

# FutureCare: Action Plan for Health 2026

A Clinician-led 10-Point Action Plan to Reform the Health Service



IHCA  
**FUTURE  
CARE**

Defining Ireland's Health Future

One cannot step  
into the same  
river twice, the  
only constant  
is change.

Heraclitus

Capacity, governance and funding form the three structural pillars of a resilient health system. Ireland's health service continues to struggle under the weight of these interdependent weaknesses: chronic capacity constraints, inconsistent clinical governance and the absence of a coherent funding model capable of sustaining continuous growth in demand.

Dangerous overcrowding in public hospitals, limited access to diagnostics and the absence of a universal electronic health record (EHR) remain the most visible symptoms of systemic strain. These deficits are not simply infrastructural; they represent barriers to clinical effectiveness, patient safety, and the integration of new technologies such as artificial intelligence and predictive analytics. Without a digitised clinical record that provides patients and their clinicians with access to healthcare records, Ireland will continue to lag behind international peers in quality improvement, data-driven decision-making and system efficiency.

Improving clinical governance is equally critical. The evidence from Irish hospitals and international comparators is clear: where governance structures are weak or overly centralised, accountability is diluted, risk management becomes reactive and quality improvement stalls. Strengthened governance, with clinicians embedded in leadership roles, is essential to deliver consistent outcomes and restore public confidence in the health system.

Demographic change adds urgency. Demand for healthcare will continue to rise due to sustained population growth, longer life expectancy and immigration. The proportion of older adults is increasing rapidly — a cohort that consumes the majority of inpatient and long-term care resources. At the same time, informed and educated patients are less willing to tolerate prolonged waiting lists for routine or elective care.

These pressures will force fundamental changes in how healthcare is organised, funded and delivered. The Irish health system must evolve from a model that reacts to crises to one that anticipates and manages demand through better capacity planning, transparent governance and a funding structure that aligns incentives with patient outcomes as well as throughput.

**The IHCA undertook research in November 2025 to ascertain insights from its members on various issues to help shape this new clinician-led Action Plan for reforming the Irish health system.**

# Capacity

A discussion of capacity in Irish healthcare must begin with three interdependent domains: acute hospital beds, emergency and unscheduled care and digital infrastructure. Together, these determine the system's ability to respond to rising demand, absorb seasonal surges and deliver timely, safe, and effective care.

When compared internationally, Ireland's acute hospital capacity remains among the lowest in Europe. In 2023, the country had 289 hospital beds per 100,000 people, ranking sixth lowest among EU27 nations<sup>1</sup>. This is significantly below the EU average of 511 and less than half the provision in countries such as Germany (766 beds per 100,000). While the number of open acute inpatient beds has grown modestly, from 10,592 in 2016 to 11,581 in 2022<sup>2</sup>, this increase of fewer than 1,000 beds has not kept pace with demand, population growth, or demographic change. Most recent figures put the total number of 'open' inpatient beds at 11,942 in June 2025<sup>3</sup> – an increase of just 361 beds over the past three years. In 2023, the Economic & Social Research Institute (ESRI) estimated public acute hospitals needed 1,000 inpatient beds immediately and an additional 330 beds a year just to keep up with demand from population pressures<sup>4</sup>. It is regrettable that the HSE National Service Plan 2026 has committed to deliver just 134 additional and 43 replacement acute hospital beds (177 in total) this year<sup>5</sup>.

While the population has grown by 20% (+895,000) since 2008, available public hospital inpatient and day case bed capacity has increased by less than 8% (+1,054 beds) over the same time period, confirming a clear mismatch between the current capacity and demand for acute hospital care. The Government's latest bed capacity expansion plan pledges to open 3,000 additional hospital inpatient beds by 2031 on top of those already committed to or underway<sup>6</sup>. This is very much welcomed by the IHCA. However, this would bring the total number of hospital beds in Ireland to under 17,900 by 2031, or just 3.19 beds per 1,000 population based on CSO population projections<sup>7</sup> – still significantly below the EU average.

Separately, ICU bed numbers need to be increased to the minimum 579 recommended more than a decade ago<sup>8</sup> and to over 900 critical care beds to reach the OECD average on a population basis<sup>9</sup>. These represent 70% and 170% increases from the current c. 340 available ICU beds (June 2025)<sup>10</sup>.

This expansion of ICU capacity is essential to avoid delays in ICU admission, the cancellation of essential surgery, increased incidence of hospital-acquired infection and to cater for any potential Covid-19 and other surges.



