

IRISH PATIENTS' ASSOCIATION

Activity Report Series

Report No 02/2026

February 2026

A periodic record of patient advocacy activity, drawing on real patient cases to document emerging patterns, systemic pressures, and the lived experience of navigating Ireland's health system.



Irish Patients' Association

Stephen McMahon
Irish Patients Association

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Author
Stephen McMahon

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About the series

The Activity Report Series provides a periodic record of patient advocacy activity undertaken by the Irish Patients' Association. Drawing on patient cases handled by the Association, the reports highlight recurring themes, systemic pressures, and emerging issues affecting patients navigating the Irish health system.

These reports contribute to the ongoing public record of patient experience and system performance within the Irish health system.

OVERVIEW

In February 2026 the Irish Patients Association handled 25 active patient cases and responded to 16 media enquiries. Research published during the month covered national waiting list trends, the financial burden of cross-border healthcare, the predictable surge pattern around public holidays, and the governance failures underlying the Rotunda Hospital planning controversy.

Sustained across a full year, this operational rate equates to approximately 300 patient advocacy cases and 190–200 media engagements annually — delivered by a voluntary organisation without core State funding.

The Association is supportive of the ethical use of AI and acknowledges that without AI-assisted research and drafting support, a package of this scope and analytical depth would be near impossible to produce on a timely basis. Voluntary organisations with limited resources should consider the strategic case for integrating AI tools into their operations — access to AI levels the intellectual and research capacity available to organisations regardless of scale. AI-assisted drafting and research support was used in the preparation of this report. All analysis, interpretation, judgement, and conclusions are entirely those of the Irish Patients Association and its author.

PATIENT CASEWORK

The 25 cases handled in February spanned clinical care reviews, consent and information failures, waiting list navigation, cross-border treatment access, complaints escalation, and administrative delays. In each case the patient is seeking something very basic: a clear answer, an understanding of where they stand, and a pathway through a system that is often difficult to navigate. **Across the Association's casebook, the same themes recur in the language patients use to describe their experience,**

On Communications

"I know the doctors are busy, but sometimes it feels like you are talking into the air. You leave the appointment still not understanding what happens next."

"The hardest part is not knowing. If someone just explained clearly what is happening and why, it would make a huge difference."

On Consent and Information

"I left the appointment and realised I didn't really understand what had been agreed. I had questions afterwards but didn't know who to ask."

On Waiting Lists

"You feel like you are somewhere in a system but you cannot see where you are in the queue or how long it might take."

On Cross-Border Treatment

"I didn't know treatment abroad was even possible until someone told me. It shouldn't be that hard to find out what your options are."

On Navigating Complaints

"It's not that there aren't processes, it's that nobody explains how you are supposed to use them."

The cases differ. The underlying need does not.

The need to be treated with dignity and respect — to be seen and to be listened to — lies at the heart of every patient encounter. Because no matter how shattered the body or mind, the spirit is there all the same. Protecting that awareness is protecting the patient's most fundamental right.

Patients have the right to be informed. They have the right to access the information that concerns their own care. They have the right to give meaningful consent, and to have complaints heard and resolved in a timely manner. And above all else, they have the right to trust the system that is meant to care for them.

These rights are not aspirational. They are the baseline of ethical healthcare.

Over more than thirty years of patient advocacy, and across approximately 500 cases each year, the Irish Patients Association has engaged with an estimated 15,000 patients. Their experiences have helped illuminate where the system works — and where it does not.

These are not isolated cases. They reflect patterns that continue to appear in the Association's February caseload, and across every month of its work.

SYSTEMIC ANALYSIS

Five structural failures recur consistently across the February casework.

Communication as a patient safety issue.

Patients leaving appointments without understanding their diagnosis, treatment pathway, or waiting list position are not experiencing a courtesy failure — they are experiencing a patient safety failure.

Inaccessible information.

Information exists within the system but is not reliably conveyed in ways patients can act on. The problem is not absence of information; it is delivery failure.

Opaque waiting pathways.

Patients cannot determine their position, likely timeframe, or options. Transparent waiting list management is a basic governance standard, not an aspirational one.

Administrative complexity imposed on patients.

Patients routinely require advocacy support simply to navigate complaint procedures, clinical review pathways, or cross-border treatment applications. Systems that require expert navigation to access are systems that exclude the people who most need them.

