IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Pre-Budget Submission 2027

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Ireland has a growing and ageing population, as a result, demand on our health services is constantly increasing. Years of poor planning and underfunding has left us with significant deficits across our health system. Underbudgeting has led to inevitable overspending in a service that is facing year-on-year increases in demand and the inevitable extreme cost-cutting measures are damaging to the health system both in the short and long term.

Unsafe staffing, poor working conditions and inadequate and outdated facilities are all impacting on patient safety and driving poor morale and difficulties in recruiting and retaining doctors. Meanwhile strategic reform, as envisaged under Sláintecare, to expand consultant care and services in General Practice all require additional planning and funding, without such current medical staffing resources will be spread even thinner.

In this year's Pre-Budget Submission, the IMO is calling for an end to the annual cycle of under-budgeting, over-spending and cost-cutting in health and the introduction of a multi- annual approach to funding healthcare with a realistic allocation of resources based on population need and for priority to be given to developing a safe medical staffing framework across HSE settings to deliver safe, quality care to patients and to address burnout and improve morale and retention of the medical workforce.

Summary of Recommendations:

Multi-Annual Planning and Budgeting

The IMO is calling for the introduction of a multi-annual approach to funding healthcare allowing for better planning and capacity building, as well as the development of new initiatives.

The Pay and Numbers Strategy which lays out the recruitment targets and staff ceilings must take into account safe medical staffing levels, predicted increases in patient demand and strategic priorities for reform.

Safe Medical Staffing

The IMO is seeking engagement with the Department of Health, the HSE and other stakeholders on developing, resourcing and implementing a safe staffing framework for doctors working in HSE settings.

- **Guidance should define the optimum number and appropriate grade of doctors necessary for a given clinical workload based on the volume of admissions and acuity of patients, as well as other clinical and non-clinical workload.**
- **Consideration should be given to local factors, as well as strategic, legal and performance related requirements.**
- **The medical staffing and skill mix should be continuously monitored to ensure that it is delivering optimal patient outcomes and robust mechanisms should be in place to report breaches of workplace safety with clear lines of senior management responsibility.**

Medical Workforce Planning

The IMO is calling on the Department of Health and the HSE to ensure that medical workforce planning and modelling aligns with:

- **Predicted changes in population growth, age structure and prevalence of disease**

- **Optimal medical staffing levels and supports needed under a safe medical staffing framework**
- **Additional staffing requirements to deliver on strategic objectives, new clinical programmes and evolving models of care**
- **Planning should be based on Whole Time Equivalents (to take into account part-time working) and predictable attrition rates.**

The IMO is calling for a rapid expansion of post graduate medical training places to meet the needs of the current and future workforce needs across Ireland.

Investment in Acute Bed Capacity

The IMO is calling on the Government to:

- **increase the number of new inpatient beds from 3,438 to at least 5,000 under the *Acute Hospital Bed Capacity Expansion Plan 2024-2031***
- **develop a detailed plan laying out the costs, timeline and staffing for the delivery of new hospital beds. This should be kept under ongoing review.**
- **publish a quarterly report on the actual number of new acute inpatient hospital beds, mental health beds, nursing home beds and rehabilitation beds being opened in excess of the current number and broken down by Regional Health Area.**

Healthcare Facilities as Critical Infrastructure

The IMO is calling on the Government to amend the Critical Infrastructure Act 2026 to include public healthcare facilities as critical infrastructure and to streamline the development and building of vital healthcare infrastructure.

Tax Incentives for Investment in General Practice Infrastructure

The IMO is calling on Government to establish a tax incentive scheme which would allow individual GPs (as opposed to corporate entities) who invest in their infrastructure to write off the cost of such investment against tax over a defined period of time.

General Practice in Rural and Urban Deprived Areas

The IMO are calling for an increase in dedicated funding for both rural practices and urban deprived practices.

Universal Expansion of the Chronic Disease Management Programme in General Practice

The IMO are calling for the Chronic Disease Management Programme in General Practice to be expanded on a universal basis to all patients with specified chronic conditions over 18 years old.

