

IRISH PATIENTS' ASSOCIATION

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The Activity Report Series provides a periodic record of patient advocacy activity undertaken by the Irish Patients' Association. Drawing on evidence from patient advocacy, clinical data, governance analysis, and international research, the reports document systemic pressures and emerging issues affecting patients navigating the Irish health system.

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The System Pattern — What This Analysis Shows

This is not a single-issue report. It brings together evidence from multiple parts of the health system — waiting lists, stroke and neurological rehabilitation access, emergency department pressure, COVID-19 evaluation, internal audit findings, infrastructure delivery, and system vulnerability.

Each of these areas is well understood in isolation. This analysis examines what happens when they are considered together.

Across all sections, a consistent pattern is evident.

Waiting lists continue to grow, with 805,823 patients recorded in March 2026 and total system demand approaching 986,170 when all categories are included. Long-wait cohorts are increasing, confirming that backlog is ageing rather than reducing. This position is reached despite more than €1.2 billion invested in waiting list reduction programmes since 2023.

Stroke and brain injury patients wait an average of 172 days for specialist inpatient rehabilitation. Patients with prolonged disorders of consciousness wait 269 days. These are clinically significant delays in time-critical pathways, occurring in a system where outcomes are strong once care is accessed.

Emergency department data shows a 30.9% increase in patients on trolleys across a comparable five-day period following St Patrick's Day in 2026 versus 2025. This reflects sustained pressure in acute capacity during predictable demand surges.

Internal audit findings identify control weaknesses, policy non-compliance, and over 2,000 corrective actions without a centralised tracking mechanism. The COVID-19 evaluation discussion acknowledges system fragility and gaps in preparedness but does not examine accountability for implementation.

The National Children's Hospital has missed 18 completion dates, with over 200,000 children ageing out of eligibility during the delay period. Infrastructure delay is not neutral. It determines who benefits and who does not.

Individually, these findings relate to different parts of the system. Taken together, they point to a common issue.

The system does not lack data, analysis, or stated intent. The recurring gap is between what is known and what is delivered.

For patients, this is experienced as delay, uncertainty of access, and time lost at points where timing matters most.

This report presents the Irish Patients' Association's activity record for March 2026. It draws on evidence from multiple independent sources spanning patient advocacy, clinical data, governance analysis, and international research to document the condition of Ireland's health system as experienced by patients during the reporting period.

Sources Assembled in This Report

- IPA Assessment of the COVID-19 Evaluation Expert Panel discussion (30 March 2026) (Section 2)
- National Treatment Purchase Fund waiting list data for March 2026 (Section 3)
- NRH Inpatient Waiting List — Parliamentary Question Response: Response to PQ 12817 (25 February 2026), providing the waiting list breakdown across all NRH programmes (Section 3A)
- NRH Programme Outcome Data 2024: Published by the National Rehabilitation Hospital, providing waiting times, lengths of stay, and discharge destinations (Section 3A)
- NAI Pre-Budget Submission 2026: Neurological Alliance of Ireland, detailing unfunded community teams and national bed shortfalls (Section 3A)
- MY NEURO SURVEY 2024: Survey of 674 adults by the Neurological Alliance of Ireland, outlining regional access failure rates (Section 3A)
- Healthcare resource statistics — beds, Statistics Explained: Eurostat data (extracted July 2025), detailing rehabilitative care beds per 100,000 inhabitants across EU member states (Section 3A)
- Rehabilitation for Children and Young People in Ireland Following Acquired Brain Injury: August 2023 strategic report confirming Ireland's specialist workforce deficits (Section 3A)
- Specialist Rehabilitation following Major Injury (NCASRI) Final Audit Report: April 2019 national clinical audit identifying the shortfall of specialist trauma rehabilitation beds in England (Section 3A)
- Post-Acute Inpatient Rehabilitation Mapping Project — A National Overview of HSE Funded Services: September 2024 HSE report documenting the national shortfall of 175 post-acute inpatient neuro-rehabilitation beds (Section 3A)
- Audit of Delayed Transfer of Care Among Neuro-Rehabilitation Patients in Acute Irish Hospitals: 2019 HSE audit documenting 17,413 acute bed days lost due to delayed transfers (Section 3A)
- Estimates of Global Needs for Neurorehabilitation — A Systematic Analysis Based on the GBD-WHO Rehabilitation Database 2021: 2026 study outlining the global escalation of neurological disorders requiring rehabilitation (Section 3A)
- INMO Trolley Watch data — St Patrick's Day surge analysis (Section 3B)
- HSE Internal Audit findings released under the Freedom of Information Act on 23 March 2026 (Section 4)
- National Children's Hospital delay analysis (Section 5)
- International healthcare ranking and access analysis (Section 6)
- Media reporting analysis — February 2026 waiting list coverage (Section 7)

The Association notes, as in the February '26 report, that AI-assisted drafting and research support was used in the preparation of this report. All analysis, interpretation, judgement, and conclusions are those of the Irish Patients' Association and its author.

