 have critically undermined the capacity to deliver frontline acute services, both in terms of current day to day resourcing and capital infrastructure and equipment. Hospital consultants are struggling to treat an increased numbers of patients with inadequate and often obsolete equipment, insufficient staffing and other essential frontline resources.

It is critically important that the resourcing of frontline acute hospital and mental health services permits the treatment of patients presenting for care in medically acceptable timeframes otherwise waiting lists will continue to rise. It is not possible for hospitals and mental health services to cut spending to stay within unrealistic annual budget limits without extremely adverse consequences which jeopardise the safety and quality of care that can be provided and limit the number of patients treated.

The continuing consultant recruitment and retention crisis needs to be resolved as a matter of urgency. The State must end the discrimination against new entrant Consultants and honour the 2008 Consultant Contract in order to restore trust and regain the country's international competitiveness in recruiting Consultants.

The growing cost of clinical indemnification, whether through the SCA or medical defence organisations, has a clear impact on the health budget and the capacity of the health service to provide high quality patient care. Proposals on the lowering of the indemnity caps and the provision of indemnity on a commercial basis through the SCA should be brought to Cabinet for consideration as a matter of priority. Regulations and Rules of Court should be introduced without delay to give effect to the newly enacted legislation on Pre-Action Protocols. Government initiatives to reform the law of tort and examine court sittings should be expedited.

APPENDIX

Appendix 1: Acute Hospital Funding 2008 – 2015 (€millions)

	2008	2009	2010	2011	2012	2013	2014	2015
Hospital Deficits €millions	**7**	**27**	**79**	**125**	**279**	**70**	**284**	**226**
% deficit	**0.2%**	**0.6%**	**2.0%**	**3.3%**	**7.7%**	**1.80%**	**7.5%**	**5.7%**

Source: HSE Performance Reports (2008 – 2015)

Appendix 2: Health expenditure as a share of GDP (2015 or nearest year)

	Ireland	France	Germany	Spain	United Kingdom	Italy	United States
Health expenditure as a % of GDP (2015)	9.4	11.0%	11.1%	9.0%	9.8%	9.1%	16.9%

Source: OECD Health Statistics 2016

Appendix 3: Hospital Activity: 2008 – 2015

	2008	2009	2010	2011	2012	2013	2014	2015	% Change 2008/ 2015
% Treated/ Tgt **Inpatient Discharges**	*+1.8%*	*+3.7%*	*+8.8%*	*+2.5%*	*+7.4%*	*-1%%*	*+.02%*	*+.02%*	-
Treated	604,320	595,022	588,860	588,623	603,911	595,109	642,892	644,990	6.73%
Target	593,859	573,360	540,993	574,400	562,133	600,887	591,699	643,748	8.40%
% Treated / Tgt **Day-case**	*+7.9%*	*+4.4%*	*+5.7%*	*+6.5%*	*+5%*	*+0.79%*	+1.4%	*0.2%*	
Treated	637,140	675,611	728,269	804,274	826,825	836,789	861,057	878,821	37.93%
Target	590,016	647,000	689,310	755,100	787,557	830,165	797,328	877,199	48.67%
Treated Inpatient and Daycase Total	**1,241,460**	**1,270,613**	**1,317,129**	**1,393,347**	**1,430,736**	**1,431,898**	**1,503,949**	**1,523,811**	22.74%
% Treated / Tgt **Emergency Admissions**	*-0.3%*	*-.08%*	*+11.7%*	*+3.1%*	*+7.5%*	*+3.3%*	*-1.3%*	*-0.80%*	
Treated	368,341	366,690	369,031	372,644	384,641	393,846	396,936	447,557	21.5%
Target	369,368	367,000	330,298	361,400	357,600	380,990	402,202	451,157	22.14%

Source: HSE Performance Reports (2008 – 2015)

Appendix 4: Waiting list figures (2012 – 2016)

Total Inpatient and Daycase waiting list numbers 2013 – 2016

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016	69,649	71,559	72,881	74,274	74,986	76,696	-	-			-	-
2015	63,740	64,892	66,872	67,165	67,359	67,195	68,786	68,563	69,076	69,046	68,824	68,086
2014	47,112	49,154	50,537	50,453	50,689	52,595	54,066	53,431	56,902	59,463	61,084	63,105
2013	45,458	45,537	47,413	47,943	48,279	49,290	50,912	49,695	49,496	49,325	47,654	44,870
2012	46,760	46,828	46,379	46,059	45,277	44,990	44,590	43,051	41,732	43,422	43,710	44,047