Multi-Annual Planning and Budgeting

Ireland has a growing and aging population. Figures show that

- Since 2016, Ireland's population has grown by 15% from 4.76million to almost 5.5million in 2025[1];
- In addition to this, Ireland's population of those 65 and older has increased by over 35% from 637,500 in 2016 to 861,100 in 2025;
- By 2040, the population is expected to grow by a further 5 to 15 % reaching up to 6.3million with the proportion of those 65 and older growing from 1 in 7 to 1 in 5.[2]

Decades of underinvestment have left us with significant deficits in acute bed and manpower capacity across the health system

- While the number of consultants employed in the HSE has increased in recent years, at 87.6 WTE per 100,000 population[3] the number of consultants employed falls well below the target of 110 consultants per 100,000 population in the Taskforce on the NCHD Workforce ;[4]
- Ireland has 2.54 public acute hospital beds per 1,000 population compared to an EU average of 3.8;[5]
- In 2025, almost all our Model 3 & Model 4 hospitals operated above the safe occupancy rate of 85% and 8 hospitals operated above 100% occupancy;[6]
- Over 114,000 patients were treated on trolleys in our EDs and wards in 2025[7], while in May this year the number of patients on an NTPF waiting list surpassed one million;[8]
- Capacity issues also exist in General Practice. Over the last 10 years the number of GP specialists registered in Ireland has risen by 29% from (3,062 in 2016 to 3,959 in 2025[9]) the net increase in GPs with a PCRS contract has increased by just 10.7% (from 2914 in 2016 to 3,227 in 2025. [10]

Recent estimates show the need for a substantial increase capacity across the health system to meet the needs of a growing and ageing population

- 1,599 additional WTE consultants are needed by 2030[11] to achieve the target of 110 consultants per 100,000 population recommended by the Taskforce on the NCHD Workforce;[12]
- The Department of Health broadly estimates that a 31% increase in medical practitioners or 5,365 additional doctors are required by 2040 across both public and private sectors;[13]

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[1] Central Statistics Office (PEA04).and Department of Health. Health in Ireland: Key Trends - Demographics. gov.ie. 2026.
[2] Brick, A., Kakoulidou, T., and Humes, H. (2025). Projections of national demand and bed capacity requirements for public acute hospitals in Ireland, 2023–2040: Based on the Hippocrates model, ESRI Research Series 213,
[3] Based on 4781 consultants WTEs and a population of 5.458,600
[4] The National Taskforce on the NCHD Workforce. National Taskforce on the Non-Consultant Hospital Doctor (NCHD) Workforce: Final Recommendations Report. gov.ie. Department of Health; 2024.
[5] OECD Health Statistics 2026
[6] HSE, PQ 5699/26, M Daly TD
[7] INMO Trolley Watch 2025
[8] NTPF Waiting Lists May 2026
[9] Medical Council, Retention data
[10] PCRS Data
[11] Based on a 6,380 consultants needed for a pop of 5.8m in 2030 and 4,781 employed in the HSE as of May 2026
[12] The National Taskforce on the NCHD Workforce. National Taskforce on the Non-Consultant Hospital Doctor (NCHD) Workforce: Final Recommendations Report. gov.ie. Department of Health; 2024.
[13] Department of Health 2025, Ireland's Future Health and Social Care Workforce

- The ESRI estimate that by 2040 an additional 4,400 to 6,800 public *inpatient beds* and 650 to 950 additional *day case beds* are required; [14]
- Similarly the ESRI project a requirement for 943-1211aditional GPs by 2040 (25-31 percent increase). [15]

Numerous reports have highlighted the need for a multi-annual approach to planning and funding healthcare allowing for greater certainty around financing allowing for better planning and capacity building, as well as the development of new initiatives.[16] [17] [18]Instead each year we are subjected to an annual cycle of underbudgeting, overspending, and cost cutting with consequent impact on staff recruitment and service delivery.

The Irish Fiscal Advisory Council have highlighted how overruns in health spending are not just a result of poor spending control but primarily a result of poor budgeting with marginal increases in spending that fail to take into account previous year's spending, known pay increases, demographic pressures, rising demand and health inflation.[19]

Similarly, the Pay and Numbers Strategy, negotiated between the Department of Health and the Department of Public Expenditure, Infrastructure, Public Service Reform and Digitalisation lays out the HSE's recruitment targets and staff ceilings within annual budget constraints, with no regard for staffing levels required to assure safe and quality service for both staff and patients nor the number of additional staff required to meet the needs of a growing and ageing population and strategic reform.

Recommendations:

The IMO is calling for the introduction of a multi- annual approach to funding healthcare allowing for better planning and capacity building, as well as the development of new initiatives.

The Pay and Numbers Strategy which lays out the recruitment targets and staff ceilings must take into account safe medical staffing levels, predicted increases in patient demand and strategic priorities for reform.