Briefly: What This Analysis Covers

Theme	Finding
Preparedness	Preparedness gaps and system fragility were explicitly acknowledged, including capacity constraints, workforce limitations, and a health system that entered the pandemic already under strain
Implementation failure	Repeated identification of problems without delivery of solutions
Patient absence	No patient or advocacy voice at the expert table
Public role	Referenced mainly as compliance and behaviour, not decision-making
Ethics	Ethical dimensions of decisions were evident, particularly in relation to restrictions and wider societal impact, but were not examined in a structured or explicit way.
Equity	Unequal impact acknowledged, but not tested or addressed as a system failure
Governance gap	Governance structures, composition, and decision-making effectiveness were questioned, with no examination of accountability or system-level responsibility
Communications	Communications were positively referenced, particularly daily briefings, with limited examination of how information was conveyed or how different perspectives were represented
Core insight	The discussion points to not a lack of knowledge, but persistent challenges in implementing, funding, monitoring, and evaluating what is already known
Accountability gap	Responsibility for action sits outside the discussion and remains unresolved
Key question	Whether the gap between knowledge and action warrants formal investigation

The discussion reflects a system that understands its failures but has not ensured that they are acted upon.

The expert panel discussion was informed, reflective, and at times candid. Key weaknesses were openly acknowledged, including lack of preparedness, structural fragility, and the consequences of delayed and disrupted care. However, the discussion also revealed a deeper and more familiar issue: not a lack of insight, but a failure to implement what is already known.

Several critical absences were evident. There was no patient or patient advocacy representation within the expert panel itself. While the role of the public was referenced repeatedly, it was largely framed in terms of compliance, behaviour, and impact rather than participation in decision-making. Ethical issues were central to the decisions described, particularly in relation to access, prioritisation, and restriction, but there was no structured examination of ethical governance or the systems required to support it in future crises.

Several important issues were acknowledged but not interrogated. It was accepted that Ireland did not follow its own pandemic plan and did not activate established emergency governance structures. This was not examined in terms of accountability or decision-making responsibility. The unequal impact of the pandemic across society was noted, including its disproportionate effect on vulnerable groups, but no structural response or corrective framework was proposed. Long-standing system pressures, including waiting lists and workforce strain, were identified as legacy risks for future crises, again without clear pathways for resolution.

Equity — a central test of any health system — was raised but not fully examined in the discussion. The characterisation of the Irish healthcare system as "generally equitable" warrants scrutiny. Evidence from the Irish Patients' Association indicates that approximately one in three individuals without private health insurance are on a public waiting list. This is not consistent with equitable access based on need. Where such assertions remain unexplored, they risk shaping policy assumptions in ways that understate the scale of structural inequity within the system.

Some of the most significant insights emerged indirectly. Dr Mike Ryan posed the question of how many recommendations are ever fully implemented, funded, monitored, and evaluated. That question goes to the heart of the challenge. It reflects a pattern long observed within the Irish health system, where reports are produced, lessons are identified, but reforms are not consistently delivered. The discussion itself was framed from the outset as not seeking to apportion blame — a position that, while understandable, also limits examination of accountability.

In her closing remarks, Professor Anne Scott observed that the principle of "Nothing about me without me" has become "a bit of background noise". The discussion itself reflected that observation. Across issues of access, prioritisation, and unequal impact, patients were present primarily at the point of consequence rather than as participants in decision-making. The principle is recognised but not yet embedded in how decisions are made. Recognition without implementation is where such principles lose force.

The overall tone of the discussion was collegiate and aligned, reflecting a high level of shared expertise. However, the absence of external challenge or perspectives beyond the expert community limited the scope of the analysis. The system, in effect, examined itself through its own lens. Patients appeared most clearly at the point of consequence — in delayed diagnoses, disrupted care pathways, and lives altered by decisions taken elsewhere — rather than as participants in the decisions themselves.

The discussion also highlighted a gap in relation to communications and the information environment. While daily briefings were widely regarded as effective, there was no examination of how media structures shaped which voices were heard and which were not. Patient and lived-experience perspectives were largely absent from that space. In a future crisis, where misinformation and fragmented communication will be even more pronounced, this omission represents a preparedness gap that requires direct attention within crisis governance.

The central lesson from this discussion is clear. Ireland does not lack knowledge of what needs to change. The gaps are known, the lessons are identified, and the risks are understood. The challenge lies in implementation, accountability, and structural reform. Without addressing both the culture of delay and the normalisation of failure to deliver, the system risks entering the next crisis with the same underlying weaknesses.

Dr Mike Ryan's question highlights a system where recommendations are repeatedly identified through investigations and reports yet not implemented in a timely or meaningful way. Change and reform in our health care system must not be preceded by preventable funerals and injury to patients.

The panel discussion identifies a consistent pattern where lessons are recognised but not implemented. It does not examine why. That gap between knowledge and action is where accountability sits, and it is not resolved within this forum. Whether that gap warrants formal investigation is a legitimate question.

IPA View

Experience, including during the pandemic, shows that when patient voice and advocacy are built into the system before a crisis, outcomes improve. The system does not always know best, and neither do advocates. Together, however, better patient-centred decisions can be made.

The COVID-19 evaluation identified a system that understands risk but does not always act on it in time.

COVID-19 was a biological contagion — a virus moving from person to person. What is now emerging is different in origin but similar in consequence. It is economic and political contagion — a crisis originating in global energy and supply systems that moves through interconnected markets until it reaches households, health services, and patients.