Over 12 months

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016	6,982	7,842	9,553	10,254	11,107	12,600						
2015	6,303	7,559	8,717	9,433	9,180	8,139	9,063	9,577	10,143	9,449	7,779	5,665
2014	183	434	446	292	634	1,031	1,562	1,805	2,591	3,645	4,532	5,380
2013	272	384	503	653	931	849	1,063	1,003	934	847	797	0
2012	893	1,200	548	512	199	167	232	386	131	268	214	36

Over 15 months

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016	2,115	3,079	4,296	4,603	5,416	6,579						
2015	2,562	3,263	4,187	4,356	4,195	3,078	3,968	4,705	5,442	4,969	3,293	746
2014	56	143	175	118	150	183	291	477	773	1,174	1,465	1,744
2013	141	177	217	229	263	213	274	338	322	283	218	0
2012	384	413	210	185	88	31	66	127	51	114	105	13

Breakdown of Inpatient and Daycase Waiting List:

	Dec-15	Jun-15	Jun-16	% Change from June 2015	% Change from Dec 2015
Adult Day cases	43,231	43,573	48,749	11.88%	12.76%
Adult Inpatient	17,484	17,077	20,024	17.26%	14.53%
Child Daycase	4,063	3,449	4,471	29.63%	10.04%
Child Inpatient	3,308	3,096	3,452	11.50%	4.35%
Total	68,086	67,195	76,696	14.14%	12.65%

Total Outpatient waiting list numbers 2013 – 2016

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016	383,713	390,410	399,086	407,257	415,584	420,545	-	-	-	-	-	-
2015	395,720	399,399	405,501	412,422	414,778	402,156	401,060	404,320	401,496	396,571	385,507	375,440
2014	309,496	323,304	331,281	338,943	343,412	347,685	360,753	364,182	371,829	377,502	382,008	385,781
2013	-	-	384,632	379,164	367,783	369,339	371,255	374,104	386,384	378,840	357,624	300,752

Over 12 months

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016	41,188	45,952	52,111	56,167	62,202	65,835						
2015	66,622	71,547	77,319	83,347	85,130	70,564	66,621	66,378	64,985	59,977	38,870	37,197
2014	9,604	13,438	16,295	22,746	28,185	31,813	37,876	41,604	46,642	51,286	55,733	61,400
2013	-	-	103,420	100,488	91,182	87,842	87,425	84,153	84,380	71,435	56,259	4,937

Over 15 months

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016	13,763	17,693	20,267	23,956	30,095	34,674						
2015	42,157	45,402	49,000	51,313	52,734	37,567	33,221	34,003	34,263	31,289	11,664	9,887

2014	4,239	4,567	4,984	7,134	9,871	11,967	15,967	19,579	24,001	27,996	31,190	36,682
2013	-	-	80,332	76,219	68,615	66,442	66,054	64,222	64,118	52,975	41,540	3,618

Total GI Endoscopy Waiting List numbers 2012– 2016

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016	16,390	17,119	18,579	19,416	19,424	19,850	-	-	-	-	-	-
2015	12,926	13,706	14,206	14,519	15,769	15,925	15,986	16,311	16,839	16,891	16,038	15,961
2014	8,024	8,990	9,102	8,938	9,758	10,684	11,521	11,287	11,961	12,355	12,798	12,978
2013	8,297	7,863	8,504	8,702	8,584	8,644	9,020	8,954	9,387	9,328	9,311	7,892
2012	12,627	12,756	13,258	13,523	13,349	12,718	10,835	8,904	7,869	8,236	7,488	7,661

Source: NTPF (2012 – 2016)

Appendix 5: Deficits by acute hospitals (April 2016)

