



Rialtas na hÉireann
Government of Ireland

Budget 2019

Health Budget Oversight & Management: Alignment of Health Budget and National Service Plan

JENNY CONNORS

HEALTH VOTE

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This paper has been prepared by IGEES staff in the Department of Public Expenditure & Reform. The views presented in this paper do not represent the official views of the Department or the Minister for Public Expenditure and Reform.

Summary

Overall Health Expenditure

- In 2018 the funding level available to health reached €16.2bn, this is 19% greater than expenditure in 2013 of €13.6bn. **The 2018 allocation marked a record as the highest in the history of the State.**
- Health expenditure fluctuated over the last decade reflecting changes in the economic climate.
 - **From 2010 to 2013, health spend was relatively flat** as a number of measures were implemented to contain expenditure levels.
 - **From 2013 outturn to 2018 allocation, health spend increased by around €2.6bn or 19%.** This increase is substantial over a short period and equates to an average annual increase of €560m.

Budget Management

- Over the last decade the health service has consistently received supplementary funding, this is funding in addition to the original Budget allocation.
- The context in which this supplementary funding was provided was very different across the decade.
 - From 2010 to 2015, funding provided to Health resulted in reduced annual Budget allocations. **While there was large supplementary funding provided in both 2014 and 2015 at over €600m, these were in the context of reduced original Budget allocations for both those years.**
 - From 2016 onwards the Budget provided increased the annual allocation and on average **provided an additional €431m annually to health. Despite this increase, the health sector continued to overspend and the supplementary funding provided ranged from €195m to around €645m.**

Planning Tools

- One of the key planning tools available to the HSE is the National Service Plan (NSP). Under legislation the published NSP must be in line with the agreed Budget allocation and must set out the additional staff that are expected to be hired in the forthcoming year within this Budget allocation.
- **Since 2013, the published NSPs have not fulfilled all of these legislative requirements.** The key planning tool available to the HSE is therefore not being used appropriately or effectively.
- This makes monitoring expenditure difficult and may have led to Budget overruns despite the Health sector getting significant annual increases in their overall Budget provision since 2016.

At its simplest level, Budget management and the planning process within the Health sector could be significantly improved if the annual NSP fulfilled all legislative requirements. This would also provide greater transparency and improve the performance monitoring process.

Introduction

From 1997 to 2017, total Government expenditure on healthcare rose from €3.6bn to €15.6bn.

Health expenditure fluctuated over the last two decades. From 1997, expenditure increased considerably reaching a peak in 2009 and then falling as a result of the economic downturn. In more recent years, total health spend has increased significantly reaching record levels in 2018 of €16.2bn. Since the formation of the HSE in 2005, healthcare has consistently accounted for approximately a quarter of Voted expenditure. **In terms of outcomes, from 1999 to 2008 life expectancy in Ireland rose from 76.2 to 80.2, equivalent to an average annual increase of five months.**

In particular from 2014 outturn to the 2018 allocation, total health expenditure increased by 19%, this growth is significant over such a short period of time. Growth over this period was primarily driven by increased expenditure in the acute hospital setting through increased staff numbers and growth in pharmaceuticals. There is an increasing need to ensure that all health resources are managed and deployed as effectively as possible.

The key objectives of this paper are to:

- Set out a broad overview of historical trends in health expenditure over the last two decades;
- Focus on the significant increase in health spend since 2014 and identify key drivers of this increase covering pay and non-pay related expenditure drivers;
- Identify Budget management and planning tools available to HSE and Department of Health and the use of these tools in recent years.