The Source of Disruption

Global energy and supply systems rely on a small number of critical maritime chokepoints. The Strait of Hormuz carries approximately 20% of the world's daily oil supply. Disruption at this level introduces immediate volatility into global energy markets — volatility that moves through production, transport, and supply systems, and ultimately into healthcare delivery.

The Contagion Mechanism

Economic and political contagion describes how disruption in one system transmits into others, including those that appear unrelated. The pathway is sequential and observable:

- Energy disruption → increased fuel and transport costs
- Pressure on agricultural production and food systems
- Rising household cost burden
- Industrial and labour market pressure
- Reduced access to care

An inflation shock can become an industrial relations issue. A household cost crisis becomes a health access problem. The chain is direct. The patient sits at the end of it.

EU-Level Recognition

In July 2025, the European Commission published its EU Stockpiling Strategy as part of the Preparedness Union framework. It identified food, water, energy, and medicines as critical goods requiring protection, and acknowledged gaps in coordination, logistics, and system readiness.

In the same period, the Health Emergency Preparedness and Response Authority set out its Medical Countermeasures Strategy, including strengthened stockpiling, agile manufacturing, and coordinated response mechanisms, with targets extending to 2030.

These strategies represent acknowledgement of risk. They do not indicate that the risks have been resolved.

Ireland's Position

Ireland holds strategic oil reserves managed by the National Oil Reserves Agency, legally required to maintain a 90-day supply of refined petroleum products. Approximately 57–68% of this reserve is held within Ireland, with 32–43% stored across EU and UK jurisdictions through commercial "stock ticket" arrangements.

This provides a degree of buffer for energy supply. It does not extend to medicines, diagnostic inputs, or critical medical materials — the areas where patient risk is most direct. Ireland's position as a peripheral island state increases exposure to supply chain disruption. The State is dependent on sea and air freight, with limited alternative routing options.

Clinical Example — Diagnostic Dependency and Supply Fragility

Helium provides a clear example of supply chain vulnerability. It is a critical input in MRI imaging, required to maintain superconducting magnets at operational temperature. Without it, MRI systems cannot function.

Global helium supply is highly concentrated and exposed to geopolitical disruption. Liquid helium cannot be stored long term without loss, and delivery windows are constrained. MRI is central to diagnosis across cancer, neurological conditions, and acute injury. Where supply is constrained, imaging capacity is reduced, translating into delayed diagnosis and deferred treatment.

A spokesperson for Siemens Healthineers stated told the Irish Patients Association Report Series,

"This response reflects the information available at the time it was provided, given the rapidly evolving situation.

In the foreseeable future, we do not anticipate any significant impact on our MRI business for Ireland as a result of a potential helium shortage. Together with our partners, we have robust mitigation measures in place and have successfully managed similar situations in the past. These measures include supplier and regional diversification, storage solutions, and the use of strategic reserves.

In Ireland currently we have no helium supply disruptions affecting our customers as a result of the situation in the Middle East. Our global helium team continues to monitor developments closely and, at this stage, sees no immediate risk to helium supply. The same is true for Ireland.

Looking ahead, helium will play a significantly reduced role in MRI systems supplied. Nearly half of the systems we deliver to our customers globally are helium independent MRI systems, enabled by our DryCool magnet technology. As adoption continues to grow, helium independent systems will account for an increasing share of the MRI systems we supply across Ireland. These systems require just 0.7 litres of helium — reducing consumption by more than 99 per cent compared with conventional MRI."

The question this raises is at system level. Where critical diagnostic capacity depends on global supply chains, responsibility extends beyond individual suppliers. It rests with the State and the health system to ensure that appropriate contingency planning, prioritisation frameworks, and resilience measures are in place to protect patient access if disruption occurs.

Wider Medical Supply Chain Vulnerability

Generic medicines depend on global petrochemical supply chains — including solvents, plastics, and packaging inputs linked to energy markets. Disruption increases cost, delays production, and creates supply instability. Pharmaceutical manufacturing relies on continuous movement of raw materials and active ingredients across long-distance supply routes. Medical systems operating on limited inventory buffers are particularly exposed.

The IPA's Role

The Irish Patients' Association is a patient advocacy organisation. Geopolitics, energy markets, and global supply systems are not its primary domain. Patient impact is.

Where disruption affects supply chains, decisions follow. If diagnostic capacity is reduced, which patients are prioritised and on what basis? If medicine supply is constrained, how is access determined? If system pressure increases, how is patient safety protected? These are not theoretical questions. They are the practical consequences of system stress.

The question is whether just-in-case mitigations are in place to reduce the vulnerabilities created by just-in-time dependency.

3

NATIONAL WAITING LIST ANALYSIS — MARCH 2026

Source: National Treatment Purchase Fund, 10 April 2026

805,823

Total pathways March 2026

+98,389

Year-on-year increase (+13.9%)

131,940

Waiting over 12 months

~986,170

Full system demand

Government Position and IPA Analytical Lens

The Department of Health notes that since September 2021 there has been a reduction of approximately 53% in patients waiting over 12 months, alongside an improvement of approximately 43% in Weighted Average Wait Time. These figures reflect genuine progress measured from the post-pandemic peak and are not disputed by the IPA.

Over the past three years, more than €1.2 billion has been committed to waiting list reduction — €443 million in 2023, €360 million in 2024, and €420 million in 2025.