Disregard for partnership in care.

Patients consistently report not being listened to or treated as participants in decisions about their own health. This is both a dignity issue and a clinical risk.

These failures are structural. They recur because they are not being addressed at the level at which they originate.

RESEARCH

Four substantive research outputs were produced during February. Taken together they document not only the scale of system failure but the financial and geographic consequences for the patients that failure leaves behind.

1. National Waiting List Trend Analysis — January 2025 To January 2026

1.3 out of every 4 uninsured adults is on a public waiting list

2,146,429 uninsured adults — 690,478 adults waiting across OP, IPDC and GI lists (January 2026)

Despite a confirmed €420 million waiting list initiative in 2025, the national outpatient waiting list surged by over 24%, adding nearly 124,000 patients to reach 631,608 by January 2026. The inpatient and day case list rose 27.5% to reach 105,501. The number of patients waiting over a year for surgery increased by 74%.

The system showed no signs of recovery at the turn of the year. The combined outpatient and inpatient lists grew by nearly 64,000 patients in the single month between December 2025 and January 2026.

Specialty	Jan 2025	Dec 2025	Change
Orthopaedics	61,309	70,262	+14.60%
Dermatology	50,864	56,894	+11.85%
Urology	21,949	24,405	+11.19%
Cardiology	37,356	39,803	+6.55%
Otolaryngology (ENT)	33,948	34,578	+1.85%

Adult specialty outpatient volumes, January 2025 – December 2025. Source: NTPF / IPA analysis.

The outpatient wait-time distribution as of 29 January 2026 confirms a substantial long tail. Of the 666,607 patients on the combined national outpatient list:

Wait Duration	% of Total	Number of Patients
0–6 Months	56.7%	378,098
6–12 Months	25.8%	171,943
12–18 Months	9.4%	62,659
18 Months +	8.1%	53,907

Total national outpatient list distribution, 29 January 2026. Source: NTPF / IPA analysis.

The concentration of long waiters at specific hospitals is stark. Galway University Hospitals reported 5,982 adult outpatients waiting over 18 months — the highest volume nationally. Beaumont Hospital reported 589 adult patients in the 18-month-plus day case category as of 29 January 2026.

A critical limitation underpins all waiting list reporting: the NTPF does not collect activity data. Published figures represent monthly snapshots of those waiting at a fixed point in time. They do not account for patients successfully treated or removed or added during the reporting period. The churn of the list remains invisible to the public.

Further structural pressure on demand is the erosion of private insurance coverage. While 46% of the population holds private cover, market growth has slowed to 1.3% annually. The 18–39 age group now has the lowest coverage rate in the population, ranging from 38.9% to 43.3%. As younger cohorts find private insurance unaffordable perhaps due to other costs of rental, food, travel etc, demand on public services increases across every waiting list category. These are the very patients who will need timely access to public care in the future.

2. Financial Burden of Cross-Border Healthcare

This analysis, A first cut to express cross-border procedure costs as weeks of gross household income across defined income profiles — quantifies what the EU Cross-Border Healthcare Directive costs Irish patients in practice. The findings expose a scheme that functions as a relief valve for those who can afford it, not a universal right for those who need it.

All figures are gross. No deductions are made for tax, PRSI, USC, or ordinary household expenditure. The true affordability burden is materially higher than the figures shown.

The Full Cost Picture

For each procedure, three figures define the patient's financial exposure: the total upfront commitment required before any reimbursement is received; the amount recoverable under the HSE DRG ceiling after approximately 16 weeks; and the unrecoverable costs that remain a permanent loss regardless of any scheme. These are the max amounts allowed by the HSE, however prices may be more competitive in other member eu states even allowing for fees for agents who make arrangements.

Procedure	Total Upfront	Recoverable (HSE DRG)	Unrecoverable
Hernia	€10,396	€8,896	€1,500
Hip Replacement	€17,395	€14,895	€2,500
Breast Reconstruction	€26,957	€24,057	€2,900
Spinal Fusion	€55,622	€51,622	€4,000

Recoverable amount assumes the foreign bill does not exceed the Irish HSE DRG ceiling. Reimbursement period approximately 16 weeks. Unrecoverable costs include travel, accommodation, and borrowing costs. Source: IPA Financial Burden Analysis, February 2026

Upfront Capital Commitment

Before any reimbursement is received, a patient must fund the full procedure cost. For a single pensioner on €299 per week, spinal fusion requires 186 weeks of gross pension income — more than three and a half years — to be committed upfront, pending reimbursement after approximately 16 weeks.