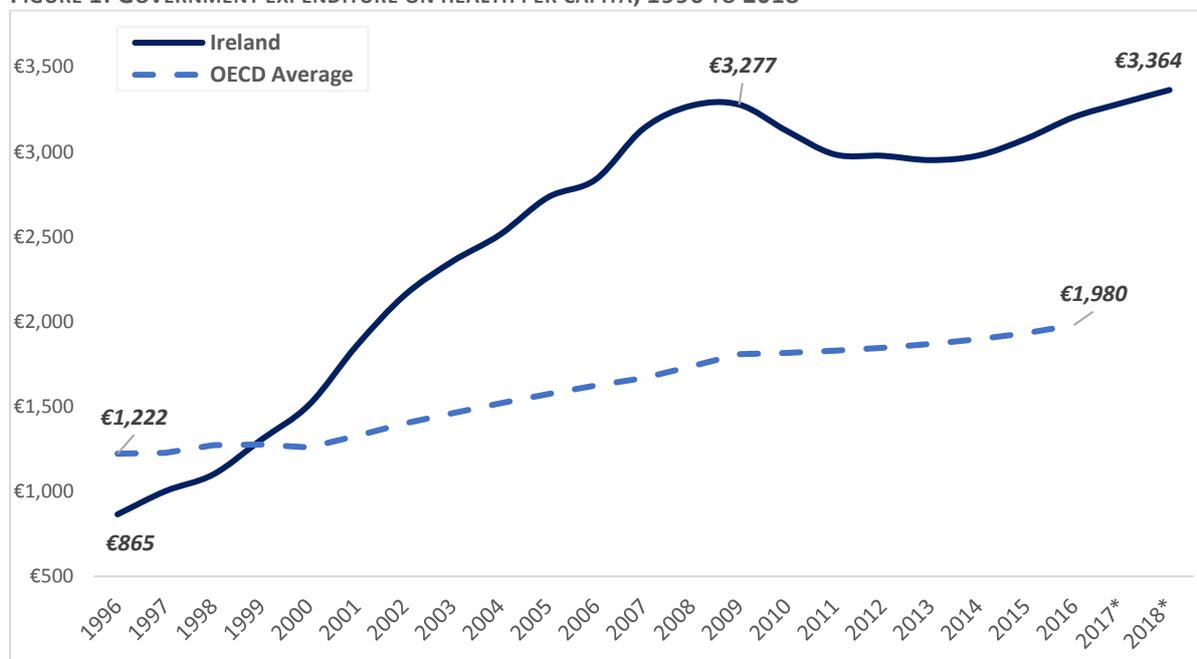
Section 1: Overview of Health Expenditure

Healthcare has traditionally been the second largest area of Government expenditure behind Social Protection, the amount spent on health has consistently risen over the past two decades. While Government spending on health would have had to increase over the past twenty years simply to keep pace with a growing population, the actual rate of expenditure growth since 1996 has been far greater than demographic pressures. Across the same period that spending on healthcare increased from €3.7bn to €16.2bn the CSO estimates that the Irish population grew from 3.7 million to 4.8 million – increases of 338% and 30% respectively.

Ireland's health spend per capita is now €3,364 which is greater than the peak in 2009 of €3,277¹.

As a consequence of the investment in health since 1996, the per capita Government spend on healthcare has increased substantially as shown in Figure 1. Government spending on health was €865 per person in 1996 but by 2009 this had more than tripled to €3,277. As with total expenditure, per capita spend declined for a period after 2009 but has been growing again since 2013. In 2017 the per capita spend of €3,287 was just above 2009 peak levels however with the 2018 allocation of €16.2bn² it is estimated that per capita spend on health today is well above peak at €3,364 per person. This is the highest health spend per capita recorded.

FIGURE 1: GOVERNMENT EXPENDITURE ON HEALTH PER CAPITA, 1996 TO 2018



Sources: Department of Health; Department of Public Expenditure and Reform; Central Statistics Office, OECD Data.
*Estimates of per capita spend available for Ireland only as OECD data is not yet available. 2018 estimate is based on 2018 Budget allocation.

¹ This is based on gross total health expenditure and CSO population figures.