Acute Hospital Division					
April 2016					
	Approved	**YTD**	**YTD**	**YTD**	**YTD**
	Allocation	**Actual**	**Budget**	**Variance**	**% Var vrs Plan**
	€000	€000	€000	€000	
Beaumont Hospital	253,784	92,293	85,033	7,260	8.54%
Rotunda Hospital	45,994	16,212	15,355	857	5.58%
HSE Funded Providers	**299,778**	**108,505**	**100,388**	**8,117**	**8.09%**
Our Lady's of Lourdes Hospital, Drogheda	130,400	46,732	43,146	3,586	8.31%
Connolly Hospital, Blanchardstown	90,078	31,874	30,368	1,506	4.96%
Cavan General Hospital	78,979	28,162	26,445	1,716	6.49%
Louth County Hospital	20,236	6,681	6,720	(38)	-0.57%
Monaghan General Hospital	8,010	2,465	2,575	(110)	-4.26%
RCSI Hosp Grp HQ	507	818	168	650	387.93%
HSE Direct Provision	**328,209**	**116,732**	**109,422**	**7,310**	**6.68%**
RCSI Hospital Group	**627,987**	**225,237**	**209,810**	**15,427**	**7.35%**
St. James's Hospital	315,618	108,368	103,824	4,544	4.38%
Tallaght Hospital - AMNCH (Acute Only)	167,404	62,281	55,825	6,456	11.56%
Coombe Women & Infants University Hospital	50,478	16,902	16,482	420	2.55%
HSE Funded Providers	**533,501**	**187,551**	**176,131**	**11,420**	**6.48%**
St. Lukes Hospital, Rathgar	39,854	13,678	13,200	478	3.62%
Midland Regional Hospital, Tullamore	84,326	30,680	27,878	2,802	10.05%
Naas General Hospital	56,376	19,171	18,638	533	2.86%
Midland Regional Hospital, Portlaoise	51,726	19,392	17,137	2,255	13.16%
Dublin Midlands Hosp Grp HQ	3,604	691	50	641	1288.95%
HSE Direct Provision	**235,886**	**83,612**	**76,903**	**6,709**	**8.72%**
Dublin-Midlands Hospital Group	**769,387**	**271,163**	**253,034**	**18,129**	**7.16%**
Mater Misericordiae University Hospital	231,044	79,199	76,600	2,600	3.39%
St Vincent's University Hospital, Elm Park	210,622	75,689	70,206	5,483	7.81%
National Maternity Hospital, Holles Street	45,338	17,050	14,525	2,525	17.38%
St. Michael's Hospital, Dun Laoghaire	23,696	7,888	7,491	397	5.30%
Cappagh National Orthopaedic Hospital	27,889	10,738	9,296	1,441	15.51%
Royal Victoria Eye & Ear Hospital, Dublin	22,424	7,779	7,377	402	5.45%
HSE Funded Providers	**561,013**	**198,344**	**185,495**	**12,848**	**6.93%**
St. Columcilles Hospital, Loughlinstown	30,602	10,640	10,117	522	5.16%
Midland Regional Hospital, Mullingar	64,760	21,995	21,496	499	2.32%
St. Luke's Hospital, Kilkenny	58,193	20,836	19,238	1,598	8.31%
Wexford General Hospital	56,365	19,887	18,656	1,231	6.60%
Our Lady's Hospital, Navan	41,361	14,464	13,841	623	4.50%
Ireland East Hosp Grp HQ	2,069	665	96	570	596.58%
HSE Direct Provision	**253,350**	**88,487**	**83,444**	**5,043**	**6.04%**
Ireland East Hospital Group	**814,363**	**286,830**	**268,940**	**17,891**	**6.65%**
Mercy University Hospital, Cork	66,156	24,053	22,068	1,985	8.99%
South Infirmary University Hospital, Cork	50,728	16,618	16,350	268	1.64%
HSE Funded Providers	**116,884**	**40,671**	**38,418**	**2,252**	**5.86%**
Cork University Hospital	259,835	89,280	85,889	3,390	3.95%
Waterford Regional Hospital	153,834	53,844	50,853	2,990	5.88%
Kerry General Hospital	72,981	25,702	24,283	1,419	5.84%
South Tipperary General Hospital	50,962	18,131	16,848	1,283	7.61%
Bantry General Hospital	17,167	5,625	5,547	78	1.40%
Mallow General Hospital	16,209	5,326	5,359	(33)	-0.62%
Lourdes Orthopaedic Hospital, Kilcreene	6,703	2,235	2,216	19	0.87%
South/South West Hosp Grp HQ	10,875	3,621	3,621	0	0.00%
HSE Direct Provision	**588,567**	**203,763**	**194,618**	**9,146**	**4.70%**
South-South West Hospital Group	**705,451**	**244,434**	**233,036**	**11,398**	**4.89%**
Galway University Hospitals	274,267	97,821	90,659	7,162	7.90%
Sligo General Hospital	108,732	40,147	35,995	4,152	11.53%
Letterkenny General Hospital	110,506	40,315	36,568	3,747	10.25%
Mayo General hospital	85,356	29,778	28,219	1,559	5.52%
Portiuncula Hospital General and Maternity	54,562	20,554	18,038	2,516	13.95%
Roscommon County Hospital	17,996	6,681	5,958	723	12.13%
Saolta Hosp Grp HQ	2,987	492	988	(496)	-50.18%
HSE Direct Provision	**654,407**	**235,788**	**216,425**	**19,363**	**8.95%**
Saolta University Health Care Group	**654,407**	**235,788**	**216,425**	**19,363**	**8.95%**
St. John's Hospital	16,848	6,297	5,873	424	7.22%