[14] Brick, A., Kakoulidou, T., and Humes, H. (2025). Projections of national demand and bed capacity requirements for public acute hospitals in Ireland, 2023–2040: Based on the Hippocrates model, ESRI Research Series 213,
[15] Connolly S, Kakoulidou T, McHugh E. Projections of national demand and workforce requirements for general practice in Ireland, 2023–2040: Based on the Hippocrates model. ESRI. 2025.
[16] Casey E & Carroll K, Nov 2021, The path for Ireland's health budget Analytical Note No. 14 Irish Fiscal Advisory Council
[17] Department of Health 2025, *Ireland's Future Health and Social Care Workforce,* Dublin DOH
[18] Brick, A., Kakoulidou, T., and Humes, H. (2025). Projections of national demand and bed capacity requirements for public acute hospitals in Ireland, 2023–2040: Based on the Hippocrates model, ESRI Research Series 213,
[19] Carroll, K 26 May 2026, Health overruns – Budgeting as if yesterday never happened – Beyond the Budget Series, Irish Fiscal Advisory Council

Safe Staffing

Working in an overcrowded system, combined with chronic understaffing and unsafe working conditions, impacts staff morale, productivity, patient safety, and quality of care.

A recent IMO survey of doctors working in the HSE[20], found that:

- 94.6 per cent of respondents reported low to moderate morale;
- 64 per cent of NCHDs and 60 per cent of Consultants reported unsafe staffing as a factor driving low morale, highlighting concerns around patient safety;
- Nearly 98% of all respondents agreed that HSE cost cutting measures would negatively impact patient services.

High turnover rates, difficulties in recruiting and retaining staff, and high reliance on locum staff are all indicative of a health system that remains chronically stressed and understaffed.

- One fifth of consultant posts are either unfilled or filled on a temporary locum basis – 105 consultant posts are vacant for over one year[21]
- Consultants are being asked to work Saturday as a core rostered day but are not being allocated the relevant support staff that they would have in place on a week day to ensure that this can be done safely and effectively. Equally, there are not enough consultants in post to support five day working let alone six day working. While the IMO have no objection to weekend working, a whole of hospital approach is required in tandem with increased consultant recruitment otherwise rostering consultants on Saturdays is simply window dressing that reduces, rather than increases, capacity.
- NCHDs continue to work illegal and unsafe hours. A recent IMO survey, carried out in 2025, found that 70% of NCHDs are working more than 48 hours per week and over half (51%) have been rostered for a 24-hour shift.
- The HSE had previously identified the need for allocation of additional NCHDs in areas where required to ensure legally compliant working hours and hours in line with the NCHD Contract and related agreements. Under these agreements, hospitals in breach of the agreement and the Organisation of Working Time Act are due to be sanctioned for these breaches and such sanctions used for the benefit of NCHDs.
- There is an ever-increasing reliance on non-training posts which runs counter to the agreed approach of all NCHD posts being converted to training posts.
- We lose over 450 medical trainees and newly qualified doctors each year (17% of medical graduates after the intern year with recent graduates spending longer periods abroad, 22% of trainees after Basic Specialist Training and 20% on completion of after Higher Specialist Training).[22]
- Over €832 million was spent on agency staffing in the HSE in 2025 of which over €179 million was spent on medical/dental agency staffing.[23]

[20] https://www.imo.ie/news-media/news-press-releases/2026/irish-medical-organisatio/index.xml
[21] NDTP 2026 – Medical Workforce Report 2025-2026 – HSE National Doctors Training and Planning
[22] NDTP Medical Recruitment and Retention Report 2025
[23] PQ 23540-26 Deputy Ken O'Flynn https://about.hse.ie/api/v2/download-file/file_based_publications/PQ_32540-26_-_Ken_OFlynn.pdf/

The relationship between poor working conditions, doctor burnout and patient safety is well documented[24] [25] [26]. In 2024, there were 109,300 adverse events recorded in the HSE, ranging from minor events and near misses to serious incidents resulting in patient harm.[27] The OECD estimates that 13 per cent of total health expenditure is spent on managing the clinical impact of unsafe care.[28]

Safe staffing is not just a matter of having enough staff for a given workload, but is also about ensuring staff have the knowledge, skills, and experience to operate safely.[29] Safe staffing is associated with increased productivity, including better outcomes, reduced patient mortality, reduced staff turnover and burnout, and increased job satisfaction. While a safe staffing framework for nursing has been developed by the Department of Health, no framework exists for medical staff.