Against that investment, the March 2026 figures show 805,823 patients waiting, a year-on-year increase of 98,389. The >12 month cohort continues to expand. The >18 month cohort, which briefly reduced in February 2026, has reversed in March.

A patient waiting today does not measure their experience against September 2021. They measure it against last year, last month, and the appointment they are still waiting for.

1. Total Waiting List Position

Metric	Mar 26	vs Feb 26	vs Jan 26	vs Dec 25	YOY vs Mar 25
Total Pathways	805,823	795,031	779,812	753,776	707,434
Mar 26 +(-) vs	—	+10,792	+26,011	+52,047	+98,389
Mar 26 % +(-) vs	—	+1.4%	+3.3%	+6.9%	+13.9%

Growth is sequentially slowing but not reversing. Absolute numbers continue to increase across all reference periods.

2. Long Waits Analysis

>12 Months+	Mar 26	vs Feb 26	vs Jan 26	vs Dec 25	YOY vs Mar 25
Waiting 12 Months+	131,940	127,572	125,344	118,331	111,350
Mar 26 +(-) vs	—	+4,368	+6,596	+13,609	+20,590
Mar 26 % +(-) vs	—	+3.4%	+5.3%	+11.5%	+18.5%
Waiting 18 Months+	59,146	57,745	58,614	52,370	51,997
Mar 26 +(-) vs	—	+1,401	+532	+6,776	+7,149
Mar 26 % +(-) vs	—	+2.4%	+0.9%	+12.9%	+13.7%

The short-lived reduction in the >18-month cohort observed in February 2026 has reversed in March. The >12-month cohort shows continuous increase, confirming backlog ageing across the system.

3. Waiting List Categories — >12 Months Analysis

Category	Mar 26 >12M Total	vs Feb 26	vs Dec 25	YOY vs Mar 25
Outpatient (OPD)	110,312	+3,593 (+3.4%)	+10,084 (+10.1%)	+15,167 (+15.9%)
Inpatient / Day Case (IPDC)	19,922	+447 (+2.3%)	+2,441 (+14.0%)	+4,399 (+28.3%)
GI Endoscopy	1,706	+328 (+23.8%)	+1,084 (+174.3%)	+1,024 (+150.1%)

GI Endoscopy — strongest deterioration signal in the dataset: the >12-month cohort grew +150.1% year-on-year, from 682 patients in March 2025 to 1,706 in March 2026. Acceleration between December 2025 and March 2026 (+174.3%) confirms the deterioration is intensifying.

4. Full System Demand — March 2026

Category	Patients
Headline Waiting	805,823
Planned Procedures	110,628
Pre-Admit	36,443
Suspended	33,283
Total System Demand	986,170

The headline figure of 805,823 represents patients actively waiting. A further approximately 180,000 patients sit outside this figure in planned, pre-admit, and suspended categories. Total system demand is approaching one million patients.

5. Hospital and Specialty Examples

Specialty / Hospital	Mar 25	Mar 26	+(-)	YOY %
Beaumont Hospital (Adult Outpatient)	40,505	54,019	+13,514	+33.4%
Orthopaedics (Adult Outpatient)	62,988	75,880	+12,892	+20.5%
Dermatology (Adult Outpatient)	52,638	57,082	+4,444	+8.4%
GI Endoscopy >12 Months	682	1,706	+1,024	+150.1%

Beaumont Hospital's adult outpatient waiting list grew +33.4% year-on-year — more than double the national outpatient average of +11.8% — indicating significant local capacity constraint or referral concentration above the national pattern.

The relevant question is not whether progress has been made since 2021. It is whether the current trajectory is sufficient to reduce the backlog in a meaningful and sustained way. The data indicates that it is not.

A patient waiting today does not measure progress from a 2021 baseline. The experience is defined by current waiting time, uncertainty of access, and the impact of delay on health and quality of life. The continued growth in long wait categories reflects a system where delay remains a routine feature of care rather than an exception.

The data demonstrates a system under sustained pressure, where waiting list growth continues despite increased activity and significant financial investment. The backlog is not reducing. It is ageing.

3A

STROKE & NEUROLOGICAL REHABILITATION — THE INVISIBLE WAITING LIST

National Rehabilitation Hospital | Waiting list data, outcomes, and system gap

Stroke and neurological rehabilitation patients are among the most clinically complex and time-sensitive in the Irish health system. They do not appear in the NTPF national waiting list figures. They are not counted in the headline 805,000. They wait in a parallel system — without public visibility, without published monthly data, and without the scrutiny that published figures attract.

181

Total NRH inpatient waiting list (all programmes)

54

Stroke patients waiting for admission

172

Days avg. wait — Stroke & Brain Injury

269

Days avg. wait — PDOC patients

Source: NRH CEO Office response to PQ 12817, Deputy Sherlock, 25 February 2026. Official, citable data from the National Rehabilitation Hospital.

1. NRH Inpatient Waiting List — 25 February 2026

Programme	Patients Waiting	Adult / Paediatric
Brain Injury	44	Adult
PDOC (Prolonged Disorders of Consciousness)	10	Adult
Stroke	54	Adult
POLAR Programme	18	Adult
Spinal Cord System of Care	30	Adult
Paediatric Programme	25	Paediatric
Grand Total — All Programmes	181	—

Stroke patients represent the single largest cohort on the NRH inpatient waiting list — 54 of 156 adult patients (35% of the adult waiting list). Brain Injury patients account for a further 44 (28%). Together, these two cohorts represent nearly two thirds of all adults waiting for specialist inpatient rehabilitation at Ireland's national facility.