Acute Hospital Division April 2016					
	Approved Allocation	YTD Actual	YTD Budget	YTD Variance	YTD % Var vrs Plan
HSE Funded Providers	**16,848**	**6,297**	**5,873**	**424**	**7.22%**
Limerick University Hospital	173,416	65,745	56,574	9,171	16.21%
Ennis Hospital	16,217	6,141	5,362	779	14.54%
Nenagh Hospital	15,297	5,772	5,057	715	14.14%
University Maternity Hospital, Limerick	18,951	7,077	6,265	812	12.96%
Croom Hospital	11,747	4,477	3,884	593	15.28%
UL Hospital Group HQ/Ortho	**2,638**	**1,155**	**873**	**282**	**32.27%**
HSE Direct Provision	**238,266**	**90,367**	**78,014**	**12,352**	**15.83%**
University of Limerick Hospital Group	255,114	96,664	83,887	12,777	15.23%
Temple Street, Children's University Hospital	89,474	30,913	29,825	1,088	3.65%
Our Lady's Hospital for Sick Children, Crumlin	124,266	43,815	41,776	2,039	4.88%
National Childrens Hospital, Tallaght	15,811	6,205	5,291	915	17.29%
Nat Childrens Hosp Grp HQ	1,329	510	0	510	
HSE Funded Providers	**230,879**	**81,443**	**76,891**	**4,552**	**5.92%**
The Children's Hospital Group	**230,879**	**81,443**	**76,891**	**4,552**	**5.92%**
Regional and National Services	65,760	25,208	12,599	12,609	100.08%
HSE Funded Providers	1,758,904	622,810	583,197	39,613	6.79%
HSE Direct Provision	2,364,445	843,957	771,425	72,531	9.40%
Total Hospital Groups	**4,123,348**	**1,466,767**	**1,354,622**	**112,145**	**8.28%**

Source: April 2016 HSE Data Report

Appendix 6: Monthly Delayed discharges 2014 – 2016 (HSE Performance Reports)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016	559	556	592	617								
2015	728	705	715	697	675	626	557	577	609	570	558	509
2014	620	604	612	642	665	658	692	730	746	782	835	719

Source: HSE Performance Reports (2014 – 2016)

Appendix 7: Acute division variance from YTD actual vs budget (€000s) (2014 – 2016)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016	21,477 **(6.28%)**	48,806 **(7.24%)**	81,829 (8.04%)	112,145 (8.28%)								
2015	10,684 **(3.1%)**	27,708 **(4%)**	42,949 **(4%)**	61,231 **(5%)**	75,858 **(5%)**	93,514 **(5%)**	112,415 **(4.85%)**	122,431 **(4.60%)**	137,300 **(4.58%)**	153,914 **(4.62%)**	172,502 **(4.7%)**	12,857 **(0.31%)**
2014	20,265 **(6.4%)**	39,548 **(6.5%)**	62,903 **(6.8%)**	80,414 **(6.5%)**	104,504 **(6.7)**	129,767 **(7.0%)**	160,282 **(7.3%)**	181,829 **(7.3%)**	205,992 **(7.3%)**	218,800 **(7.0%)**	242,115 **(7.0%)**	5,145 **(0.1%)**

Source: HSE performance Reports (2014 – 2016)

Appendix 8: Numbers on Inpatient and daycase and outpatient waiting lists waiting over 15 months (by specialty)

Specialty	Jun-14	Jun-16
Ophthalmology	1	1,495
Orthopaedics	4	632
General Surgery	32	534
Urology	16	606
Otolaryngology (ENT)	49	930
Plastic Surgery	20	385
Cardiology	0	307
Gynaecology	27	224
Pain relief	2	189
Vascular surgery	2	322

Numbers on outpatient waiting lists waiting over 15 months (by specialty)

Specialty	Jun-14	Jun-16
Otolaryngology	2,189	7,363
Orthopaedics	2927	4,473
General Surgery	678	672
Dermatology	559	3,584
Ophthalmology	492	2,572
Gynaecology	218	1,956
Urology	908	2,349
General Medicine	15	1115
Cardiology	284	535
Neurology	824	1,844