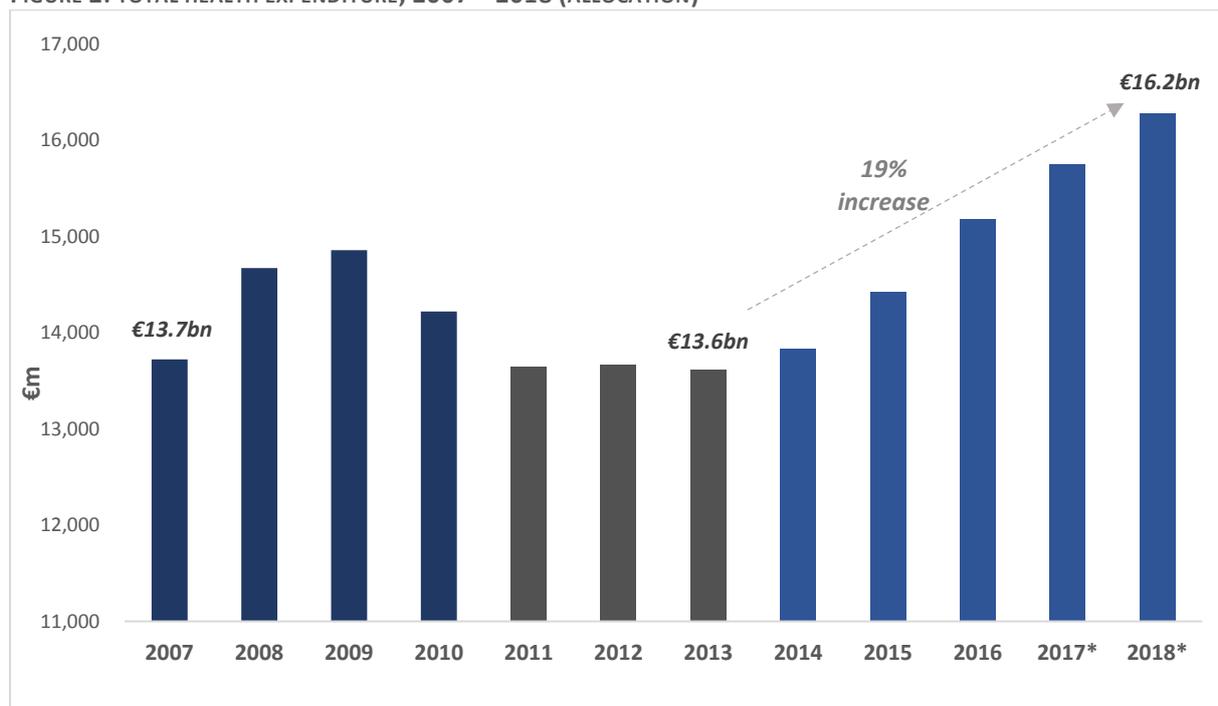
² Gross allocation set out in Rev plus €950m in off vote income held by HSE.

Since 2000 Irelands health spend per capita has moved ahead of the OECD average.

The rate at which Irelands health spend per capital has increased has been significant. While average health spend per capita across OECD countries also increased over the period, it appears to have been at a much slower pace than the increase in Irelands spend per capita.

It is difficult to compare historical health expenditure on a like-for-like basis due to a number of significant changes that have taken place. These include the transfer of the Domiciliary Care Allowance to the Social Protection Vote in 2010, the transfer of Children and Families expenditure to the Children and Youth Affairs Vote in 2014 and the disestablishment of the HSE Vote. Figure 2 attempts to control for these changes as far and provide comparative figures. It is clear from Figure 2 that the amount Government spend on health has increased substantially since 2007. The allocation in 2018 reached €16.2bn, this is 19% greater than the trough in expenditure in 2013 of €13.6bn.

FIGURE 2: TOTAL HEALTH EXPENDITURE, 2007 – 2018 (ALLOCATION)



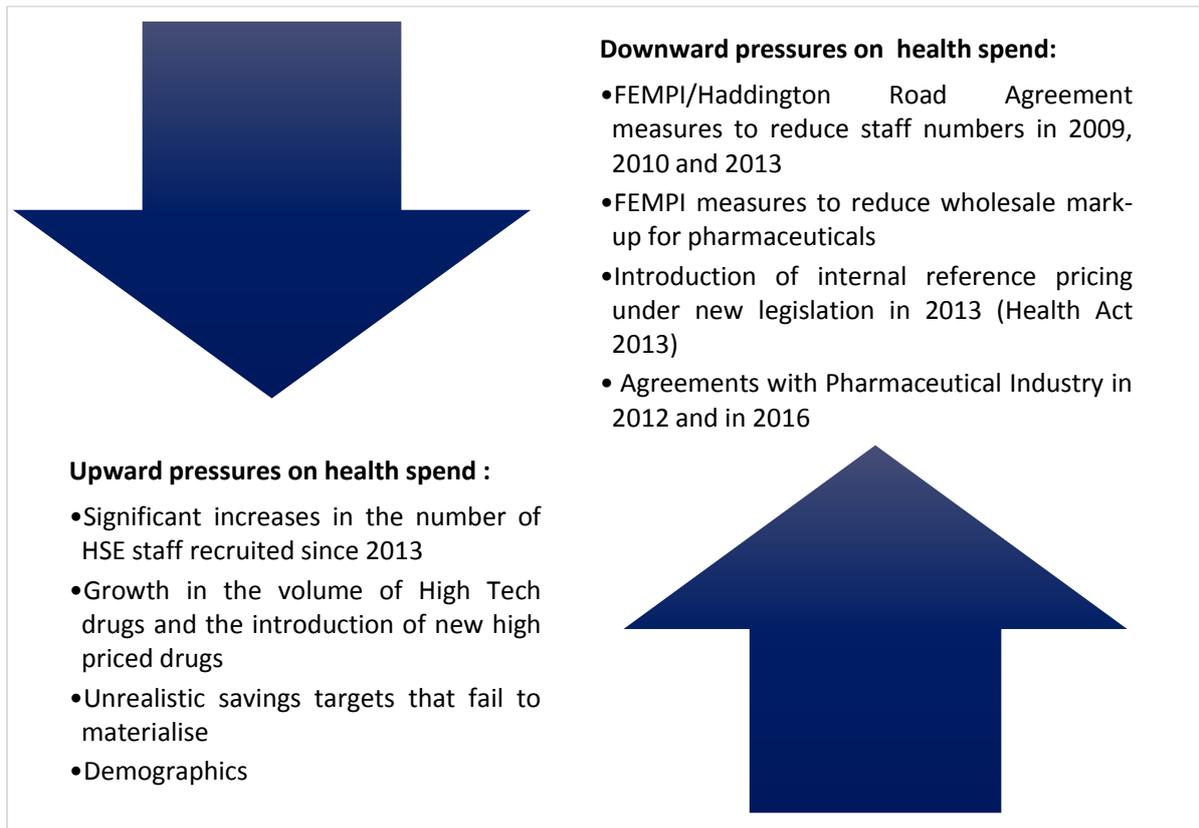
Sources: Department of Health; Department of Public Expenditure and Reform. Figures include around €1bn in off Vote Income.