2. NRH Programme Outcome Data — 2024

The NRH publishes outcome data for its inpatient programmes. These figures reflect the 2024 reporting period and provide the clinical context within which the waiting list figures above must be understood.

Stroke Programme

Metric	Stroke Programme 2024
Total admissions	99 patients
Average waiting time for admission	172 days
Average length of stay	110 days
Discharged to home (vs acute or residential care)	71%

Brain Injury Programme

Metric	Brain Injury Programme 2024
Total admissions	116 patients
Average waiting time — Brain Injury Programme	172 days
Average waiting time — PDOC Service	269 days
Average length of stay — Brain Injury	101 days
Average length of stay — PDOC	143 days
Discharged to home — Brain Injury	67%
Discharged to home — PDOC	71%

3. Understanding PDOC — Prolonged Disorders of Consciousness

PDOC patients represent the most clinically complex and vulnerable cohort within the neuro-rehabilitation system. Prolonged Disorders of Consciousness describes a clinical state following severe acquired brain injury in which a patient has wakefulness without full awareness — including vegetative state and minimally conscious state — persisting beyond defined clinical timeframes.

PDOC patients are not unconscious in the colloquial sense. They may have cycles of sleep and wakefulness, respond to some stimuli, or show intermittent signs of awareness. The clinical and ethical complexity of assessing, treating, and supporting these patients — and their families — is substantial. Specialist assessment is essential and cannot be replicated in a standard hospital or general rehabilitation setting.

In Ireland, the National Rehabilitation Hospital is the designated specialist facility for PDOC patients. There is no alternative pathway. If the NRH PDOC Service has no capacity, these patients wait — in acute hospitals, in settings not designed for their needs, for periods now measured in the data below.

WAIT 269 days	PDOC patients face the longest waits in the NRH system. While stroke and brain injury patients wait an average of 172 days, PDOC patients wait an average of 269 days — nearly nine months — for admission to the only specialist service in Ireland equipped to assess and manage their condition.
OUTCOME 71%	Despite the profound severity of their condition, 71% of PDOC patients admitted to the NRH in 2024 were discharged to home — rather than to acute hospital or residential care. Specialist care, when accessed, produces meaningful outcomes even for this cohort.
CURRENT BACKLOG 10 patients	As of 25 February 2026, 10 adult PDOC patients are on the NRH inpatient waiting list. Each is waiting in a setting not designed for their needs, for a service with no equivalent elsewhere in Ireland.

The 269-day average wait for PDOC patients is the most acute access failure documented in this section. It is not a clerical delay or an administrative bottleneck. It is nine months in which a patient with a catastrophic brain injury — whose family may not know if they will ever recover awareness — is waiting in a setting unable to properly assess or support them.

4. What the Data Shows — Across All Three Programmes

Finding	Significance
172 days avg. wait — Stroke	Nearly 6 months from referral to admission. The critical post-stroke rehabilitation window is substantially compressed before patients arrive.
172 days avg. wait — Brain Injury	Identical to Stroke. Patients with acquired brain injury face equivalent delay accessing Ireland's only comprehensive inpatient programme.
269 days avg. wait — PDOC	Over 9 months for patients with Prolonged Disorders of Consciousness — the most clinically vulnerable cohort. Delay at this level is not administrative. It is clinical.
54 stroke patients currently waiting	The single largest cohort on the NRH adult IP list as of 25 February 2026. Each represents a person whose rehabilitation window is passing.
71% discharged home after stroke rehab	When patients reach the NRH, outcomes are strong. 71% return home rather than to acute or residential care. The problem is access, not quality.
67% discharged home after brain injury rehab	Similarly strong outcomes for Brain Injury patients who complete the programme. The evidence of effectiveness is present. The capacity is not.

These are not patients waiting for elective procedures. Stroke and brain injury rehabilitation is time critical. Neurological science is unambiguous: the plasticity of the brain its capacity to reorganise and recover function is most responsive in the period immediately following injury. Every day of delay is a day of recovery potential that cannot be recovered.

5. System Context — The Wider Neuro-Rehabilitation Gap

The NRH waiting list does not exist in isolation. It reflects a national system that has consistently failed to build the capacity required. The Neurological Alliance of Ireland (NAI) — representing nearly 40 member organisations and over 860,000 people living with neurological conditions — documented this in its Pre-Budget Submission 2026.

System Gap	Evidence
National bed shortfall	Only 131 of the minimum recommended 306 post-acute inpatient neuro-rehabilitation beds are in place — a shortfall of 175 beds. (HSE Inpatient Rehabilitation Mapping Report, September 2024)
Community team gaps	Four community neuro-rehabilitation teams remain unfunded: Midlands, North Dublin/North East, South East, and North West. The North West operates with just one quarter of standard team posts funded.
Regional access failure	NAI's MY NEURO SURVEY 2024 (674 respondents): 58–92% of respondents across all regions could not access community neuro-rehabilitation services in the previous 12 months.
Acute system cost	An HSE audit of 8 major acute hospitals (2019) found 110 neuro-rehabilitation patients accrued 17,413 acute bed days due to delayed transfer of care — a direct consequence of insufficient downstream capacity.
Unfulfilled Programme for Government commitments	The current Programme for Government commits to completing the community neuro-rehabilitation team rollout, developing specialist inpatient rehab beds, and implementing community-based services in each HSE region. None of these commitments is fully delivered.