These structural shortages have direct clinical consequences. Ireland's acute hospitals routinely operate at 95%–96% occupancy, well above the recommended safe operating threshold of 85%. In the first half of 2025, national bed occupancy reached 95.9%, up from 94.2% in 2024<sup>11</sup>. Nine hospitals reported occupancy levels exceeding 100% – including St Luke's Hospital, Kilkenny (116%), University Hospital Limerick (114%) and St Vincent's University Hospital (111%) – and 31 exceeded 85%. Sustained overcapacity is not a mark of efficiency; it is a risk factor. International research correlates high occupancy rates with higher mortality, greater incidence of hospital-acquired infections, longer waiting times and increased staff burnout<sup>12,13</sup>.

The population aged over 65 reached 15.5% in 2024, up from 11.2% in 2010 and continues to rise faster than the EU average<sup>14,15</sup>. Older patients account for over half of inpatient bed days<sup>16</sup>. The ESRI projects a need for at least 6,800 additional inpatient beds by 2040, alongside further expansion of day-case, emergency and outpatient capacity<sup>17</sup>.

Hospital stays are relatively short with the average length of stay just over 6 days<sup>18</sup>, but increase

dramatically with patients' age<sup>19</sup>. Admitted patients are more likely to be elderly and have a medical illness. The length of hospital stay is inexorably increasing as the cohort of elderly citizens are expanding faster than the rest of the population<sup>20</sup>. In the context of current high emergency readmission rates of 12% for patients with acute medical illness to the same hospital within 30 days<sup>21</sup>, the likelihood of meaningful reduction in hospital length of stay appears to be slim.

In 2024, 3.98 million outpatient attendances represented a 9% increase on 2023 and exceeded planned activity by 6%<sup>22</sup>. The outpatient attendance figure for the end of 2025 is expected to reach over 4 million<sup>23</sup>. Total Emergency Care activity (EDs and Injury Units) climbed to 1.84 million attendances in 2024, up 9% on the previous year<sup>24</sup>, and could top 1.9 million in 2025<sup>25</sup>. These upward trends reflect not only population growth but also improved public access and diagnostic capability, each of which generates additional downstream demand.

Of admitted patients, approximately 80% are emergency admissions<sup>26</sup>. The remainder consists of patients who require maternity care or same-day acute medical assessment. The scale of the urgent care service is such that elective care is being gradually pushed out of the acute public hospitals, with inevitable inexorable increases in hospital waiting lists.

As a result, waiting lists remain entrenched. Data from the National Treatment Purchase Fund (NTPF) show that at the end of December 2025, more than 107,000 patients were waiting for inpatient or day-case procedures, approximately 34,600 were awaiting a GI endoscopy and almost 612,000 were waiting for an initial outpatient consultation<sup>27</sup>. A further 287,600 individuals were awaiting diagnostic imaging at the end of Quarter 3 2025<sup>28</sup>, more than a two-thirds increase on the number compared with 2019<sup>29</sup> (+117,632 or +69%), with nearly a quarter (66,916 or 23%) of these waiting more than a year. Taken together, more than 1 million people are waiting for some form of hospital treatment.

Capital funding of in excess of €3bn must be provided to fast-track the delivery of all eight Surgical Hubs and four Elective Hospitals promised by Government<sup>30</sup>. The majority of this funding has yet to be allocated, with concern that the Elective Hospitals will never be delivered. This is a major concern for Consultants who cannot provide timely care to their patients without the required access to the necessary facilities.

**More than 1 million people are waiting for some form of hospital treatment, including inpatient or daycare care, diagnostics or outpatient appointments.**

It is accepted that a substantial portion of existing hospital capacity also continues to be taken up by patients who have no medical need to remain in wards, but do need some care. While the number of Delayed Transfers of Care (DTOC) on any given day has reduced from around 600 pre-Covid to around 400 patients currently<sup>31</sup>, this still resulted in an estimated 145,000 bed days lost due to DTOC in 2025.<sup>32</sup> These delayed discharges are not just occupying beds that could be used by other patients but also put those patients at higher risk of acquiring infections and losing mobility.

Reducing this number is critical to improving efficiency and will require the Government to deliver the 4,500 additional long-term and short-term residential beds in community nursing homes in the public system promised in the previous National Development Plan 2018-2027.