Health expenditure has fluctuated over the last decade reflecting changes in the economic climate.

Spending contracted during the recession years – largely the result of central pay agreements and the recruitment moratorium – but has grown again since 2013. From 2014 to 2018 spend increased dramatically as health outturn increased by an average of €560m annually from the post-crisis trough of €13.6bn. The 2018 spend marked a record as the highest in the history of the State.

Section 2: Key Drivers of Health Expenditure from 2014 to 2017

The fluctuations in health expenditure illustrated previously in Figure 2 are as a result of a number of upward and downward spending pressures. These factors have influenced the overall level of expenditure directed toward health. See below for health pressures over the last decade.



The rapid increase in expenditure from 2014 to 2017 is significant and is of serious concern for the future sustainability of health expenditure. When discussing the significant increase in overall spend there are three key factors which appear to be driving the increase and these include, overall staffing levels, pharmaceuticals and State claims.

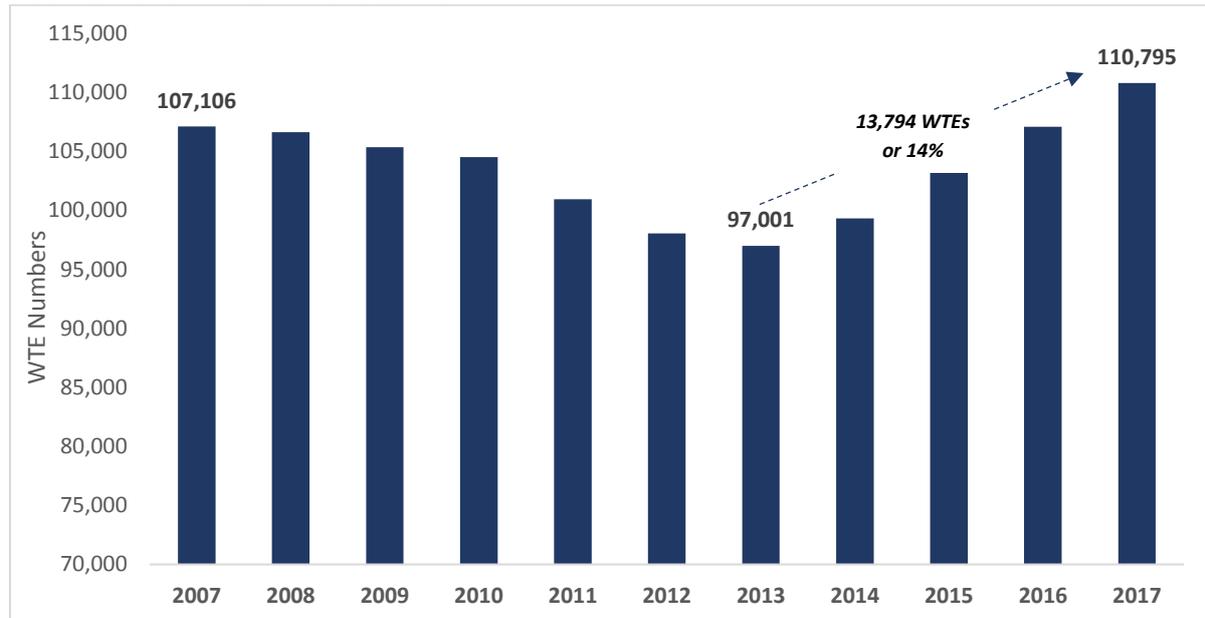
Pay Related Expenditure

I. Overall Staffing Levels

From 2013 to 2017, HSE staffing levels have followed the same trajectory as overall health spend and hospital spend³. The HSE have significantly increased the number of WTE health staff across all grades since 2013. HSE staff levels are now greater than the numbers employed in 2007 at peak levels.

