IMO Submission to the Evaluation of the Response to the COVID 19 Pandemic

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The Irish Medical Organisation (IMO) is the trade union and representative body for all doctors in Ireland including Consultants, NCHDs, General Practitioners, Public and Community Health Medicine.

From the outset, and throughout the evolving waves and phases of the COVID 19 pandemic the IMO, as a key stakeholder in the delivery of healthcare, worked proactively with the Department of Health and the HSE. Doctors across all healthcare settings rapidly adapted to the new reality of delivering healthcare to patients as part of the national effort.

The combined efforts of doctors and other frontline healthcare workers, coordinated and consistent public health messaging from NPHET during the pandemic and the support of the public around mitigating the spread of infection through social distancing, mask-wearing and vaccinations ensured that Ireland had among the lowest excess mortality rates due to COVID 19 in the EU. As a trusted profession many doctors participated in extensive public health messaging through the media.

The evolution of the pandemic as it pertained to the health services, doctors and patients involved in the early stages:

- The cancellation of all non-urgent or time sensitive elective care in hospitals as the system became quickly overwhelmed with patients requiring care associated with COVID 19;
- Rapid adaptation of the General Practice model so as to ensure it could manage both COVID and non-COVID related healthcare and take on additional covid related work;
- Deployment of doctors from across the system to covid related activity in terms of treating covid patients and in relation to outbreak management, testing and contact tracing and implementation of public health measures;
- Agreement with private hospitals to make available additional acute and ICU/HDU beds to the public health system.

Doctors across all healthcare settings responded positively to the national effort at this time and continued to deliver care in the most challenging of circumstances where they were working long hours without rest, unable to access appropriate PPE and in addition to their working lives engaged in significant out of hours activity on COVID related educational webinars as the disease and public health related restrictions continued to evolve. This had a significant impact on their physical and mental health particularly in the care of critically ill covid patients who were without family during their period of hospitalisation. Levels of stress and risk of burnout amongst the medical profession increased significantly.

As the system adapted to a new reality and began opening, on a phased basis, services in an environment of social distancing and infection control doctors and other healthcare colleagues again pivoted to delivering care in different ways eg. Video consults and managing patients with limited in-person contact.

The very welcome introduction of a national vaccination programme once again necessitated doctors rapidly adjusting workflow and priorities to ensure the successful roll out of the programme. As trusted professionals doctors extensively engaged in educating and reassuring the public on the benefits of the vaccine which in no small part ensured a successful roll out in

terms of update and delivery. The only obstacle to a fast vaccine roll out was the availability of vaccines which meant GPs and Community Health Doctors had to respond in real time to delivering vaccines to the relevant patient cohorts as supply became available. Given the nature of the delivery of vaccines in the early stages of the campaign this required significant out of hours work which was willing undertaken by doctors and their teams to protect patients.

At all stages of the pandemic, the various waves of COVID, continued to result in pressures across the system and the challenges of reintroducing services and management of a vaccine programme at the same time should not be underestimated.

However the COVID 19 pandemic exposed the underlying fragility of our health services. Decades of underinvestment left us with overwhelming capacity and medical workforce issues across the whole system. The health service entered the pandemic already overstretched, under resourced and operating at dangerous capacity levels.

The Key issues facing our members were

Insufficient acute bed capacity critical care and inpatient bed capacity – Ireland had and still has among the lowest number of inpatient beds (2.9 per 1,000 population) and critical care beds (5.2 per population) in the EU and the highest occupancy rates (89.9%). It was estimated that Ireland required up to 5,000 additional inpatient beds and 300 critical care beds to meet population demand. Even with the temporary agreement with the private hospitals to make available an additional 2000 beds and approximately 100 Intensive Care and High Dependency Units (HDUs)to the public health system, capacity still fell below requirements.

Furthermore, the HSE estimated that social distancing and infection control measures had reduced capacity by on average 25% and up to 50% in some specialties such as surgery while at the same time 15- 20% spare capacity was required in the likely event of a surge.