Procedure	Single Pension	Couple Min.	Couple Max Band	Couple 150%
Hernia	35 weeks	17 weeks	10 weeks	7 weeks
Hip Replacement	58 weeks	29 weeks	17 weeks	11 weeks
Breast Reconstruction	90 weeks	45 weeks	26 weeks	17 weeks
Spinal Fusion	186 weeks	93 weeks	53 weeks	35 weeks

Weeks of gross household income required to fund total upfront procedure cost. Income profiles: Single Pension €299/wk; Couple Minimum Pensions €599/wk; Couple Medical Card Maximum €1,050/wk; Couple 150% Band €1,575/wk.

The Unrecoverable Burden — What No Scheme Refunds

Reimbursement covers the clinical element only. Travel, accommodation for patient and carer, and borrowing costs during the 16-week reimbursement period are permanent, certain, and entirely the patient's to bear. They cannot be reclaimed under any scheme.

Procedure	Unrecoverable €	Single Pension	Couple Min.	Couple Max Band	Couple 150%
Hernia	€1,500	5 weeks	3 weeks	2 weeks	1 week
Hip Replacement	€2,500	8 weeks	4 weeks	3 weeks	2 weeks
Breast Reconstruction	€2,900	10 weeks	5 weeks	3 weeks	2 weeks
Spinal Fusion	€4,000	13 weeks	7 weeks	4 weeks	3 weeks

Unrecoverable costs: travel, accommodation (patient and carer), and estimated borrowing costs during 16-week reimbursement period. Source: IPA Financial Burden Analysis, February 2026.

The Geographic Premium: An Unquantified Inequity

The unrecoverable cost figures above represent a national average. They do not reflect the materially higher burden carried by patients travelling from regional Ireland.

A patient in Dublin accessing treatment in Belgium faces one outbound flight, one return flight, and one hotel stay for themselves and their carer. A patient from Donegal, Kerry, or Mayo faces all of that — plus return travel to Dublin airport, which may require an overnight stay in Dublin before departure and additional accommodation on return if recovery prevents same-day travel home. The carer bears the same compounded costs.

The reimbursement ceiling is identical regardless of where in Ireland the patient begins their journey. The scheme treats a patient in Rathmines and a patient in Castlebar as financially equivalent. They are not.

This geographic premium is not captured anywhere in current reporting. It falls hardest on the patients already furthest from services, already most reliant on the public system, and already carrying the greatest waiting list burden. Geography compounds income. The scheme has no mechanism to account for either.

Endometriosis: Disease Burden, Surgical Capacity, and Cross-Border Realities

Endometriosis illustrates with particular force why cross-border access cannot function as a privilege available only to those with the financial means to use it. It is a chronic inflammatory condition estimated to affect 10% of women globally — approximately 155,000 women in Ireland. The average diagnostic delay in Ireland is nine years. The annual economic cost per woman has been established internationally at €9,579, driven primarily by lost productivity (Simoens et al., 2012).

Applying established international epidemiological data to Ireland's baseline of 155,000 affected women, between 7,750 and 18,600 Irish women are living with severe, bowel-infiltrating deeply infiltrative endometriosis (Wills HJ et al., 2008; Kaufman LC et al., 2011). Approximately one third of women with endometriosis will experience infertility (Macer & Taylor, 2012). The HSE estimates that 47% of women with fertility issues in Ireland have endometriosis.

In October 2025 the Department of Health launched the National Framework for the Management of Endometriosis. Under this framework the HSE pledged to deliver more than 100 additional surgeries in the coming months and committed to recruiting an additional colorectal surgeon to support complex, deeply infiltrative procedures. This domestic commitment is welcome. It does not, however, address the immediate needs of women already waiting.

The Endometriosis Surgery Abroad Interim Scheme#**A Necessary but Inequitable Pathway**

To address urgent need while domestic services scale up, the HSE established the Endometriosis Surgery Abroad Interim Scheme (ESAIS). This is a targeted initiative entirely separate from the general EU Cross-Border Directive. Under ESAIS the HSE pays the approved foreign centre directly for clinical costs, and reimburses basic economy return travel for the patient and, where recommended by the Irish consultant, one accompanying carer.