# 114,000

The number of admitted patients treated on a trolley in 2025

Trolley Watch Data

# 1,000 additional beds

needed immediately

# 330 extra beds

needed each year to keep up with demand

ESRI estimate

# 96%

The average percentage bed occupancy rate in Irish hospitals

# 85%

The recommended bed occupancy rate

HSE/WHO



# €2 billion

The estimated cost of delivering an Electronic Health Record

Former Minister for Health  
Stephen Donnelly

# >1 million

The number of people awaiting some form of hospital treatment

# <1%

The €200 million budget provided to the NTPF in 2026, as a proportion of the overall Health Budget

NTPF and Revised Estimates 2026



# 3,322

Number of additional Hospital Consultants needed by 2030

# 5,285

Number of additional Hospital Consultants needed by 2042

Parliamentary Budget Office

Part of the solution to addressing the deficits in our acute public hospitals therefore lies in strengthening our step-down and community capacity. Severe bottlenecks in patient flow must be addressed by improving discharge pathways and community supports, especially at weekends, to ensure the safe and timely transfer of clinically discharged patients.

Emergency Departments (EDs) have become the most visible pressure point in the health service. While some improvements can be seen in trolley numbers, overcrowding remains at an unacceptable level, with the persistent “trolley crises” a direct result of chronic bed shortages and limited step-down capacity. In 2024, more than 122,000 patients were treated on trolleys while awaiting a hospital bed – the highest number ever recorded<sup>33</sup>. In 2025, the total number of admitted patients treated on a trolley fell to just over 114,000, which placed the system more on par with pre-pandemic levels<sup>34</sup>, but was still more than double (+58,300) the corresponding number two decades ago, when the Emergency Department overcrowding crisis was described by the then Minister for Health as a ‘national emergency’<sup>35</sup>.

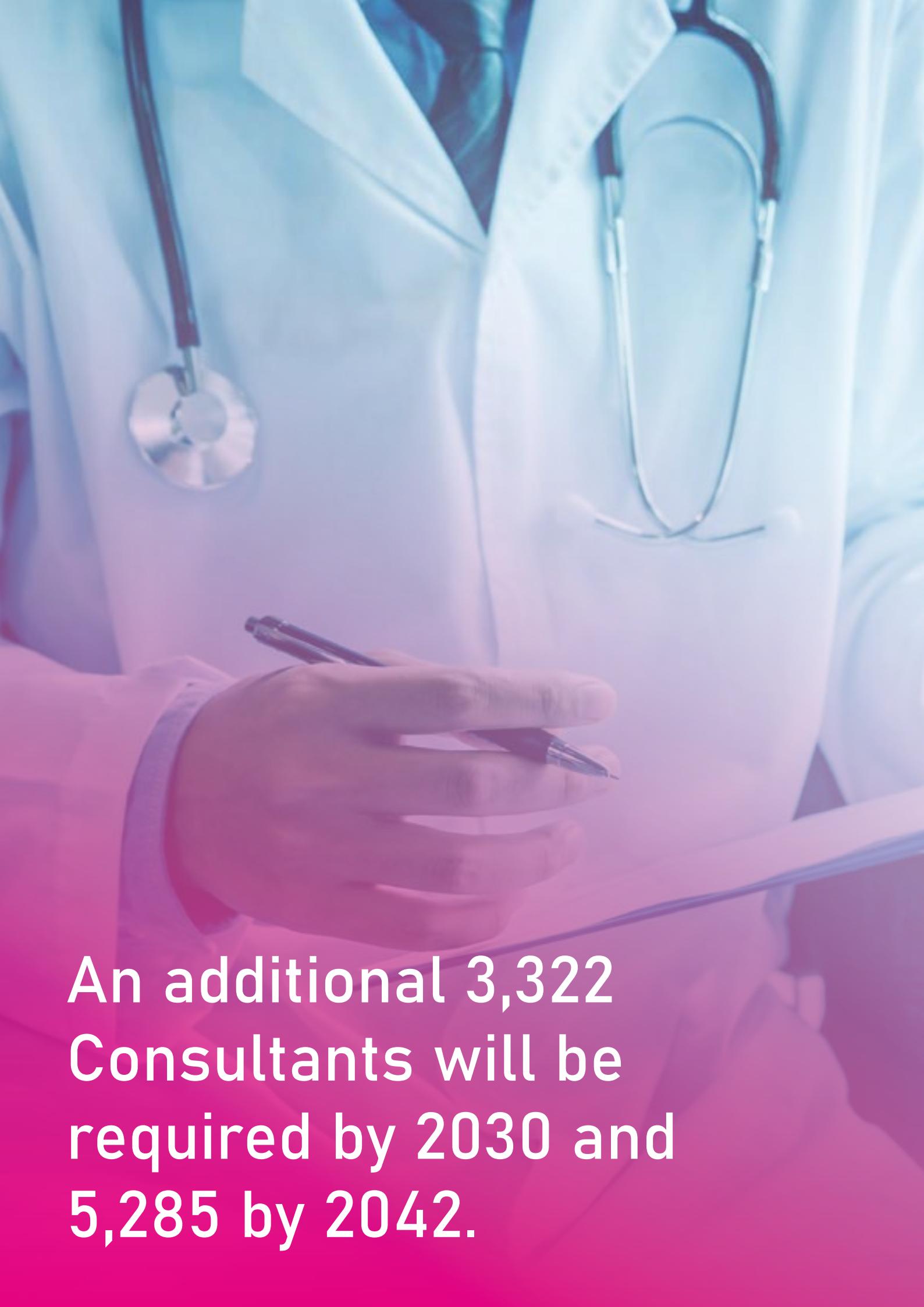
The HSE National Audit of Emergency Departments revealed additional concerns around safety and triage quality. Only 40% of patients were triaged within the 15-minute standard (target 95%)<sup>36</sup>. Under-triage affected 9% of cases and over-triage 10%, indicating inconsistencies in acuity recognition which may be associated with delays in care as other patients may be prioritised, contributing to longer wait times. In some departments, fewer than one in four patients were triaged on time. These findings underscore that the issue extends beyond physical capacity to include process design, staffing levels, and governance.