The lack of inpatient and critical care capacity had significant implications on patient care across the system including:

- Doctors were confronted with difficult decisions in relation to prioritising patients in a system beset by chronic bed shortages;
- Delays in accessing time sensitive diagnostics and cancer care treatment;
- Patients presenting late or non-presentation for fear of contracting COVID 19 and of burdening the system;
- Growing backlog of waiting lists for non-urgent outpatient and inpatient care;
- Cancellation of key prevention programmes including cancer screening programmes and school vaccination programmes.
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Poor IT infrastructure across hospital and community services- Many services adopted remote consultations, however doctors largely expressed dissatisfaction with telemedicine – with concerns around security and their ability to provide safe consultations. Across hospital and community services, poor IT equipment, software or private rooms limited the possibilities to undertake video consultations or for multi - disciplinary team meetings. Ongoing use of paper based records hindered the smooth transfer of patients between settings. The cybersecurity attack on the HSE in May 2021 further compounded existing challenges in delivering care, with IT systems across the HSE effectively shut down.

Under resourcing of Public Health - Despite the key role played by Public Health doctors, Public Health Departments across the country were significantly under-resourced and understaffed and there was poor understanding of the role of Public Health medicine prior to the pandemic.

The failure to invest in an electronic case management system for public health hampered timely and efficient testing and contact tracing.

Insufficient staffing levels- COVID 19 exacerbated pre-existing staff shortages with the vast majority of hospital and community based teams working even longer hours to cover deployment of staff to COVID 19 care, requirements to self-isolate or take sick leave if displaying symptoms or contracting the virus and reduced productivity as a result of infection control measures. Across the HSE and General Practice significant difficulties arose in sourcing locums affecting the ability of doctors to take either sick leave or annual leave.

Poor protection and supports for healthcare workers - PPE was in adequate (both in terms of availability and suitability) particularly during the first wave as globally health systems competed for PPE, exposing doctors and other healthcare workers and their families to risk of infection.

COVID 19 without doubt had a significant impact on the mental health of doctors . Across the system, there was an absence of adequate supports for doctors both in terms of occupational health services and mental health supports for doctors dealing with sudden additional deaths from COVID 19. There was little or no opportunities for doctors and other healthcare professionals to debrief from the traumatic events of the day.

Mixed political and public health messaging - Coordinated and consistent public health messaging from NPHET during the pandemic and the actions of the public (social distancing, mask-wearing vaccinations etc) ensured that infection rates in Ireland among the general population were low. It was critical that public health messaging is coordinated and aligned across the system to maintain public confidence and understanding. During the Omicron wave there was a significant shift in policy which was contrary to public health advice and led to a surge in disease.

Key lessons and Recommendations

The COVID 19 pandemic highlighted that when the Government and HSE work proactively and collaboratively work with doctors better outcomes are possible which benefit patient care and the development of our health services.

The lack of capacity within the health system pre-COVID 19 meant there was little resilience available to deal with even a small surge in demand. Apart from small increases in critical care capacity and some strengthening of the Public Health Function, our health system still remains under- resourced and ill-prepared for future emergencies.

Unfortunately there has been little increase in inpatient bed capacity despite our growing and ageing population and the status quo of Emergency Department overcrowding has returned with patients boarding on trolleys, and long delays in accessing inpatient beds.

Both critical care beds and inpatient beds numbers per 100,000 population still fall far below the EU average. Data from the HSE shows that average occupancy rates for the first half of 2025 exceeded 95.9% with nine hospitals operating beyond full capacity and well beyond safe occupancy rates of 85%. [1]

Table 1 – Source OECD

	2019	2023	EU Av 2023
Critical care beds per 100,000 population	5.2	6	17
Acute beds per 1,000 population	2.9	2.9	4.2
Occupancy rates (acute beds)	89.9%	87%	71%