³ From 2015 to 2017, Acute Services employed the greatest quantum of additional staff compared to other areas of the health sector <file:///C:/Users/CONNORSJ/Downloads/3.-HSE-Pay-and-Staffing.pdf>

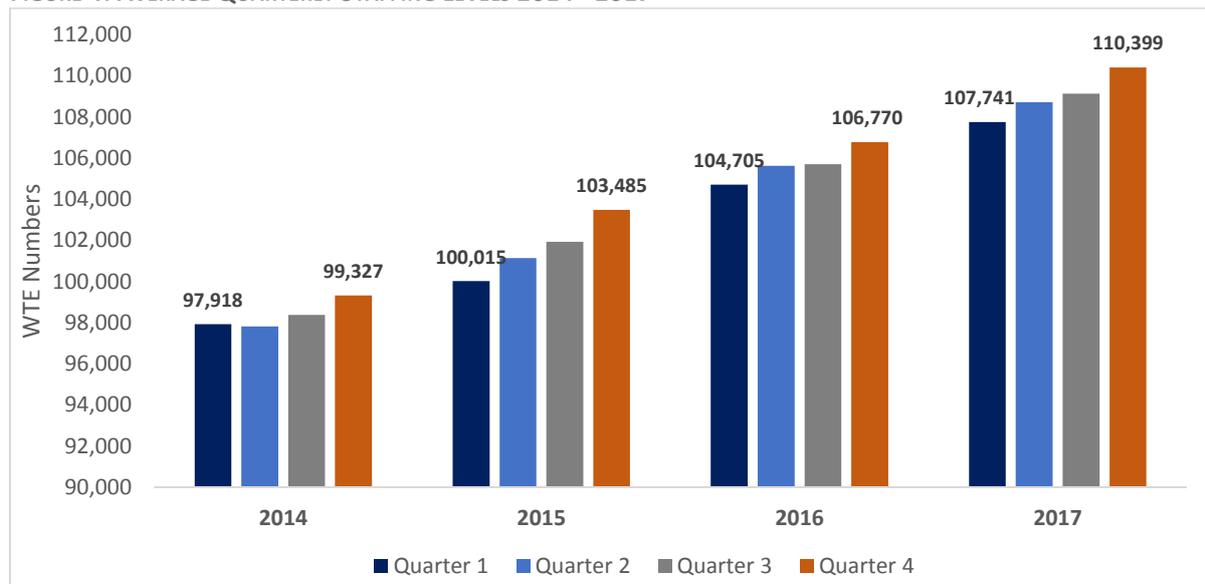
FIGURE 3: HSE STAFFING LEVELS 2009 - 2017⁴



Source: HSE Employment Report

As shown in Figure 3 above the HSE have significantly increased recruitment since 2013 with total WTE⁵ numbers increasing by 13% from 2013 to 2017. In conjunction with the overall increase, there has also been a reoccurring trend in recruitment toward the end of the year as monthly HSE recruitment increases significantly in the final three months of the year. **In the final quarter of each of the last three years, the HSE has recruited on average an additional 1,432 staff. This level is around half of their annual recruitment in just a three month period.** See Figure 4 below for quarterly staffing levels from 2014 to 2017.

FIGURE 4: AVERAGE QUARTERLY STAFFING LEVELS 2014 - 2017



Source: HSE Employment Report

⁴ Figure 3 illustrates HSE staffing levels controlled for historical changes, these are in line with the changes explained in section 1 such as the removal of the Department for Children.

⁵ Whole Time Equivalents

Recruitment in the final months of the year does not have substantial impact on expenditure in that year but rather the majority of the Budget impact is experienced in the following year. The expenditure pressure is essentially carried over. For example, if additional staff are recruited in the final quarter of the year (Q4) this results in 30% of the total cost of those staff being paid in that same year while the remaining 70% will be paid in the following year. Both the increase in overall staff numbers and the timing of recruitment has contributed toward significant overruns on the pay Budget agreement in recent years. See Table 1 below for overruns from 2015 to 2017.