Ireland’s diagnostic capacity is similarly constrained. Nationally, there are 38 CT, MRI, and PET scanners per million population, 17% below the EU average of 46 and roughly half the capacity of Germany and Italy<sup>37</sup>. Outdated equipment further limits productivity: 210 radiology and ultrasound machines were due for replacement in 2024 at an estimated cost of €50 million<sup>38</sup>, with the estimated cost of replacing 4,500 items of healthcare equipment no longer supported by the manufacturer put at over €105 million<sup>39</sup>. Between 2019 and 2024, only €318 million was spent on equipment renewal, compared with a €3.6 billion requirement estimated for 2017–2021<sup>40</sup>.

Alongside the physical infrastructural deficits throughout the health service are the significant digital deficits, the most prominent of which is the absence of Electronic Health Records (EHRs), which is having a significant negative impact on patient care, morale and productivity. The digital transformation of Irish healthcare remains partial and fragmented. Most family practices and private hospitals now operate electronic records, but most public hospitals still depend on paper charts. Only five of 19 maternity hospitals use electronic records<sup>41</sup>, with most acute general hospitals lacking integrated digital prescribing or order entry.

This fragmentation hinders patient safety, audit and coordination. The Digital Health Framework 2024–2030<sup>42</sup> and the Health Information Bill<sup>43</sup> establish a foundation for reform, but delivery is estimated to require capital investment of at least €2 billion<sup>44</sup> – comparable to the cost of the National Children’s Hospital. The IHCA recommends a doubling in IT spending from 2% to 4%–6% of the total health budget to deliver this vital component of our health infrastructure, thereby enhancing patient care and treatment and meeting EU Digital Decade targets<sup>45</sup>.

Ireland should emulate the Scandinavian model, where national data architecture coexists with regionally managed clinical systems<sup>46</sup>. These countries demonstrate that a centralised electronic record, supported by strong governance and interoperability standards, enhances patient safety and administrative efficiency.



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Consultants will be  
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# Consultant Staffing

Despite the appointment of additional Consultants in recent years, Ireland still has the lowest number of medical specialists per 1,000 population in EU at 1.77, 34% below the EU average.

Ireland would need an additional 4,850 medical specialists (Consultants and NCHDs) to achieve the EU average number of specialists on a population basis. Workforce projections from the independent Parliamentary Budget Office (PBO), which takes into account conservative population growth, increase in chronic diseases, and recommended Consultant:NCHD ratios, indicate an additional 3,322 Consultant will be required by 2030 and 5,285 extra Consultants by 2042 to meet the demands of a growing and ageing population<sup>47</sup>.

Most recent HSE data confirms that one in every six Consultant posts (763) were filled by temporary, locum or agency doctors in October 2025<sup>48</sup>. These vacant and temporary filled posts not only have a direct effect on the delivery of care to patients and waiting lists, but also impact on the supervision and training of NCHDs, which in turn can result in patient and professional safety issues. The Irish Medical Council (IMC) in its recent workforce reports has expressed its concern over the inability of the health service to adequately fill these vacant Consultant posts<sup>49 50</sup>.