In line with the recommendations of the *Report on the National Taskforce for the NCHD Workforce,* [30] priority should be given to defining benchmarks for medically safe staffing levels, including a clinician tier for a variety of clinical situations. The development of guidance on acceptable staffing levels for a given workload should also be prioritised, including the optimum number and appropriate grade of doctors necessary for a given volume of admissions, case mix, number of inpatients and outpatients covered, and support provided between specialities Workload should also factor in non-clinical tasks including education, training and supervision, quality assurance etc.

Gower and al[31] recommend that staffing levels should be flexible and consider local demand patterns, departmental configurations and specific challenges and risks associated with operations and changes in workload faced by different services. They also identify the need for real-time data to support informed decisions on staffing levels as well as risk analysis to assess safety and quality of care in different scenarios.

Other factors for consideration when establishing safe staffing levels include:

- Additional medical and multi-disciplinary staffing levels required to meet the strategic objectives to deliver consultant care over an extended working day and at weekends
- Legal requirements to comply with the Organisation of Working Time Act which regulates maximum weekly hours, rest periods, night work, and annual leave to protect employee health, safety, and welfare.
- Quality indicators such as the target to admit or discharge patients within 6 hours from arrival at the Emergency Department

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[24] Garcia CL, Abreu LC, Ramos JLS, Castro CFD, Smiderle FRN, Santos JAD, Bezerra IMP. Influence of Burnout on Patient Safety: Systematic Review and Meta-Analysis. Medicina (Kaunas). 2019 Aug 30;55(9):553. doi: 10.3390/medicina55090553. PMID: 31480365; PMCID: PMC6780563.

[25] Mul Fedele ML, López Gabeiras MDP, Simonelli G, et al. Multivariate analysis of the impact of sleep and working hours on medical errors. BMC Public Health. 2023;23(1):2317. doi:10.1186/s12889-023- 17130-4.

[26] Hodkinson A, Zhou A, Johnson J, et al. Associations of physician burnout with career engagement and quality of patient care: Systematic review and meta-analysis. BMJ. 2022;378:e070442. doi:10.1136/bmj2022-070442

[27] Bowers F. Over 109,000 adverse incidents reported in HSE last year. RTE. RTE; 2025.

[28] Slawomirski,l Klazinga N, 2022 The economics of patient safety: From analysis to action OECD Health Working Papers No. 145 https://dx.doi.org/10.1787/761f2da8–en

[29] Human Factors 101. Optimizing Staffing Levels and Workload for Safety and Efficiency. Human Factors 101.

[30]Department of Health; 2024. National Taskforce on the Non-Consultant Hospital Doctor (NCHD) Workforce: Final Recommendations Report.

[31] Gower H, Doran NJ, Hamza N, et al. Scoping review of guidance on safe non-consultant medical staffing recommendations for UK acute hospitals. BMJ Open 2025;15:e096087. doi:10.1136/ bmjopen-2024-096087

The medical staffing and skill mix should be continuously monitored to ensure that it is delivering optimal patient outcomes and robust mechanisms should be in place to report breaches of workplace safety with clear lines of senior management responsibility.

Recommendations:
The IMO is seeking engagement with the Department of Health, the HSE and other stakeholders on developing, resourcing and implementing a safe staffing framework for doctors working in HSE settings.

- **Guidance should define the optimum number and appropriate grade of doctors necessary for a given clinical workload based on the volume of admissions and acuity of patients, as well as other clinical and non-clinical workload.**
- **Consideration should be given to local factors, as well as strategic, legal and performance related requirements.**
- **The medical staffing and skill mix should be continuously monitored to ensure that it is delivering optimal patient outcomes and robust mechanisms should be in place to report breaches of workplace safety with clear lines of senior management responsibility.**
- **That any such framework reflects the contractual entitlements and rostering principles applicable to NCHDs as well as the need to ensure all NCHDs can receive appropriate training and development.**

Workforce Planning

In December 2025, the Minister for Health announced the publication of *Ireland's Future Health and Social Care Workforce*,[32] - *"Acknowledging the need to address current and future population health and social care needs, this paper sets out an evidence-informed case for change to increase the supply of the health and social care workers, enable reform, build capacity and improve access to care over the next 15 years."*

The report lays out 20 actions across 5 pillars – Plan, Build, Optimise Performance, Retain and Recruit and Invest, however implementation has yet to progress.