Sources: NAI Pre-Budget Submission 2026; HSE Post-Acute Inpatient Rehabilitation Mapping Report (2024); MY NEURO SURVEY 2024 (NAI); HSE Audit of Delayed Transfer of Care (2019).

6. International Comparators — Ireland in a European and Global Context

The NRH waiting list and national bed shortfall must be understood against the backdrop of Ireland's international standing on rehabilitative care capacity. The data is unambiguous.

European Rehabilitative Care Beds — 2023 Eurostat Data

Country / Benchmark	Rehab Beds per 100,000	vs Ireland
Germany	193.8	62.5×
Poland	191.7	61.8×
France	148.3	47.8×
Austria	131.7	42.5×
EU Average	48.8	15.7×
Ireland	3.1	—

Ireland has 3.1 rehabilitative beds per 100,000 inhabitants. The EU average is 48.8 — more than fifteen times Ireland's capacity. Germany and Poland each provide over 190 beds per 100,000 — more than 62 times Ireland's provision. Ireland is not an outlier at the lower end of European performance. It is in a category of its own.

Ireland's Neuro-Rehabilitation Specialist Capacity — 2023

Metric	Ireland — 2023 Position
Adult rehabilitation medicine specialists (nationwide)	11 consultants — 10% of European average
Paediatric rehabilitation — consultant WTE	1.25 whole-time equivalent
Dedicated inpatient beds — children	8 beds (all located at the NRH)
Recommended minimum (national strategy)	306 beds — 6 per 100,000 population
Current shortfall against national minimum	175 beds (HSE Mapping Report, September 2024)

Global Demand — 2021 Global Burden of Disease Data



Ireland, with 3.1 rehabilitative beds per 100,000 against a global demand rate of 2,758 per 100,000, is not approaching the scale of provision required. The trajectory of demand means the gap will widen, not narrow, without deliberate structural investment.

Summary: Ireland's International Position

Ireland provides 3.1 rehabilitative beds per 100,000 inhabitants — against an EU average of 48.8. It has 11 adult rehabilitation medicine specialists nationally — 10% of the European average. It has 1.25 paediatric rehabilitation consultant WTE for the entire country. Against a global neuro-rehabilitation need that has nearly doubled since 1990, Ireland's capacity has not kept pace with national strategy targets, let alone European norms. This is not a marginal shortfall. It is a structural deficit with documented clinical consequence.

7. Irish Patients Association View.

Stroke and neurological rehabilitation patients are absent from Ireland's public waiting list count. They do not appear in the NTPF monthly figures. They are not included in the 805,816 patients who are publicly tracked. There is no monthly published data. There is no headline number.

The consequence of this invisibility is that the pressure on these patients does not register in the same way in public, political, or policy discourse. When waiting list figures are reported, this cohort is not in them. When progress is measured, this cohort is not counted. When funding decisions are made, the absence of visible data reduces the urgency attached to need that is, by clinical standard, among the most time-sensitive in the health system.

We make three observations on the evidence assembled in this section:

1

The NRH waiting list data, obtained through a parliamentary question (Ms Marie Sherlock T.D.), is official and citable. It shows 54 stroke patients and 44 brain injury patients waiting for specialist inpatient rehabilitation as of 25 February 2026. Average waiting time: 172 days for both cohorts. For PDOC patients: 269 days. These are not administrative delays. They are clinical delays with neurological consequence.

2

The outcomes data demonstrates that the NRH delivers strong results when patients reach it. 71% of stroke patients and 67% of brain injury patients are discharged home. The system's quality, where it exists, is not in question. The constraint is capacity — and the consequence of insufficient capacity is that access is rationed by wait time rather than by clinical need.

3

The structural gap is documented, quantified, and unaddressed. 175 beds short of the nationally recommended minimum. Four community teams unfunded. Waiting times of 172–269 days. A Programme for Government that commits to action. No delivery. The IPA notes this pattern is consistent with the implementation gap documented across this report.

The required action is not a further report. The gap is mapped. The shortfall is quantified. The Programme for Government commitment exists. What is required is implementation — funded community neuro-rehabilitation teams, post-acute inpatient beds at the nationally recommended level, and monthly published waiting list data for NRH inpatient programmes so that these patients are counted, tracked, and visible in the same way as the 805,816 patients who currently are.

Patients waiting for stroke and brain injury rehabilitation are not less urgent because they are less visible. They are more urgent. And the system currently has no public mechanism that reflects that.

3B**EMERGENCY DEPARTMENT PRESSURE***St Patrick's Day Trolley Watch Analysis | 2025 vs 2026*

The period following St Patrick's Day provides a consistent reference point for assessing system pressure within acute hospital settings. A comparison of the five working days immediately following the St Patrick's Day bank holiday in March 2026 with the equivalent period in March 2025 shows a significant increase in patients recorded on trolleys.