In addition, more than 100 doctors who are not on the Medical Council Specialist Register remain appointed to Hospital Consultant posts, in breach of the Medical Practitioners Act, 2007 and the HSE's own recruitment rules. This was raised again as a "continued concern" at a meeting of the HSE's Audit and Risk Committee in October 2025<sup>51</sup>. Specialist registration is the minimum standard to ensure high standards of patient care and safety, as clearly highlighted back in 2018 by the then President of the High Court, Mr Justice Peter Kelly, to the then Minister for Health, the HSE CEO and the Medical Council<sup>52</sup>.

Excessive workloads and understaffing is also leading to stress and burnout and is a known contributing factor to driving our doctors abroad where they can find better conditions and work-life balance<sup>53</sup>. Research from the IMC has highlighted that almost half (45%) of specialists are consistently working more than 40 hours on average per week,

in excess of their contractual hours, with close to one in five (18%) working more than 48 hours, in contravention of the European Working Time Directive<sup>54</sup>.

Results from a new IHCA survey confirm that 86% of Consultants are working above their contractual hours, with 40% working 45 hours or more per week. Of those, 17% are working 50+ hours. When asked to quantify the level of extra work or 'discretionary effort' they provided each week on a voluntary basis 'above and beyond' their contractual hours, 41% said they are working 7 hours or more extra per week, with a quarter (24%) providing 10 or more hours in 'discretionary effort' and 11% working an additional 13 hours or more.

Addressing these specialist workforce deficits, in parallel with rapidly increasing the number of hospital beds, theatres, diagnostic and other facilities, will start the health service on its journey towards a better and more productive future. The Association remains ready to collaborate constructively with the HSE and Department of Health to achieve this aim.

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# Governance

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**Governance is the framework through which healthcare organisations ensure accountability, transparency and continuous improvement. In its truest sense, it is not simply about compliance or reporting structures; it is about how values, leadership and systems align to produce consistent, high-quality outcomes for patients<sup>55</sup>.**

In Ireland, clinical governance has evolved unevenly. Despite many local examples of best practice<sup>55 56 57</sup>, there remains no unified structure ensuring that clinical decision-making, resource allocation and risk management are coherently linked from the bed to the boardroom. Fragmentation of responsibility often results in accountability diffusion, with the potential for unclear ownership of patient outcomes.

The cornerstones of effective governance are well established: clarity of accountability, transparent decision-making, a culture of learning and improvement and strong clinical leadership. These principles are interdependent. Governance that emphasises financial control without a parallel focus on quality risks creating a system where efficiency is measured by throughput rather than outcomes. Similarly, governance overly centralised in administrative structures can disconnect decision-makers from clinical realities.

International evidence increasingly supports the involvement of clinicians, particularly in executive leadership roles<sup>58 59 60</sup>. Although the current evidence base remains modest, findings are steadily accumulating, with empirical studies from the UK, Europe and the United States reporting positive associations between doctors' participation on boards and organisational performance<sup>61</sup>. In Australia, physicians recognised by their peers for both clinical and academic expertise have been shown to exert substantial cultural influence, fostering learning, cooperation and morale<sup>62</sup>. Evidence from the United States further indicates that hospitals led by doctors outperform those led by non-clinicians across multiple quality metrics, including service-user satisfaction, safety and adherence to evidence-based standards<sup>63</sup>.

It is clear that clinically trained managers can understand clinical challenges better, communicate with clinical staff in a language they understand, and

enjoy a credibility that non-clinicians rarely achieve. Institutions such as the Cleveland Clinic and the Mayo Clinic exemplify this model. Both are physician-led, with deeply embedded cultures of continuous improvement. Their defining principle — “the patient comes first” — is not rhetorical but structural: it shapes performance appraisal, strategic investment and staff recruitment. Clinician-led governance enhances credibility with both professionals and the public, enabling these organisations to attract and retain top talent while maintaining trust<sup>64</sup>.

Irish healthcare governance should evolve along similar lines. This means embedding clinician leadership at every level, from service line management to hospital boards and HSE executive committees. Governance frameworks should explicitly recognise clinical accountability as equal in importance to financial stewardship. Moreover, governance reform must address culture. A culture that values openness, peer review and accountability will achieve more sustainable improvement than any structural change alone.