Appendix 9: Consultant Establishment as at 31st March 2016

Consultant Establishment as at 31st March 2016							
GROUPSPECIALITY	SPECIALITY	SUBSPECIALITY	DUBLIN & MID LEINSTER	DUBLIN NORTH EAST	SOUTH	WEST	Grand Total
ANAESTHESIA	ANAESTHESIA	Anaesthesia	84	77	66	71	298
		Intensive Care	8	5	7	9	29
		Paediatric Anaesthesia	14	11			25
		Pain Medicine	3	3	2	2	10
ANAESTHESIA Total			109	96	75	82	362
EMERGENCY MEDICINE	EMERGENCY MEDICINE	Emergency Medicine	23	21	17	18	79
		Paediatric Emergency Medicine	2			1	3
	PAEDIATRIC EMERGENCY MEDICIN	Paediatric Emergency Medicine	4	3	1		8
EMERGENCY MEDICINE Total			29	24	18	19	90
INTENSIVE CARE	INTENSIVE CARE	Intensive Care	4	5		1	10
		Paediatric Intensive Care	7	3			10
INTENSIVE CARE Total			11	8		1	20
MEDICINE	CARDIOLOGY	Cardiology	16	11	9	9	45
	CLINICAL GENETICS	Clinical Genetics	4				4
	CLINICAL PHARMACOLOGY	Clinical Pharmacology	3		1	1	5
	DERMATOLOGY	Dermatology	12	7	8	9	36
		Paediatric Dermatology	2	4			6
	GENERAL MEDICINE	Cardiology	6	7	5	6	24
		Clinical Pharmacology & Therapeutics				1	1
		Endocrinology/Diabetes Mellitus	16	14	10	12	52
		Gastroenterology	20	16	12	12	60
		Gastroenterology & Liver Disease	5	1		1	7
		General Medicine	16	14	14	18	62
		Geriatric Medicine				1	1
		Metabolic Diseases		1			1
		Nephrology	9	9	8	10	36
		Respiratory Medicine	16	13	7	11	47
		Rheumatology	10	10	9	7	36
	GENITO-URINARY MEDICINE	Genito-Urinary Medicine	2			1	3
	GERIATRIC MEDICINE	Geriatric Medicine	34	24	25	21	104
	INFECTIOUS DISEASES	Infectious Diseases	4	5	2	3	14
	MEDICAL ONCOLOGY	Medical Oncology	13	6	9	9	37
	NEUROLOGY	Neurology	13	11	8	8	40
	NEUROPHYSIOLOGY	Neurophysiology	4	5	2		11
	PALLIATIVE MEDICINE	Palliative Medicine	11	8	7	10	36
	REHABILITATION MEDICINE	Rehabilitation Medicine	9	1	1	1	12
	RESPIRATORY MEDICINE	Cystic Fibrosis	2	1	3	2	8
		Thoracic Organ Transplantation		2			2
		Tuberculosis	1	1			2
	RHEUMATOLOGY	Rheumatology	2			1	3
MEDICINE Total			230	171	140	154	695
OBSTETRICS/GYNAECOLOGY	OBSTETRICS/GYNAECOLOGY	Gynaecological Oncology	2	2	2	2	8
		Maternal Fetal Medicine	4	2		2	8
		Obstetrics/Gynaecology	38	29	30	26	123
		Reproductive Medicine		2	1	1	4
		Uro-Gynaecology	1			2	3
OBSTETRICS/GYNAECOLOGY Total			45	35	33	33	146
PAEDIATRICS	GENERAL PAEDIATRICS	Community Child Health	9	3	7	8	27
		Developmental Paediatrics				1	1
		Endocrinology	3	1		2	6
		Gastroenterology	3		1		4
		General	14	7	17	16	54
		Infectious Diseases	2				2
		Metabolic Diseases		4			4
		Nephrology	3	3			6
		Neurology	2	3	2		7
		Oncology	3				3
		Paediatric Cardiology			1		1
		Respiratory Medicine	5	3	2	3	13
		Rheumatology	2				2
		Paediatric Neurodisability	1	2		1	4
	NEONATOLOGY	Neonatology	13	9	5	7	34
	PAEDIATRIC CARDIOLOGY	Paediatric Cardiology	8				8
PAEDIATRICS Total			68	35	35	38	176
PATHOLOGY	BIOCHEMISTRY	Biochemistry	2	2	1	2	7
	CHEMICAL PATHOLOGY	Chemical Pathology	3	2		1	6
		Paediatric Chemical Pathology		1			1
	HAEMATOLOGY	Haematology	20	9	9	13	51
		Paediatric Haematology	4	1	1		6
		Transfusion Medicine	4		2		6
	HISTOPATHOL0GY	Cytology	5	1	4	4	14
		Histopathology	26	27	18	27	98
		Neuropathology		2			2
		Ocular Pathology	1				1
		Oral Pathology	2				2
		Paediatric Histopathology	2	2			4