The report broadly estimates that a 31% increase in medical practitioners is needed by 2040 but acknowledges that there are current deficits in the number of medical practitioners that will need to be addressed, alongside more in-depth calculations to project the exact number of practitioners needed in each specialty.

Beyond aligning merely aligning training places with future demand, workforce planning must take into account safe medical staffing. As above, the development of a safe medical staffing framework is vital to identifying and addressing the current deficits in medical staffing and supports required across HSE settings to deliver safe, quality care to patients and to address burnout, improve morale and retention of the medical workforce.

In addition to population growth predictions workforce planning must take into account additional staffing requirements to deliver strategic objectives as laid out under Sláintecare, new clinical programmes and evolving models of care.

With growing demand for less than full-time working, an ageing consultant workforce and difficulties in recruiting and retaining young graduates, planning must be based on Whole Time Equivalents and predictable attrition rates.

Finally, there needs to be a swift increase in the number of postgraduate medical training places in Ireland. The number of training posts must take into consideration the needs of the current and future healthcare workforce.

The IMO supports augmenting trainee numbers in specialities where disparities exist, while simultaneously ensuring that an increase in trainee numbers is done sustainably through proper resourcing in training capacity, support for trainers, protected training time and top-quality training facilities.

Workforce planning, development across the regional health areas and training reform must be organised in tandem so that additional training places translate into a sustainable future workforce, improve access to care and promote an equitable healthcare service across Ireland.

Recommendations:

The IMO is calling on the Department of Health and the HSE to ensure that medical workforce planning and modelling aligns with:

- **Predicted changes in population growth, age structure and prevalence of disease**
- **Optimal medical staffing levels and supports needed under a safe medical staffing framework**
- **Additional staffing requirements to deliver on strategic objectives, new clinical programmes and evolving models of care**

[32] Department of Health 2025, *Ireland's Future Health and Social Care Workforce*, Dublin DOH

- **Planning should be based on Whole Time Equivalents (to take into account less than full-time working) and predictable attrition rates.**

The IMO is calling for a rapid expansion of post-graduate medical training places to meet the needs of the current and future workforce needs across Ireland.

Investment in Acute Bed Capacity

Based on the projected growth and age of the population the most recent ESRI report highlights the need for an additional 650 to 950 *day patient beds* (a growth of between 25 and 37 per cent and 4,400 to 6,800 *inpatient beds* (a growth of between 40 and 60 per cent) by 2040.[33]

In March 2024, the Government published the *Acute Hospital Bed Capacity Expansion Plan 2024-2031*[34] providing for an additional 3,438 inpatient beds by 2031, however, figures show that as of December 2025, just 254 new acute beds had been delivered (292 by June 2026) with a net increase of 157 beds available since the *Acute Inpatient Bed Capacity Expansion Plan* was announced in 2024.

Figures from 2025 show the majority of Model 3 and 4 hospitals are operating beyond the recommended 85% occupancy rate, while 8 hospitals had occupancy rates over 100%.

Insufficient capacity manifests overcrowding and delays in our Emergency Department with consequent impact on patient care. INMO figures show that there was over 114,000 patients boarding on trolleys in Emergency Departments and Wards in 2025 while just 57.9% of patients are admitted or discharged within the target of 6 hours. [35]

The results of ED crowding are compromised care with patient and staff dissatisfaction[36] [37] delays in receiving time sensitive treatments such as receiving antibiotics in patients with pneumonia[38] [39], delays in receiving pain medication[40], delays to treatment of heart attacks[41], delays in trauma care[42], patients leaving without being seen[43] increased length of hospital stay[44] and increased mortality.[45]

The IMO is calling on the Government to:

- **increase the number of new inpatient beds from 3,438 to at least 5,000 under the *Acute Hospital Bed Capacity Expansion Plan 2024-2031***
- **develop a detailed plan laying out the costs, timeline and staffing for the delivery of new hospital beds. This should be kept under ongoing review.**
- **publish a quarterly report on the actual number of new acute inpatient hospital beds, mental health beds, nursing home beds and rehabilitation beds being opened in excess of the current number and broken down by Regional Health Area.**

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[33] INMO Trolley Watch 2025

[34] Government of Ireland 2024, *Acute Hospital Bed Capacity Expansion Plan 2024-2031* Dublin: 2024

[35] HSE Management Data Report December 2025 https://about.hse.ie/api/v2/download-file/file_based_publications/Management_Data_Report_December_2025.pdf/

[36] Tekwani KL, et al. Emergency Department Crowding is Associated with Reduced Satisfaction Scores in Patients Discharged from the Emergency Department. Western Journal of Em Medicine: Integrating Emergency Care with Population Health. 2013;14(1):11-5.

