Joint Committee

On

Health

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OPENING STATEMENT

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By

Bernard Gloster,

Chief Executive Officer,

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Introduction:

Good morning, Chair and members of the committee, thank you for the invitation to meet with the committee today to discuss matters relating to long-term planning in the health services having regard to demographic changes as well as the need for on-going capital investment and the development of services.

I am joined today by my colleagues.

- Dr. Colm Henry, Chief Clinical Officer
- Mr. Patrick Lynch, National Director Planning & Performance
- Mr. Brian O'Connell, National Director Head of Strategic Health Infrastructure & Capital Delivery
- Ms. Kate Killeen White, Regional Executive Officer Dublin and Midlands.

I welcome the opportunity together with colleagues from the Department of Health to engage on the broad range of issues in respect of future planning. I attach as an Appendix to this opening statement a briefing document as requested by the Committee.

Our Population and Health Status:

We serve a population of almost 5.5 million people. The life expectancy in Ireland for 2025 is projected to be approximately 82.7 years overall, with 80.8 years for males and 84.7 years for females. This represents a slight increase from previous years, driven by factors like falling mortality rates for major diseases and a growing population. Life expectancy has been steadily increasing, and we now rank among the highest in Europe in that regard. For two decades pre the pandemic life expectancy here grew faster than the EU average. There are many contributing factors to this outcome. In more recent decades there have been significant improvements in some of the major determinants of health such as housing quality, education, air quality, diet, smoking cessation and physical activity.

This broad range of social, environmental and economic factors are substantial determinants of health. Within Healthcare itself significant improvements in provision of and access to healthcare, advances in diagnostics and therapeutics, research, and workforce growth by specialty have all contributed to our overall health status. We have seen improvements in health outcomes for older people, a high rate of self-perceived good health, and decreasing mortality from diseases like some cancers and particularly circulatory problems.

Despite many successes and improvements, we know from analysis of demographic trends, prevalence of chronic disease and the traditional inpatient centric model of healthcare we have relied on, that planning for healthcare can no longer be viewed through the single lens of just increased investment for more of the same. There are many factors but two are critical to planning at this point.

First The ESRI and others report that the population aged 65 years and over is projected to grow from 0.78 million in 2022 to over 1.3 million by 2040, increasing their share of the total population from 15% to 21%. Within that we can see clearly that the over 85 age group at circa 85,000 is likely to quadruple over the next 30 years and this is a particular marker for health care planning. (We have also seen the general population numbers substantially altered due to global movement and unprecedented geopolitical factors).

Second With an expected prevalence of chronic diseases of 53.8% among adults aged 50+ years, the number of people with chronic diseases in Ireland could increase from approximately 778,000 people in 2016 to 1.08 million by 2030. The term “chronic diseases” refers to long-term health conditions which are slow to progress and require ongoing management. Behavioral and metabolic risk factors for these conditions remain substantial: 17% of adults are current smokers, 60% are overweight or obese, and less than half meet minimum physical activity recommendations.

According to 2023 figures, chronic diseases account for approximately 40% of hospital admissions and approximately 75% of bed-days.

Ireland’s acute bed occupancy rates remain among the highest in the OECD (approximately 95%), leaving little capacity to absorb demand shocks. This is particularly relevant during the winter season when emergency respiratory admissions have been shown to increase thus reducing capacity for overall chronic disease management in the population, particularly patients with co-existing or underlying chronic conditions.

Future Planning:

The HSE focus on future planning, consistent with Government policy, direction and investment is focused primarily on the following areas.

- Healthy Lifestyle (Improve Health to Reduce Traditional Demand)
- Clinical Excellence (Social Care, Primary Care, Diagnostic, Secondary Care, Tertiary Care, Integrated Care)
- Accessible, Affordable and Safe Care

The approach this year and for the years ahead is to achieve improvements in all these areas through sustainable foundations. These include;

- Financial Resource Use (Improved Efficiency)
- Workforce Resource Use & Ways of Working (Improved Productivity)
- Infrastructure (Capacity Reflective of New Methodologies – Surgical Hubs, Chronic Disease Hubs, Primary Care Centres and Bed Stock)
- Technology and Digital (Resource Systems, EHR, Virtual Care)

Finance:

The 2026 Health (excl Disability) budget allocation is €25.2bn with an additional Capital allowance of €1.5bn, increasing on the 2025 opening allocations of €23.7bn and €1.3bn respectively.

Having worked to improve control and reduce dependency on supplementary health funding, with continued focus required in that area, the next phase of emphasis will be on maximum efficiency and productivity. Budget 2026 provides for an additional 3,300 WTE to the workforce. What will be different is the allocation methodology of those.

The contrasts in service performance across Regions show that excellence is possible - but not yet consistent. The regional model of Sláintecare must be about aligning the performance of every service to the standards already achieved in our best-performing areas**.** It is only in this context that we achieve comprehensive balance across Health Regions. The Minister's clear instructions for 2026 are to use existing and new resources combined to enable Regions focus on their areas of challenge and underperformance thereby bringing us closer to national equity. This approach, a first, sets the basis for longer term planning with the possibility of moving closer towards Population Based Resource Allocation and further efficiency in strategies such as Activity Based Funding. We must however get to a point where experience is more uniform across the Country and hence the 2026 approach is very welcome. After 2026 a next obvious step is muti annual funding linked to multi annual planning.

Workforce:

The Health Workforce will continue to need to grow to meet demand. However, planning is now taking account of the unprecedented growth to date. In 2026 the Department of Health funded part of the HSE will have an opening allowance of 133,306 WTE rising to 136,606 WTE by year end. This is up from 101,000 (excl Disability) at the start of 2020. These are enormous numbers requiring major permanent financial underpinning. This rate of growth is not sustainable for our economy and the focus for the future has to be beyond the traditional view of additional workforce.