	IMMUNOLOGY	Immunology	2	3		1	6
		Paediatric Immunology	2				2
	MICROBIOLOGY	Microbiology	14	16	8	10	48
		Virology	3				3
	NEUROPATHOLOGY	Neuropathology		1	2		3
PATHOLOGY Total			90	67	45	58	260
PSYCHIATRY	CHILD PSYCHIATRY	Child Psychiatry	36	24	19	19	98
		Learning Disability	1	2	5	3	11
		Substance Misuse	1	1			2
	FORENSIC PSYCHIATRY	Forensic Psychiatry	9				9
		Learning Disability	1				1
	GENERAL PSYCHIATRY	Forensic Psychiatry			1	1	2
		General Psychiatry	58	40	46	40	184
		Learning Disability	8	12	5	5	30
		Liaison Psychiatry	6	7	4	2	19
		Old Age Psychiatry	14	12	10	10	46
		Psychotherapy	1			1	2
		Rehabilitation Psychiatry		5	5	7	17
		Substance Misuse	4	2			6
PSYCHIATRY Total			139	105	95	88	427
RADIOLOGY	NEURORADIOLOGY	Neuroradiology		6	2		8
	PAEDIATRIC RADIOLOGY	Paediatric Radiology	6	5			11
	RADIOLOGY	Breast Radiology	8	12	9	7	36
		Interventional Radiology	5	3	3	4	15
		Musculo-skeletal	1	2			3
		Nuclear	3	2			5
		Paediatric Radiology	1	4	3	1	9
		Radiology	51	37	36	42	166
		Vascular Radiology			1		1
RADIOLOGY Total			75	71	54	54	254
RADIATION ONCOLOGY	RADIATION ONCOLOGY	Paediatric Radiation Oncology	2				2
		Radiation Oncology	14		7	4	25
RADIATION ONCOLOGY Total			16		7	4	27
SURGERY	CARDIO-THORACIC SURGERY	Cardio-thoracic Surgery	6	1	3	3	13
		Paediatric Cardio-thoracic Surgery	3				3
		Transplantation		3			3
	GENERAL SURGERY	Breast Endocrine	2	2	2		6
		Breast Surgery	6	4	6	7	23
		Colo-rectal Surgery	11	7	1	6	25
		Gastro-intestinal Surgery	8	14	10	8	40
		General Surgery	9	4	11	13	37
		Hepato-biliary Surgery	6	1			7
		Paediatric Surgery		2			2
		Urology				1	1
		Vascular Surgery	10	7	6	6	29
	NEUROSURGERY	Neurosurgery		7	3		10
		Paediatric Neurosurgery		4			4
	OPHTHALMIC SURGERY	Medical Ophthalmology	2				2
		Neuro-ophthalmic Surgery		1			1
		Ophthalmic Surgery	9	6	5	10	30
		Paediatric Ophthalmology	1		1		2
		Vitreo-retinal Surgery	2	2	3		7
	ORAL AND MAXILLOFACIAL	Oral & Maxillofacial	5		1	4	10
	ORTHOPAEDIC SURGERY	Orthopaedic Surgery	20	19	15	21	75
		Paediatric Orthopaedic Surgery	5	3	2	3	13
		Spinal Surgery	2	3	1	2	8
	OTOLARYNGOLOGY	Otolaryngology	13	9	9	15	46
		Paediatric Otolaryngology	3	3			6
	PAEDIATRIC SURGERY	Paediatric Surgery	4	3			7
		Paediatric Urology	1				1
	PLASTIC SURGERY	Cleft Lip and Palate		1	1		2
		Plastic Surgery	10	6	4	4	24
	TRANSPLANTATION	Urology		7			7
	UROLOGY	Paediatric Urology	1				1
		Transplantation		2			2
		Urology	9	3	7	10	29
SURGERY Total			148	124	91	113	476
Grand Total			960	736	593	644	2933

Source: HSE Annual Report – Approved Consultant Establishment as at 31st March 2016