[37] Rondeau KV, Francescutti LH. Emergency department overcrowding: the impact of resource scarcity on physician job satisfaction. J Healthcare Manag. 2005;50(5):327-40; discussion 41-2.

[38] Pines JM, et al The association between emergency department crowding and hospital performance on antibiotic timing for pneumonia and percutaneous intervention for myocardial infarction. Acad Emerg Med. 2006;13(8):873-8.

[39] Bernstein SL, Aronsky D, Duseja R, Epstein S, Handel D, Hwang U, et al. The effect of emergency department crowding on clinically oriented outcomes. Acad Emerg Med. 2009;16(1):1-10.

[40] Hwang U, Richardson LD, Sonuyi TO, Morrison RS. The effect of emergency department crowding on the management of pain in older adults with hip fracture. Journal of the American Geriatrics Society. 2006;54(2):270-5.

[41] Schull MJ, Vermeulen M, Slaughter G, Morrison L, Daly P, Schull MJ, et al. Emergency department crowding and thrombolysis delays in acute myocardial infarction. Annals of Em. Med. 2004;44(6):577-85.

[42] Richardson D, McMahon KL. Emergency department access block occupancy predicts delay to surgery in patients with fractured neck of femur. EMA - Emergency Medicine Australasia. 2009;21(4):304-8.

[43] Weiss SJ, Ernst AA, Derlet R, King R, Bair A, Nick TG. Relationship between the National ED Overcrowding Scale and the number of patients who leave without being seen in an academic ED. Am J Emerg Med. 2005;23(3):288-94.

[44] Liew D, Liew D, Kennedy MP. Emergency department length of stay independently predicts excess inpatient length of stay. Med J Aust. 2003;179(10):524-6.

[45] McCarthy ML. Overcrowding in emergency departments and adverse outcomes: Death and admission rates are higher when length of stay is longer. BMJ. 2011;342(7809). .

Increase and Decrease in Inpatient Beds since March 2024

NEW REGIONAL GROUPS	Beds Committed*	Beds Planned 2025-2031*	Beds Delivered in 2025*	Beds Delivered to Jun 2026****		Total Beds Dec 2024**	Total Beds Dec 2025**	Occupancy Rates 2025***
Dublin and Midlands								
Total Children's Health Ireland	27					361	361	86.8%
Coombe Women and Infants UH						189	189	92.5%
Midlands Regional Hospital Portlaoise		48				139	139	81.1%
Regional Hospital Mullingar		48				203	203	94.2%
Midlands Regional Hospital Tullamore		72				233	233	97.4%
Naas General Hospital		48				202	202	86.6%
St James' Hospital	6	159	6			727	739	97.2%
St Luke's Radiation Oncology network						56	56	82.1%
Tallaght University Hospital		196				472	472	105.2%
Dublin & South East								
National Maternity Hospital	60					152	152	76.7%
Royal Eye and Ear Hospital						25	25	42.7%
St Columcille's Hospital		24				115	115	92.2%
St Luke's General Hospital Kilkenny	18	64	18			260	274	113.6%
St Michael's Hospital Dun Laoighaire		24				96	96	93.0%
St Vincent's University Hospital	6	189				546	546	111.5%
Wexford General Hospital		97				222	222	99.6%
National Rehabilitation Hospital		60				120	120	97.0%
Tipperary General Hospital (TUH)		48				250	250	103.6%
University Hospital Waterford		98				472	472	86.9%
Kilcreene Orthopaedic Hospital	18		8			20	32	52.3%
Dublin & North East								
Cappagh National Orthopaedic Hospital		30				101	95	46.7%
Mater Misericordaie UH	11	122	10			696	671	95.0%
Our Lady's Hospital Navan		15				102	102	88.3%
Beaumont Hospital		232		20		726	726	95.9%
Cavan & Monaghan General Hospital		74				242	242	85.7%
Connolly Hospital	15	48	15			364	364	96.7%
Louth County Hospital						1	1	
Our Lady of Lourdes Drogheda	16	96	15			443	458	94.6%
Rotunda Hospital		6				168	168	102.0%
HSE West & NorthWest								
Galway University Hospital		228				665	665	na
Letterkenny General Hospital		72				378	378	93.2%
Mayo General Hospital		96				272	272	87.7%
Portinuncula Hospital	10	6	10			195	186	72.7%
Roscommon Hospital		20				66	66	85.7%
Sligo Regional Hospital	69		26			318	318	95.1%
HSE South West								
Bantry General Hospital		24				47	47	96.2%
Cork University Hospital	1	341	18			652	675	91.7%
Cork University Maternity Hospital						193	193	70.2%
Mallow General Hospital		24		24		71	71	62.0%
Mercy University Hospital		82				200	200	108.0%
South Infirmary Victoria UH						121	121	85.8%
University Hospital Kerry		108				283	292	82.1%
HSE Midwest								
Croom Orthopaedic Hospital						44	44	85.7%
Ennis Hospital		48				50	50	105.6%
Nenagh Hospital		24				52	52	92.1%
St John's Hospital Limerick		42				89	89	89.9%
University Hospital Limerick	184	84	128			538	650	111.3%
University Maternity Hospital Limerick						102	102	79.7%
National Total:	**441**	**2997**	**254**	**44**		**12039**	**12196**	