What the scheme does not cover is where the equity gap opens. ESAIS explicitly excludes accommodation for patient and carer, food and daily living costs, luggage charges, local transport, and travel agent fees. These costs are permanent, certain, and fall on every patient regardless of income — on top of a condition that already costs each woman €9,579 annually in lost productivity and absence from work.

A woman with severe endometriosis travelling say from rural Connacht for surgery abroad faces the same unrecoverable accommodation and subsistence costs as a woman travelling from Dublin — plus the additional burden of getting to an international airport in the first place. The ESAIS, as currently structured, functions as a clinically necessary pathway that is financially accessible primarily to those who can absorb significant out-of-pocket international travel costs. That is not an interim scheme operating equitably. It is an interim scheme that replicates the inequities of the general cross-border system in a population of patients who are among the most clinically and economically vulnerable.

HSE Transparency: Unanswered Questions

On 26 February 2026 the Association submitted a series of questions to the HSE regarding cross-border healthcare activity, including a direct inquiry as to whether any medical conditions are prioritised in the processing of applications. Despite follow-up contact, no formal response had been received as of 7 March 2026. The Association is considering next steps.

This is a question every patient navigating the cross-border system has a right to have answered. If conditions are being prioritised, the basis for that prioritisation should be published, transparent, and accountable. Silence is not an administrative response to a patient rights inquiry.

Reform

1. The Minister for Health should fulfil the statutory obligation under the EU Cross-Border Directive to ensure the scheme functions as a universal patient right — not an option available only to those willing and able to make a significant personal financial sacrifice to access care they are entitled to by right.
2. The HSE should be directed to establish and publish the socioeconomic profile of patients accessing cross-border treatment, so that equity of access can be measured, reported, and where necessary remedied.
3. That profiling must include the geographic origin of each patient, so that the regional unrecoverable cost premium can be quantified and addressed as a distinct equity gap.
4. The HSE should publish a clear, accessible statement of whether any conditions are prioritised in the processing of cross-border and ESAIS applications, the criteria on which any such prioritisation is based, and the governance framework under which those criteria are reviewed.

A right that cannot be measured cannot be guaranteed. The time for that measurement is now.

3. Public Holiday Surge Analysis: The St. Brigid's Day Pattern

The Association published analysis of trolley figures across the three years since St. Brigid's Day became a public holiday, based on INMO Trolley Watch data. The pattern is now established and predictable.

Year	Patients on Trolleys	Change on Prior Year	Change on 2024 Baseline
2024	477	—	—
2025	793	+66.3%	+66.3%
2026	676	-14.8%	+41.7%

Patients on trolleys, day after St. Brigid's Day bank holiday. Source: INMO Trolley Watch / IPA analysis.

Year	Full Week Total	Change on Prior Year	vs 2024 Baseline
2024	3,181	—	—
2025	3,267	+2.7%	+2.7%
2026	3,430	+5.0%	+7.8%

Full working week trolley totals following St. Brigid's Day. 2026 is 7.8% higher than 2024 overall. Source: INMO Trolley Watch / IPA analysis.

In February 2025, then Minister for Health Jennifer Carroll MacNeill described the post-St. Brigid's Day spike as a “*cause for concern*” and called for a data review of consultant rostering over weekends.

The 2026 figures confirm the structural problem has not been resolved. The IMO's Consultant Committee cautioned at the time that *extending services across seven days without additional recruitment would simply redistribute existing capacity* — weakening weekday services without creating net new provision. That warning needs identifiable and transparent attention.

A predictable surge that worsens year-on-year is not a crisis. It is a managed failure.

4. Rotunda Hospital: Consequences of Policy Drift

The refusal by An Coimisiún Pleanála of the €100 million Critical Care Wing at the Rotunda Hospital on 9 February 2026 — overturning planning permission granted by Dublin City Council on 31 July 2025 — triggered political reaction and public concern about maternity safety.

However the Association published analysis situating the refusal in its full governance context. The core finding: urgency in 2026 cannot be separated from the decisions, and non-decisions, of the preceding decade.