Date	2026 Trolleys	2025 Trolleys	Difference
17 / 18 March	517	362	+155
19 March	483	442	+41
20 March	485	385	+100
23 / 21 March	576	363	+213
24 March	584	468	+116
TOTAL	2,645	2,020	+625 (+30.9%)

Total increase: +625 patients | Percentage increase: +30.9% across the five-day comparable period.

The increase of 625 patients across a comparable five-day period represents a substantial rise in acute hospital overcrowding. Four of the five days in March 2026 recorded higher trolley numbers than the equivalent days in 2025. This indicates that the increase is not attributable to a single outlier event but reflects sustained system pressure across the period.

The data suggests that acute hospital capacity did not recover to baseline levels following the bank holiday period. Instead, pressure accumulated and persisted throughout the working week. Where baseline capacity is insufficient, short-term increases in demand translate rapidly into overcrowding. Patients on trolleys represent individuals awaiting admission to appropriate care settings. Prolonged waiting in emergency departments is associated with delayed treatment, reduced patient dignity, and increased clinical risk.

The post St Patrick's Day comparison demonstrates a marked increase in acute hospital pressure in 2026 compared with 2025. The data reflects a system that remains vulnerable to predictable demand surges.

This section presents findings from HSE Internal Audit reports released under the Freedom of Information Act 2014. Findings are reproduced from source documentation and grouped for clarity. They reflect the position at the time of audit and FOI release.

Scope — FOI Release Covers

- OPS013DM1125 — Naas NTPF Income Review
- SPI001FIN1124 — Payroll Fraud Risk
- OPS012HR1125 — Health & Safety Function
- ICT003DPO1125 — Data Protection Programme
- FOI Addendum

Key Findings

Finding	Detail
Policy non-compliance	Consultant payments made outside approved frameworks. NTPF income processes did not align with policy requirements.
Financial Control Weaknesses	The audit identified the absence of consistent reconciliation processes and weaknesses in oversight mechanisms for income and expenditure.
Procurement Compliance Issues	Procurement processes were not followed in multiple instances. Documentation of compliance was incomplete.
Payroll System Weaknesses	€12.7 million in payroll overpayments identified. The audit noted weaknesses in control and recovery processes.
Fraud Risk Controls	The audit identified the absence of a comprehensive fraud risk framework and structured monitoring mechanisms.
Governance — Health & Safety	Weak oversight of the Health & Safety function. Governance structures were not operating effectively, with unclear lines of accountability.
Data Protection Programme	Gaps identified in the implementation and oversight of data protection controls. Monitoring structures were incomplete.
Corrective Actions	Over 2,000 corrective actions were identified. The audit noted the absence of a centralised tracking and follow-through mechanism.

Conclusion: Policy non-compliance identified | Financial control weaknesses | Procurement compliance issues | Payroll control weaknesses | Fraud risk control gaps | Governance weaknesses identified | Corrective actions outstanding

In October 2025, the Irish Patients' Association submitted an appeal to the Office of the Information Commissioner under the Freedom of Information Act 2014. The subject matter of the appeal is before the OIC and is not addressed in this report pending the outcome of that process.

The appeal is referenced here because of what the chronology of its handling indicates not about the IPA's case specifically, but about the operation of the FOI oversight system.

Chronology

Date	Development
1 Oct 2025	Appeal submitted. €50 fee requested by the OIC.
3 Oct 2025	Fee paid and confirmed by the IPA.
12 Nov 2025	IPA requested a status update. OIC advised the case had moved to the investigations team, awaiting assignment. Backlog acknowledged. No timeline provided.
23 Jan 2026	IPA followed up again. OIC advised its case management system had been rendered unavailable following a cyber-attack in December 2025. No projected timeline was available.
20 Mar 2026	IPA wrote formally. The appeal had been outstanding for 170 days from submission to first substantive response. No proactive updates had been issued.
25 Mar 2026	OIC issued a substantive response.

OIC Response — 25 March 2026

53

Cases ahead of IPA in investigations queue

+27%

Increase in applications accepted for review in 2024

HIGHEST

Since FOI Act introduced in 2014

- A new case management system was introduced in March 2026
- No reliable estimate available for case allocation or completion timelines
- OIC acknowledged that communication with applicants had not been as proactive as intended
- The statutory four-month timeframe applies only insofar as practicable

The significance of this material is system-level. A 27% increase in demand the highest on record since the Act's introduction in 2014 reflects sustained pressure on the mechanism through which citizens, advocacy organisations, journalists, and public representatives seek access to information.

The right of access to information is a patient right, a citizen right, and a democratic right. The capacity of the body charged with upholding it warrants attention and support alongside the systems it oversees.

18

Missed completion dates

Aug 2022

Original contract baseline

206,047

Children aged out of paediatric eligibility

Repeated delay in delivery has moved beyond isolated programme slippage. Eighteen missed completion dates indicate a sustained loss of programme control rather than discrete scheduling adjustments.

Over 200,000 young people who were within paediatric eligibility when this hospital was due to open have now aged out of the system. They will never access it as children. That is an irreversible consequence of delay. — Stephen McMahon, Co-Founder & Chairman, Irish Patients' Association

Cohort Impact

Central Statistics Office data indicates that 206,047 individuals aged 15–17 in 2022 would have been within paediatric eligibility at the time the hospital was originally due to open. By 2025–2026, that cohort has aged out of paediatric eligibility entirely. This cohort will not access the facility within paediatric eligibility.