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A surgeon in an operating room, wearing a blue surgical cap and a blue surgical mask, looking upwards and to the right. In the background, another surgeon is visible, and the operating room is filled with medical equipment and bright lights.

The IHCA believes the Department of Health should institute mandatory, internationally recognised quality assurance and accreditation standards for all public hospitals.

# Accreditation Standards

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The monitoring role of the Health Information and Quality Authority (HIQA) was expanded in 2024 under the commencement of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 to cover private hospitals as well as publicly-funded health services, with the first inspection reports of private hospital published by HIQA in October 2025<sup>65</sup>. As part of its inspections, the Authority monitors compliance with the National Standards for Safer Better Healthcare. However, while HIQA may make recommendations for improvement of care, under current legislation it cannot enforce their implementation.

The general scheme of the Patient Safety (Licensing) Bill — which would introduce a new licensing requirement for all hospitals, public and private — was first approved by Government in December 2017, underwent Pre-Legislative Scrutiny at the Oireachtas Joint Committee of Health in June 2018, and was subsequently referred to the Attorney General's Office for drafting, where it remained<sup>65</sup>. Following the Government decision of June 2025 to proceed with drafting, the Bill has been placed on the Department of Health's legislative agenda but has not been prioritised in the Government's current legislation programme<sup>66</sup>.

To supplement these moves, the IHCA believes the Department of Health should institute mandatory, internationally recognised quality assurance and accreditation standards for all public hospitals, as is the practice in all private hospitals in Ireland and a small number of public acute facilities. This action would enhance patient safety, ensure quality improvement efforts do not stall, and guarantee that risk management in our public hospitals is proactive rather than reactive.

# Funding

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Ireland's health system is funded through a combination of public expenditure, private insurance and out-of-pocket payments<sup>67</sup>. Yet despite significant public investment, the alignment between funding, performance and outcomes remains weak. The current mix of models — the Beveridge-style system for public hospitals, private voluntary insurance and the National Treatment Purchase Fund (NTPF) for waiting list management — has evolved in response to changing healthcare needs.

Health spending has grown sharply over the past decade. Since 2015, the health budget has increased year on year. In 2024, health accounted for 26% of total government expenditure, which is a larger share than in any other EU member state<sup>67</sup>. However, when measured against GDP, total expenditure stood at just 5.2%, well below the EU average of 7.3%.

While the State has been generous in funding health, this trajectory is unlikely to continue indefinitely. Speaking at the IHCA's Annual Conference in October 2025, the Secretary General of the Department of Health Mr Robert Watt said that as demand for services was currently increasing by 3%-4% a year, in 18 years' time demand could have doubled.<sup>68</sup> However, Mr Watt said it would not be sustainable to double the current Health budget to a range of €50-€55 billion. Fiscal headwinds, including tax reform, bond costs and rising demands in other sectors, will constrain future growth. Incremental expansion will not bridge the gap between demand and capacity. The system must therefore evolve toward a mixed model that preserves universal access while aligning incentives for efficiency.

The NTPF offers one practical, short-term bridge. With a budget in 2024 of €239 million<sup>69</sup>, around 1% of the HSE's then €22.5 billion allocation, it treated approximately 250,000 patients<sup>70</sup>. In 2025, almost 200,000 patients had timely care arranged by the NTPF for a funding allocation of €230m.<sup>71</sup> Doubling the current NTPF budget of €200m to €400m, still less than 1.5% of the €27.4 billion Health Budget for 2026, could provide an additional 143,000 OPD appointments, IPDC procedures and endoscopies, thus reducing waiting lists substantially within five years while maintaining low administrative overheads.<sup>72</sup> It is regrettable therefore that the NTPF received a €30 million reduction in its funding in

Budget 2026. The NTPF demonstrates that outcome-linked funding can deliver measurable results and value for money<sup>73</sup>.

In addition, the health service should fully embrace a population-based resource allocation (PBRA) model, which uses population size, age, sex, deprivation and rurality, to significantly improve the efficient and equitable allocation of resources in health and social care and advance integrated care pathways.

A sustainable framework for Ireland should rest on three pillars: predictable multi-year public investment, strategic use of private and voluntary capacity, and robust financial governance ensuring accountability for both efficiency and quality.



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Health systems evolve under the twin pressures of rising expectations and finite resources. Ireland's health service now stands at an inflection point where demographic realities, patient demand and technological change will determine its future trajectory. The choices made over the next decade – particularly regarding capacity, governance and funding – will define whether the system becomes resilient and adaptable, or remains trapped in cycles of crisis management.