In November 2015, Cabinet approved co-location of the Rotunda with Connolly Hospital Blanchardstown. The clinical rationale was sound — complex maternal and neonatal cases require immediate access to intensive care and interventional radiology at Level 4 centres. The National Maternity Strategy 2016–2026 reinforced that policy, explicitly referencing rising maternal age and increasing clinical complexity. Connolly was never upgraded to Level 4 status. No funded, multi-year capital programme was delivered to enable relocation.

The 2015 decision was never rescinded: it simply at best stalled.

The IMIS National Report 2024 documents what that decade of drift produced:

Maternity Indicator	2014	2024	Change
Cesarean section rate	29.6%	40.6%	+37.2%
Induction rate	—	38.5%	—
Peripartum hysterectomy per 1,000	0.36	0.50	+38.9%

Source: *Irish Maternity Indicator System (IMIS) National Report 2024, Department of Health.*

Maternity care has become more complex, more surgical, and more resource-intensive — precisely as the 2015 clinical analysis predicted. The Commission's refusal cited the existing Government co-location policy as a material consideration in declining to approve permanent expansion of the historic campus. In effect, a commitment that was never funded and never implemented was used as a reason to deny infrastructure that is needed now. That is what policy drift costs — not in the abstract, but in the physical condition of a maternity hospital serving thousands of women and newborns each year.

Safety commitments must be matched by funded implementation, clear timelines, and periodic public review. Commitments that exist only on paper do not protect patients — they accumulate as governance liability across political cycles and across Ministers.

A Call for Cabinet Decision Accountability

The Rotunda case illustrates a governance gap that extends well beyond one hospital. An Coimisiún Pleanála was fulfilling its statutory role. To direct criticism at the planning authority for the current situation is to misread the underlying cause — a Cabinet decision that was neither implemented, amended, nor formally revisited. The refusal did not create the crisis. A decade of institutional inertia did.

Cabinet decisions are made every week with consequences for public services, infrastructure, and lives. There is no statutory requirement to publish a monthly or quarterly record of those decisions, no annual report on their implementation progress, and no formal mechanism to account for decisions that were made but never acted upon.

Had such a process been in place in 2015, the drift between the co-location decision and its non-implementation would have been visible, measurable, and challengeable at each annual review. The IPA calls for the introduction of a published Cabinet decisions record and an annual implementation progress report. Decisions can be reversed for good reasons — but they should never simply be forgotten.

PROTECTED DISCLOSURE

The Association continued engagement during February on a protected disclosure matter. That engagement reached a formal response stage. The Association is considering its position.

HSE ACCOUNTABILITY MATTER

The Association continued engagement during February on a separate long-standing accountability matter with the HSE. That matter has been the subject of an independent investigation commissioned by the HSE, with findings adverse to the HSE, and has remained unresolved since 2019. The Association is considering its position.

MEDIA ENGAGEMENT

The Association responded to 16 media enquiries during February across hospital waiting lists, patient safety, cross-border healthcare, HSE governance, and European patient rights policy. Outlets included the Irish Times, Sunday Independent, RTÉ News, Irish Examiner, Journal.ie, and specialist health sector publications.

At this operational rate the Association engages with national media approximately 190–200 times per year.

EUROPEAN POLICY

On 9 February 2026 the Association issued an embargoed media release in support of formal adoption of a modernised European Charter of Patients' Rights as a priority for Ireland's Presidency of the Council of the European Union. The initiative is backed by a global coalition spanning 138 countries. A formal proposal was submitted through the Department of Foreign Affairs consultation on Presidency priorities, which received over 430 submissions in total.

The Charter initiative represents a concrete, achievable legacy for the Irish Presidency — one that would for the first time embed patients' rights in binding European governance.

SECTOR ENGAGEMENT

During February the Association accepted an invitations, to join the judging panel for the Irish Healthcare Awards 2026, and the HSE RCSI working group on the Emergency Medicine Programme and engaged with organisations planning a national conference on maternity patient safety.

CONCLUSION

The February record is a precise illustration of what a health system in institutional drift looks like from the patient's perspective. A single pensioner cannot access surgery they are entitled to without committing up to 186 weeks of pension income. A maternity hospital is left without the infrastructure it urgently requires because a Government decision made in 2015 was never implemented. A public holiday produces a trolley surge that worsens every year while the analysis explaining why sits unresolved.

The system does not lack analysis. It does not lack commitments. What it consistently lacks is implementation with accountability attached — and an honest reckoning with the cost of delay to the patients who can least afford to wait.