*Source * PQ 57695/25 M Daly TD ** PQ 12142/26 D. Cullinane TD ***PQ 5699/23 M. Daly TD**** Dáil Ques 9 July 2026*

Healthcare Facilities as Critical Infrastructure

In 2025, the Government committed to spending €9.25bn on health capital projects over the next five years under the revised National Development Plan including the expansion of acute bed capacity and the delivery of surgical hubs and elective hospitals; however, the IMO are concerned that the pace of investment is too slow.

In addition to delays in the delivery of new inpatient beds, access to care is further exacerbated by the delays to other capital projects such as surgical hubs and elective hospitals.

In December 2022, the HSE promised to deliver five - shortly after this announcement, it became six - surgical hubs in Dublin, Limerick, Cork, Galway, and Waterford that would be fully operational in 12-18 months.[46] However, as of June 2026, only two have been delivered – the second one only opening in late June 2026. While the other four surgical hubs are slated to open by the end of 2026, there are doubts that these timelines will be met due to past timelines not being fulfilled.[47]

Similarly, in 2022, the Minister of Health promised to deliver elective hospitals in both Galway and Cork. This commitment later changed to four elective hospitals, the other two locations being in Dublin. As of early 2026, the elective hospitals in Galway and Cork are still in the design phase, while the Preliminary Business Case for the Dublin locations have yet to be submitted.[48]

The Critical Infrastructure Act 2026 was enacted on June 25th, 2026 and allows for the Government to fast-track certain projects and programmes aimed at the development of essential public critical infrastructure. The Minister for Public Expenditure, Infrastructure, Public Service Reform and Digitalisation can now direct public bodies to prioritise projects and programmes that are deemed as critical infrastructure developments. The aim of this Act is to minimise the bottlenecks that contribute to delays in developing critical infrastructure. The sectors that are considered "critical" are energy, water, wastewater, waste management, and transport, however, notably, essential public healthcare services are excluded from this legislation.

Recommendation:

The IMO is calling on the Government to amend the Critical Infrastructure Act 2026 to include public healthcare facilities as critical infrastructure and to streamline the development and building of vital healthcare infrastructure.

[46] Department of Health. Press release: Government approves next steps in development of new Elective Hospitals. gov.ie. Department of Health; 2022.
[47] Griffin N. Surgical hubs for Cork and Limerick years behind schedule. Irish Examiner. Irish Examiner; 2025.
[48] Houses of the Oireachtas. Hospital Facilities Dáil Éireann Debate, Wednesday - 25 February 2026. Houses of the Oireachtas. Houses of the Oireachtas; 2026.

Tax Incentives for Investment in General Practice Infrastructure

The IMO are seeking the introduction of a GP Infrastructure Investment Tax Relief Scheme. Such a scheme would only be open to individual GPs and GP partnerships. Limited entities would not be entitled to avail of such a scheme.

To increase GP capacity, it is necessary to increase the physical capacity available to General Practice to allow practices to expand and take on more staff and patients and also to enable practices to set up de novo or move premises entirely to a larger more suitable building.

In the main qualifying expenditure would consist of:

- Construction of new GP premises
- Extension and refurbishment of existing premises
- Additional consulting and treatment rooms

The cost of such expenditure would then be written off against tax due by the GP Practice over an agreed number of years.

While there is a cost to the exchequer in tax foregone, the State benefits in getting modern, fit for purpose general practice premises without having to put in the initial investment and over see the development. Moreover at a time when patient demand is ever increasing due to the twin accelerants of population growth and population ageing it is essential that we put in place measures that will not only help new practices to establish but also existing practices to expand.