> *This combination of limited capacity and intensive utilisation creates a system with little operational flexibility year-round; however, hospitals remain particularly vulnerable to predictable seasonal pressures, generating recurrent winter overcrowding and necessitating postponements of elective activity that compound existing access challenges. The COVID-19 pandemic highlighted the vulnerability of this configuration: with minimal surge capacity, hospitals relied on stringent public health measures imposed between 2020 and 2022 and increasing intensive care bed capacity to avoid system collapse. While these measures preserved acute care functionality, they also underscored the strategic importance of expanding baseline capacity to absorb routine fluctuations in demand to safeguard access and quality of care.[2] (OECD 2025)*

The tragic experience of COVID-19 among nursing home patients has highlighted the urgent need to plan appropriately for the health and social care needs of our older citizens. Despite our growing and ageing population and multiple reports including the report of the Covid 19 Expert panel on Nursing Home Care, there are ongoing issues for older patients with up to 400 patients delayed in hospital while awaiting access to appropriate rehabilitative care, home care supports or long term nursing home care

HSE data shows that the number of specialists across hospital, community and GP settings still falls far below the recommended levels. Based on our current population levels, approximately 2,000 additional consultants are required to assure a consultant delivered healthcare service while recent projections from the ESRI estimate that 943-1,211 additional GPs are needed by 2040.[3]

Future pandemics and severe health emergencies are inevitable but may not necessarily take the same form as COVID 19. In order to ensure that our system has the capacity and resilience to meet future emergencies, investment is required right across the health system to ensure minimum disruption to normal services.

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[1] https://www.irishtimes.com/health/2025/09/10/two-thirds-of-public-hospitals-at-unsafe-bed-occupancy-in-first-half-2025-data-show/

[2] OECD 2025, State of Health in the EU Ireland Country Health Profile 2025

[3] 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.

Recommendations

1. **Capacity and Infrastructure across the Health System**
   - **Increase the number of new inpatient beds from 3,438 to 5,000 under the *Acute Hospital Bed Capacity Expansion Plan 2024-2031* and publish a detailed plan laying out the costs timeline and staffing for the delivery of new beds;**
   - **Increase critical care capacity to 550 critical care units; Ensure that inpatient and critical care units operate at or below the recommended 85% safe occupancy rate to allow for surge capacity;**
   - **Publish and resource an investment plan to fully digitalise the health service over the next five years;**
   - **Introduce measures to address infrastructure capacity in General Practice to ensure it can meet the shift of care to community.**

2. **Medical Workforce Planning**
- **Develop and fund a comprehensive medical workforce plan across all services and healthcare settings to meet the needs of our growing population and which has built in resilience for surges in demand;**
- **Address ongoing challenges in recruitment and retention including on-going chronic staff shortages and workload pressures that impact on safety and well-being of patients and doctors.**

3. **Public Health and Disease Surveillance**
- **Ensure ongoing investment in public health and disease surveillance including:**
  - **Resource Full multi-disciplinary teams to support consultants in Public Health medicine across all domains;**
  - **Roll out of an electronic case management system to support testing and tracing and disease surveillance.**

4. **Pandemic Preparedness and Response**
- **Ensure appropriate supplies of PPE and essential medicines are available in case of emergency. Diversify supply chains to ensure supplies are maintained ;**
- **Ensure adequate risk assessments are carried out across all health settings;**
- **Regularly review national pandemic response plans to ensure they reflect potential threats and that surge capacity can be deployed at short notice.**

5. **Public Health Messaging**
- **Maintain clear public health messaging and develop a strategy to combat misinformation around disease and vaccinations.**

6. **Protection and support for doctors and other healthcare workers**
   - **Support doctors with young families through the provision of child care options in line with working hours;**
   - **Provide appropriate supports for doctors and healthcare staff including consultant led occupational health services and a range of mental health supports;**

- **Develop resilience rostering to cover close contact exclusion and sick and absent workers;**
- **Supports for Health workers who contracted Long COVID during the pandemic should be reinstated and Long COVID should be recognised as an occupational health disease.**