TABLE 1: ACTUAL PAY EXPENDITURE COMPARED TO PAY BUDGET

	2015	2016	2017
	€m	€m	€m
Actual Pay Expenditure	6,220	6,442	6,772
Pay Budget	5,975	6,341	6,533
Overrun (€m)	245	101	239
Overrun (%)	4%	2%	4%

Source: HSE Employment Report

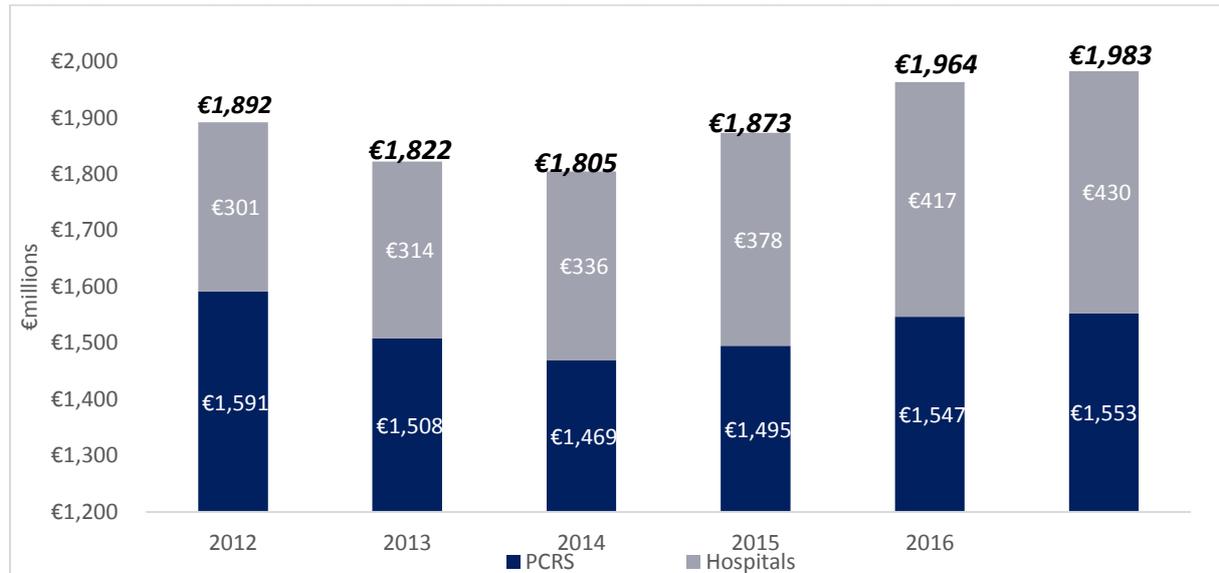
Non – Pay Related Expenditure

II. Pharmaceuticals

Pharmaceutical expenditure has fluctuated over the period 2012 to 2017. Spend on some community schemes⁶ decreased from 2012 to 2014 as a consequence of the introduction of a number of FEMPI measures and other policies to reduce pharmaceutical prices. These decreases have been offset by increases in spend on High-tech medicines. Expenditure on the High-tech drugs scheme has continually increased over the period with High-tech spend increasing by €231m or 70% over the period 2011-2017. The continued growth in High-tech drugs is driven by the introduction of new medicines and increased utilisation of existing medicines. Most drugs in the High-tech space are innovative and spend on these drugs has been increasing rapidly, primarily due to increasing volume and high prices.

⁶ General Medical Services (GMS), Drug Payment Schemes (DPS), Long Term Illness (LTI)