Recommendation:

The IMO is calling on Government to establish a tax incentive scheme which would allow individual GPs who invest in their infrastructure to write off the cost of such investment against tax over a defined period of time.

Rural and Urban Deprivation Practices

General Practice provides care in the community. Where these communities are located in remote rural areas and urban deprived areas providing the wrap around support required as well as establishing in such areas can be difficult.

In 2019, the IMO reached agreement with the HSE on the establishment of an Urban Deprivation Allowance. This built on the 2016 agreement on the Rural Practice Support Framework. Taken together these two scheme are intended to promote, support and develop practices working in such areas. However, both schemes must now be increased, expanded and improved to ensure that the patients living in such communities can continue (or in some cases, start) to access GP care in a timely manner.

A 2021 ESRI report noted that "In Ireland, those living in areas with highest levels of deprivation make significantly more use of GP services, even after controlling for many factors affecting the need for GP care and GP supply."[49]

This increased demand reflects the increased healthcare need such patients have. At present, dedicated funding for GP practices working in areas of deprivation accounts for €3 million annually. For rural practices the total funding by way of direct grant is €5 million. The scheme need to be reviewed and funding dramatically increased in order to meet the increased difficulties faced by patients and GPs working in these areas.

Recommendation:

The IMO are calling for an increase in dedicated funding for both rural practices and urban deprived practices.

[49] Barlow P, Mohan G, Nolan A, Lyons S. Area-level deprivation and geographic factors influencing utilisation of General Practitioner services. SSM - Population Health. 2021 Sept;15(15):100870.

Universal Expansion of the Chronic Disease Management Programme in General Practice

The Chronic Disease Management Programme, negotiated as part of the 2019 GP Contract, is an example of how with appropriate resourcing and planning, new programmes of care can be successfully delivered in the community.

The Chronic Disease Management Programme was launched in January 2020. In 2022, it expanded into three sub-programmes which include the Chronic Disease Management Treatment Programme, the Prevention Programme and the Opportunistic Case Finding Programme.

The Chronic Disease Management Programme is open to individuals who have either a Medical card or GP Visit card. The Chronic Disease Treatment Programme is open to those who have been diagnosed with at least one of the following chronic conditions:

- Type 2 diabetes mellitus
- Ischaemic heart disease
- Atrial fibrillation
- Heart failure
- Cerebrovascular accident (CVA)
- Transient ischaemic attack (TIA)
- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma

Furthermore, the Prevention Programme is available to those with hypertension, pre-diabetes, GDM, pre-eclampsia, Q-Risk ≥ 20%, elevated B-type natriuretic peptide (BNP) and the Opportunistic Case Finding Programme identifies patients at high risk for cardiovascular disease, diabetes and chronic kidney disease.

An audit by the ICGP[50] found substantial reductions in unscheduled care utilisation with participants enrolled in the programme experiencing 30% fewer ED attendances, 26% fewer hospital admissions and 33% fewer GP out-of-hours visits. Furthermore, nearly 91% of chronic disease care is provided exclusively in General Practice and not the hospital.

Across the Chronic Disease Management Programme, the following progress has been made to date:

- 263,245 have taken part in the Prevention Programme, with 32,097 (12.2%) receiving the care needed to prevent their entry into the Chronic Disease Management Treatment Programme.
- 567,775 patients have taken part in the Chronic Disease Management Treatment Programme to date.
- There have been 309,780 patients that have been part of the Opportunistic Case Finding Programme.

Since its implementation, the Chronic Disease Management Programme has also proved to drastically improve lifestyle outcomes between the first and third visit for those taking part in the programme:

- A 16% reduction in patients who smoke
- A 56% reduction in those who report inadequate physical activity

[50] HSE 2025 The Third Report of the Structured Chronic Disease Management Treatment Programme in General Practice

- A 13% reduction in obesity

There has also been significant reduction in patients with HbA1C levels >=64mmol, hypertension, and LDL cholesterol.

With an estimated 1.3 million people in Ireland living with one or more of the major chronic conditions, (CVD, COPD, asthma or diabetes)[51] expansion of the Chronic Disease Management Programme on a universal basis to the population over 18 would lead to significant improvement in health.

Recommendation:

The IMO are calling for the Chronic Disease Management Programme in General Practice to be expanded on a universal basis to all patients with specified chronic conditions over 18 years old.

[51] HSE National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland 2020-2025