The focus on planning for the short and medium to long term is best viewed through two lenses.

First, We are now pursuing greater flexibility in how we prioritise and change use of existing workforce to improve responsiveness and productivity. Contractual methods and Public Pay Agreements are significant enablers here.

Second Generating workforce supply through targeted third level training programmes and new methods (apprenticeship) and increased higher education pipeline in the Programme for Government will lead to a better balance between how we use what we have and how we target the generation of the most critical supply.

Infrastructure:

Our core focus on future planning for infrastructure is again not to rely solely or exclusively on traditional models. By OECD standards we are still very high in our dependency on traditional inpatient/older persons bed models. While we do need bed capacity to catch up with demand and under investment in the years of financial downturn, we also need to build infrastructure that reflects new ways of responding to demand. These include surgical hubs (five to open in 2026) and general elective reform, chronic disease hubs in the community, primary care centres, and local injury units, together with new beds where we are increasing our specialty focus (2026 Critical Care and Maternity Care and NCH). Our only likely possibility of meeting future demand is to arrive at a better balance between these new configurations and traditional beds. Targeted investment will be the only effective response rather than the approaches of the past. Linking revenue to the opening time of new infrastructure is now the priority of the Minister, as endorsed in major reviews such as Frank Clarke and proven to work in the opening of the recent 96 bed unit in Limerick. There is now a specified requirement by the Minister that Government investment in 2026 must include the outcomes of concluding and commissioning new infrastructure. Finally, infrastructure need will need to be matched with virtual care methodologies which also have proven to be effective.

Digital Care – Technology:

I believe we are much better positioned than ever before to now exploit the benefits that are available. The Minister is currently finalising her approach to the full EHR business case and we anticipate hearing from Government very shortly. Subject to approval, I believe Ireland can obtain substantial utilisation of EHR as routine practice in a relatively short few years. We are not waiting for all of a system to arrive before progressing. In 2025 we developed our HSE Health App. In 2026 we will develop our Shared Care Record. Throughout 2025 and 2026 we will bring segments of the service into EHR mode, most notably maternity units and the National Children's Hospital followed by others. All these together with the new approval will lead to a place of bringing one full Region to EHR in 2027/2028 thereby enabling national roll out to be standardised thereafter. All of our developing systems such as laboratory and NIMIS, which we will mandate in all services and be the only systems we fund, will position us for a very strong implementation of EHR. Reflecting on attempts over many years in the Health Service in this area, I firmly believe that the direction of travel now being undertaken is as good as it can be and is achievable to a lasting difference for generations to come.

We are separately now pursuing a range of virtual care constructs including both 'wards' and virtual care methods in community healthcare. 2026 will see further advancement of these. Virtual acute wards were introduced in 2024 in Phase 1 sites SVUH & UHL. 1,937 patients have been onboarded since July 2024 equating to 18,100 patient active days. These virtual wards are now fully operational, with 25-30 average patients. Both sites expect greater occupancy (can go to 40) in line with the expected surge in respiratory illnesses associated with the winter season. Phase 2 sites, originally identified as OLOL Drogheda, Tullamore & Mercy, will go live this November and I have recently added Kilkenny to this list to go live this year. UHG will be operational in early 2026. With this will bring enough evidence to make any adjustments to the methodology and thereafter introduce Virtual wards as common practice for additional capacity to all hospitals.

Virtual Care is also being used in the non-acute settings. Notable projects using Remote Health Monitoring to support patients with chronic conditions include;

- CARE Project, Letterkenny; 20 bedded COPD remote care model, has resulted in a 20% drop in COPD admissions and a 50% drop in readmissions, improved patient outcomes and estimated €4.2 million in cost saving.
- Maternity Hypertension, Our Lady of Lourdes; Home based blood pressure monitoring model, real time data provided to clinician. Cohort of 113 patients seen to date, early data suggests significant (>50%) reductions in admission rate compared with routine care.
- SMILE (Supporting Multimorbidity Selfcare through Integration, Learning and eHealth) Project, South East Region; Remote monitoring of patients with more than 2 chronic diseases. Early data for cohort (n=267) suggests 55% reduction in ED attendances, 75% less nights in hospital and 81% less GP urgent visits.
- In line with the National Telehealth Roadmap 2024-2027 and working with eHealth, an ECC approach to Telehealth usage (Attend Anywhere) has been developed and communicated with the regions. A national rollout has commenced with ECC CHNs and ICPOP / ICPCD CSTs. To date, almost 700 remote consultations via 'Attend Anywhere' have taken place across CHN, ICPOP and ICPCD teams, equating to 250 hours of consults across 20+ teams with the learnings used to streamline the Telehealth rollout across regions and teams.

Remote Health Monitoring to support Clinical care in the Ambulatory Setting tender is due for publication in the next two weeks which will enable scaling of the above and other initiatives.

Finally, we are using technology to improve our resource management systems with both IFMS (money) and NiSRP (people). In 2025 these were effectively completed in HSE, and we are now moving to full implementation in the Section 38 sector.

Adoption of these systems by these funded organisations will be mandatory in their 2026 Service Arrangements. (See Briefing)

Conclusion:

There can be no doubting that demand for healthcare is both growing and changing, that should be no surprise to anyone. The complexity of planning for the future is not in formulating the plans themselves. It is in understanding that new and different approaches are the only means by which we can meet future demand, as opposed to just the simple strategies of the past where we always needed more to do new or different. We have improved access and outcomes from healthcare but I recognise we have a distance to go and I am confident the plans in place are increasingly more realistic, achievable and critically supported by the Minister and the Programme for Government.