In healthcare, delay does not only affect timing of delivery. It determines who benefits from the infrastructure when it is delivered.

System Context — What Is Being Delayed

Activity Type	Annual Volume (Estimate)
Emergency attendances	~90,000+
Outpatient activity	~150,000+
Day cases and procedures	~40,000–60,000+

Based on these volumes, cumulative interactions during the delay period may approach one million.

Programme Timeline — 18 Completion-Date Events

#	Phase	Date	Description	Outcome
1	Contract Baseline	Aug 2022	Original agreed completion date	Missed
2	Early Slippage	Feb 2023	First revised programme	Missed
3	Early Slippage	Dec 2023	Revised programme	Missed
4	Early Slippage	Jan 2024	Incremental delay	Missed
5	Programme Instability	Jan 2024	Non-compliant baseline submission	Missed
6	Programme Instability	Feb 2024	Continued slippage	Missed
7	Programme Instability	Mar 2024	Post-2022 drift	Missed
8	Programme Instability	Apr 2024	Further non-compliant programme	Missed
9	Programme Instability	May 2024	Monthly delay pattern	Missed
10	Major Reset	Oct 2024	Significant reprogramme (PAC flagged)	Missed
11	Incremental Slippage	Dec 2024	Late 2024 shift	Missed
12	Incremental Slippage	Jan 2025	Entry into 2025 timeline	Missed
13	Incremental Slippage	Feb 2025	Continued delay	Missed
14	Major Reset	Jun 2025	Mid-2025 projection	Missed
15	Major Reset	Sep 2025	Further slippage	Missed
16	Formal Programme Date	24 Nov 2025	Ministerially confirmed (Oireachtas PQ)	Missed
17	Programme Collapse	30 Apr 2026	Established Jan 2026 (NPHDB submission)	Will not be met
18	Programme Collapse	30 Apr 2026	Reaffirmed Feb 2026 — failing within weeks	Will not be met

Governance Position

Repeated deadline revision without resolution raises questions regarding accountability mechanisms. Where programme timelines are repeatedly reset, the distinction between delay and delivery becomes less clear. The impact of delay is not neutral. It alters who benefits and when.

The CEOWORLD Health Care Index has been cited in public and policy discourse as evidence of Ireland's strong international healthcare performance. Ireland's movement from approximately 80th position to 6th position has been presented as a significant achievement.

However, the index does not publish sufficient methodological detail to allow independent validation, including transparency on indicator weighting, underlying data sources, and the distinction between access and availability. In the absence of these elements, the index cannot be independently verified as an accurate reflection of system performance.

Core Structural Contradiction

Ireland is reported as ranking highly for medicine availability within international indices. However, access data presents a markedly different picture:

Average time from EMA approval to reimbursement: approximately 645 days

Oncology medicines: approximately 644 to 732 days

Orphan medicines: approximately 709 to 759 days

These timelines place Ireland among comparatively slower systems in Europe in translating approval into patient access.

Availability vs Access — A Critical Distinction

A medicine may be...	But still...
Licensed	Not accessible in a timely manner
Technically available within a system	Delayed in availability to patients
Included within reimbursement frameworks	Subject to administrative or financial barriers

Equity of Access

Evidence from the Irish Patients' Association indicates that approximately one in three individuals without private health insurance are on a public waiting list. This is not consistent with equitable access within a universal system. Access is influenced by ability to pay. Waiting time is not determined solely by clinical need. Private provision alters access pathways.

Position

International rankings that do not incorporate time to access, waiting list burden, equity of delivery, and patient experience cannot be relied upon in isolation as indicators of real-world system performance. Ireland demonstrates high capability in medicines availability, regulatory alignment, and system infrastructure. The defining constraint is access — where it remains delayed, uneven, and influenced by private provision.

Media coverage plays a central role in shaping public understanding of health system performance. In fast-moving and resource-constrained environments, journalists translate complex data into accessible information for the public and policymakers. The structure applied to that information influences how system pressure is understood and how scrutiny is applied

Finding	Detail
RTÉ stands out as primary source of full reporting	RTÉ provided comprehensive, structured reporting including the full national position, complete category breakdown, hospital-level detail, paediatric data, and Ministerial commentary.
Limited comparable reporting elsewhere	Similarly comprehensive reporting was not widely carried across other print and transmission outlets. Coverage was more commonly partial, issue-led, or commentary-based.
System visible in headline form but not fully explained	Headline figures approaching one million entered public reporting. However, the structure of the waiting list system was not consistently conveyed.
Volume dominated coverage over duration	Coverage focused primarily on total numbers waiting. More limited attention was paid to how long patients are waiting or the consequences of delay.
A two-tier awareness gap	Patients on waiting lists experience delay directly. For the wider public, awareness is shaped by how the issue is reported. Where full reporting is not consistently replicated, a two-tier understanding emerges, a sort of social bubble emerges,
Policy performance not widely examined	There is limited evidence that February coverage assessed the waiting list figures against Waiting Time Action Plan 2026 targets or HSE National Service Plan commitments.

Conclusion: Patients experience waiting directly. The general public encounter it largely through how it is reported. Where full reporting is not consistently carried across the media landscape, understanding remains partial and scrutiny correspondingly limited. Waiting list data is publicly available. The constraint is not access to data it is the level of structure applied in interpreting it.