The evidence across this report highlights three interlinked challenges: capacity constraints, governance weaknesses and funding pressures. Ireland can learn from international examples. The Scandinavian model demonstrates that it is possible to guarantee timely access and uphold equity while engaging private providers when public capacity is exceeded.

As medical science advances and patient needs become more complex, adaptability and agility will define the success of health systems. This requires investment not only in infrastructure but also in culture: a culture that values learning, transparency and collaboration. It also requires the courage to re-evaluate long-standing organisational structures and funding mechanisms in light of new realities.

The health service Ireland needs, and the one that its population expects, will be defined by three core commitments: adequate capacity to ensure timely, safe care; accountable governance embedding clinical leadership; and sustainable funding aligning incentives with outcomes.

Delivering this vision requires both political and professional leadership. Inaction is not a neutral choice — it carries the highest cost, measured not only in euro but in delayed diagnoses and preventable harm.



# 10-Point 'FutureCare 2026' Action Plan for the Health Service

## I. Capacity and Infrastructure Investment (Top Priority)

### Execute Immediate and Sustained Expansion of Physical Capacity

1

The overwhelming number one priority is to significantly expand hospital capacity, particularly acute and critical care beds, operating theatres and outpatient facilities. The investment in additional bed capacity is required to move acute hospital occupancy below the safe operating threshold of 85%, improve access to timely care, address waiting lists, and tackle the dangerous overcrowding that correlates with higher mortality and increased infection rates.

### Fully Operationalise Elective Hospitals and Surgical Hubs

2

The Government must build and fully open all promised Surgical Hubs and Elective Hospitals. This is necessary to increase capacity for inpatient and day-case surgery and procedures, which will prevent urgent elective care from being continually cancelled and pushed out of acute public hospitals due to the competing pressure of urgent and emergency care services.

### Resolve Diagnostic Constraints and Equipment Deficits

3

National diagnostic capacity must be immediately increased, specifically for MRI and CT scanners, as Ireland currently lags significantly behind the EU average. This must be coupled with dedicated capital investment to replace outdated equipment, including the hundreds of radiology and ultrasound machines due for renewal.

### Strengthen Step-down and Community Capacity

4

Severe bottlenecks in patient flow must be addressed by improving discharge pathways and community supports. This requires immediately increasing the availability of step-down, rehabilitation, and nursing home beds, especially at weekends, to ensure the safe and timely transfer of clinically discharged patients from hospitals.

## II. Funding and Efficiency

### Align Funding with Outcomes and Use Capacity Effectively

5

In the short term, funding for the National Treatment Purchase Fund (NTPF) should be increased, rather than reduced, to double its current level, from €200m to €400m, to deliver timely care to an additional 143,000 patients, as it has proven to be a practical mechanism that uses outcome-linked funding to deliver measurable results in reducing waiting lists. In addition, a multi-annual Population-Based Resource Allocation (PBRA) model should be fully embraced to significantly improve resource distribution across the health service.

### III. Governance and Leadership

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#### **Implement Clinician-Led Governance Models**

**6**

Reform governance structures to explicitly embed clinician leadership at every level, from service line management to hospital boards. There is strong general support from Consultants for adopting a model of physician-run hospitals, recognising that clinical accountability must be given equal importance to financial stewardship.

#### **Mandate and Fund Comprehensive Quality Assurance Standards**

**7**

Institute mandatory, internationally recognised quality assurance and accreditation standards for all public hospitals, as is the practice in all private hospitals in Ireland and a small number of public acute facilities. This action would enhance patient safety, ensure quality improvement efforts do not stall, and guarantee that risk management is proactive rather than reactive.

#### **Implement Clinician-Led Governance Models**

**8**

The health system's focus must shift away from constant "firefighting" towards adequate forward thinking and strategic planning. This includes ensuring that consultants' views, which are currently often excluded, are actively considered in management decisions and strategic initiatives.

### III. Workforce and Digital Transformation

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#### **Expand and Support the Health Service Workforce**

**9**

Commitment is needed to recruit additional, suitably qualified consultants and other medical staff, as this ranks as the second highest national priority for consultants. A large number of consultants report lacking the appropriate number of consultant colleagues and wider team members needed to deliver timely patient care.