FIGURE 5: PHARMACEUTICAL SPEND ACROSS HOSPITALS AND COMMUNITY SCHEMES 2012 - 2017



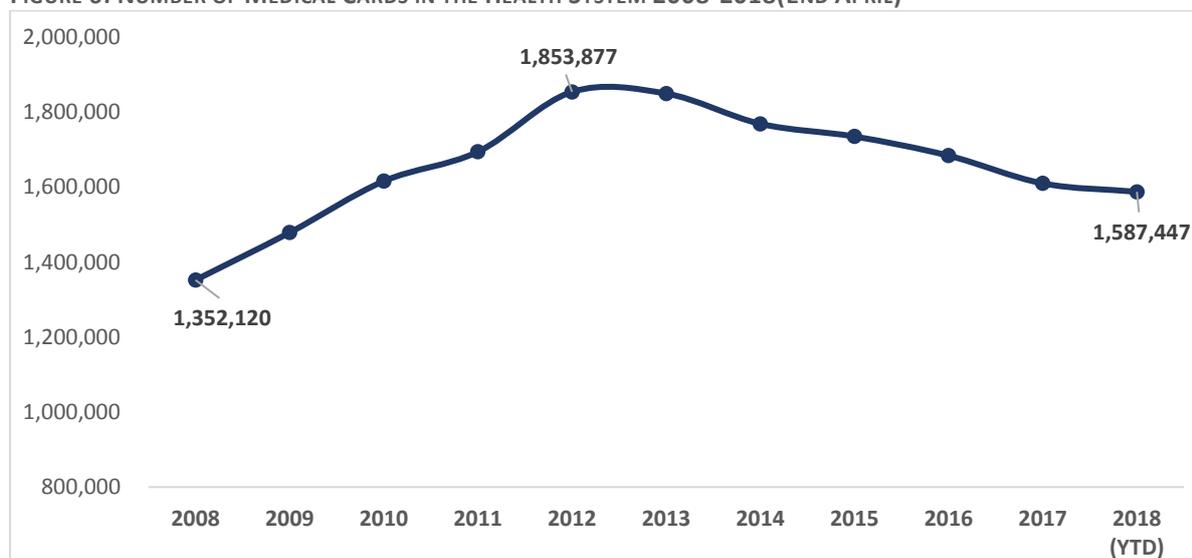
Source: PCRS Administrative Data

In 2017, expenditure on medical cards was €1.4bn. Medical card numbers peaked between 2012 and 2013 and since then have been on a downward trajectory. Medical Card numbers have fallen by 266,430 from mid-2013 to April 2018 primarily driven by improvements in the labour market.

- In 2015, medical card numbers fell by around 33,847 annually.
- In 2016, the annual reduction in medical cards was forecast to be 38,000, however numbers fell further than expected, reducing by 51,000.
- This downward trend continued in 2017 and 2018 with numbers falling by a further 74,000 in 2017 and 22,000 from January to April 2018. See Figure 6 for card numbers from 2008 – 2018 (April).

These cyclical reductions have significantly reduced non – pay related expenditure pressures.

FIGURE 6: NUMBER OF MEDICAL CARDS IN THE HEALTH SYSTEM 2008-2018(END APRIL)



Source: PCRS Administrative Data

III. State Claims Agency Expenditure

Another key driver of non-pay expenditure is the State Claims Agency (SCA). SCA expenditure has increased substantially over the last four years rising from €109m in 2014 to an estimated €354m in 2018. This is an increase of €254m or 233%. See Table 2 below for annual SCA outturn from 2014 to 2018 (estimated).

TABLE 2: SCA OUTTURN 2014 TO 2018 (ESTIMATE)

	2014	2015	2016	2017	2018*	Increase from 2014 - 2018*	
	€m	€m	€m	€m	€m	€m	%
SCA Outturn	109	205	229	283	363	254	233%
Annual Increase (€m)		96	24	54	80		
Annual Increase (%)		88%	12%	24%	28%		

Source: HSE Performance Reports *SCA outturn is a Department of Health estimate for outturn in 2018.

The increase in SCA expenditure is largely as a result of increases in medical litigation. An Expert Group chaired by Justice Meenan was established in 2018 and this group has been tasked with reviewing the current systems in place for managing clinical negligence claims. The Expert Group will also examine tort law relating to personal injuries arising in the healthcare context and will consider options for reform of the relevant tort law.