#### **Deliver an Integrated National Digital Health System**

**10**

Accelerate the digital transformation of Irish healthcare by implementing a single national Electronic Health Record (EHR) to enhance patient safety, audit, and coordination. This requires a substantial capital investment, with IT spending needing to double from its current low percentage of the total health budget.



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<sup>4</sup> ESRI, 2023. Inpatient bed capacity requirements in Ireland in 2023: Evidence on the public acute hospital system, ESRI, 29 March 2023.

<sup>5</sup> HSE National Service Plan 2026, 22 December 2025.

<sup>6</sup> Acute Hospital Inpatient Bed Capacity Expansion Plan 2024-2031, 29 May 2024.

<sup>7</sup> The population is projected to be 5,720,946 by 2031 under the CSO's moderate net migration M2 scenario; CSO statistical release, 16 July 2024. Available at <https://www.cso.ie/en/releasesandpublications/ep/p-plfp/populationandlabourforceprojections2023-2057/>

<sup>8</sup> Prospectus Report: Towards Excellence in Critical Care, 2009.

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<sup>10</sup> HSE PQ response to Deputy Richard Boyd Barrett, 10 July 2025. Available at <https://www.hse.ie/eng/about/personalpq/pq/2025-pq-responses/july-2025/pq-35668-25-richard-boyd-barrett.pdf>

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<sup>28</sup> Dáil PQ response from Minister Jennifer Caroll MacNeill to Deputy David Cullinane, 2 December 2025. Available at: <https://www.oireachtas.ie/en/debates/question/2025-12-02/516/>

<sup>29</sup> Dáil PQ response from Minister Stephen Donnelly to Deputy Neasa Hourigan, 25 January 2023. Available at: <https://www.oireachtas.ie/en/debates/question/2023-01-25/179/>

<sup>30</sup> The indicative ranges for the capital budgets for the build, technology and programme teams for the Cork and Galway elective hospitals were estimated in 2022 at between €614m-€828m and €516m-€695m respectively: Department of Health press release, 7 December 2022. A further €100m to €120m in capital funding was required for the six surgical hubs originally planned, which have subsequently been expanded to eight.

<sup>31</sup> HSE Urgent and Emergency Care Weekly Performance Update 2025–2026, 28 December 2025.

<sup>32</sup> Protect outturn for number of acute bed days lost through delayed transfers of care in 2025; HSE National Service Plan 2026, 22 December 2025.

<sup>33</sup> Trolley Watch Data. Available at: <https://www.inmo.ie/News-Campaigns/Trolley-Watch/>

<sup>34</sup> There were 108,227 and 118,367 admitted patients treated on trolleys in EDs and on hospital wards in 2018 and 2019 respectively: Trolley Watch Data.

<sup>35</sup> 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 and a total of 55,720 admitted patients on trolleys that year.

<sup>36</sup> National Office Clinical Audit (NOCA), 2024. National ED Triage Report 2023., s.l.: NOCA.

<sup>37</sup> OECD, 2023. Health at a Glance 2023. OECD Indicators. OECD Publishing, Paris. Available at: <https://doi.org/10.1787/7a7afb35-en>.

<sup>38</sup> HSE FOI response to the Medical Independent, 23 February 2024.

<sup>39</sup> €105m required to replace unsupported equipment, Medical Independent, 23 June 2024. Available at <https://www.medicalindependent.ie/in-the-news/e105m-required-to-replace-unsupported-equipment/>

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<sup>41</sup> HSE, 2025. Electronic Health Records Rolled Out in HSE Mid-West. Available at: <https://about.hse.ie/news/electronic-health-records-rolled-out-in-hse-mid-west/> [Accessed 10 Oct 2025].

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<sup>45</sup> IHCA Election Manifesto, 20 November 2024: [https://www.ihca.ie/\\_fileupload/ihca-election-manifesto-2024-final-1.pdf](https://www.ihca.ie/_fileupload/ihca-election-manifesto-2024-final-1.pdf)

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<sup>48</sup> HSE PQ response to Deputy Colm Burke, 8 December 2025: Available at [https://about.hse.ie/api/v2/download-file/file\\_based\\_publications/PQ\\_66518-25\\_-\\_Colm\\_Burke.pdf](https://about.hse.ie/api/v2/download-file/file_based_publications/PQ_66518-25_-_Colm_Burke.pdf)

<sup>49</sup> Medical Workforce Intelligence Consolidated Report 2022, Irish Medical Council, 8 March 2024.

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<sup>51</sup> HSE Audit and Risk Committee Meeting Minutes 17 October 2025.

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