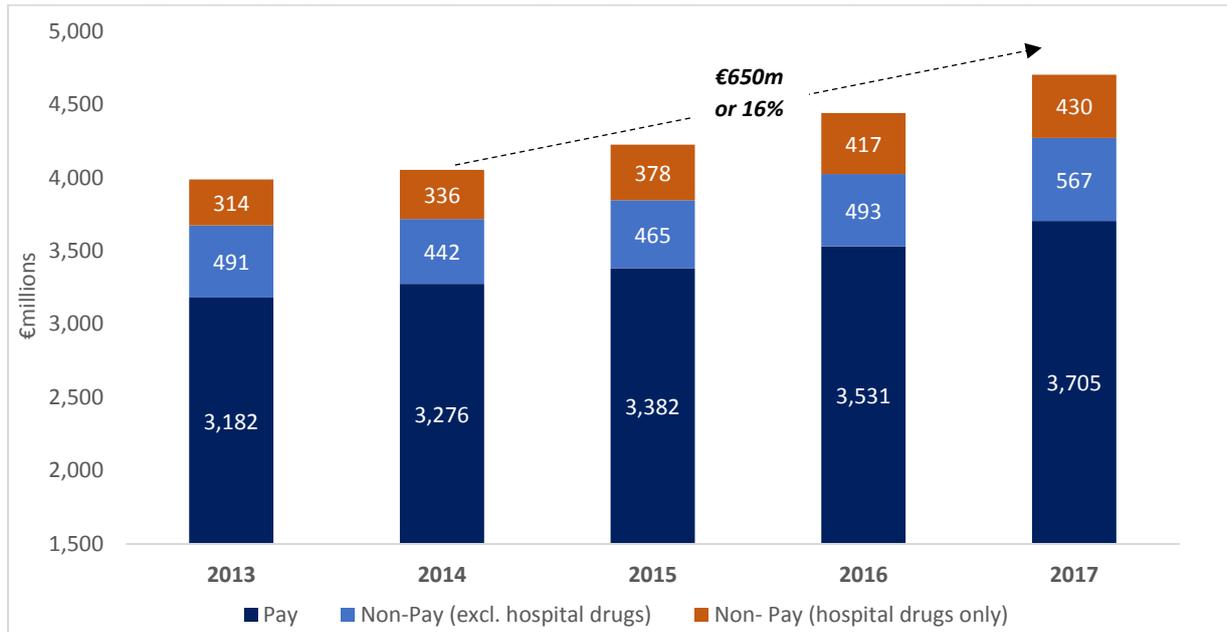
In terms of growth in spend by service area, the majority of the increases in health funding have been directed toward Hospitals.

Over the period 2014 to 2017, the service area which received most of the additional funding has been the hospital sector. This spend includes both pay and non-pay elements some of which have been identified earlier in this section. Hospital spend from 2014 to 2017 has mirrored the trajectory of overall health spend. Hospital spend remained relatively flat from 2013 to 2014 but there was a significant change in the trajectory of hospital spend beyond 2014 as spend increased substantially.

Hospital spend increased by €650m or 16% from 2014 to 2017. This growth can be broken down as follows:

- €429m or 66% is pay related expenditure
- €221m or 34% is non-pay related spend

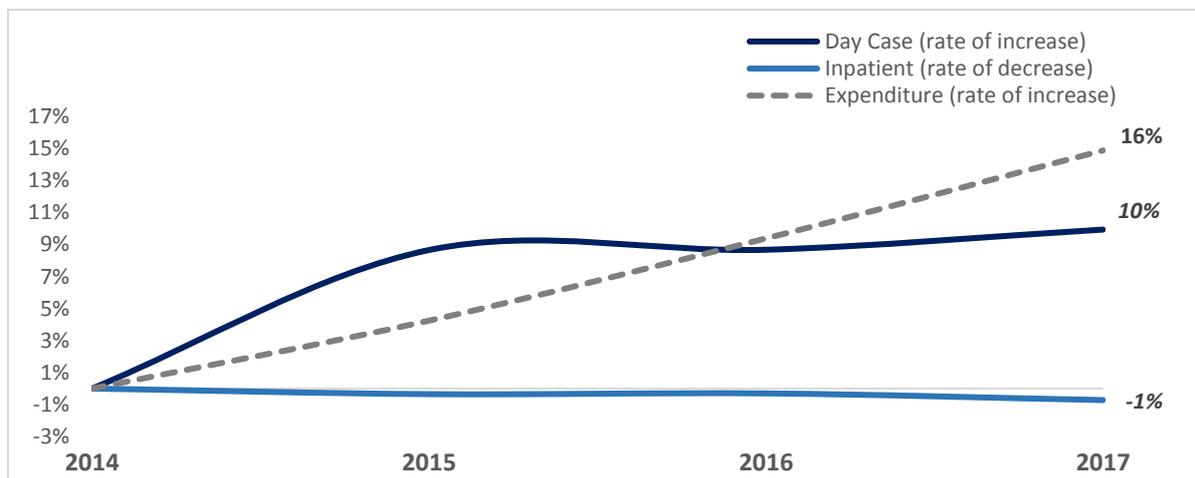
FIGURE 7: DECOMPOSING GROSS EXPENDITURE IN ACUTE HOSPITALS BY PAY AND NON-PAY 2013 - 2017



Source: HSE Administrative Data

Figure 8 below sets out the rate of change in hospital spend and hospital activity metrics. Activity metrics include inpatient discharges and daycase discharges. This graph highlights the differences between the rate of growth in day case procedures and the reduction in inpatient procedures compared with the increase in expenditure over the period 2014 - 2017.

FIGURE 8: RATES OF CHANGE SINCE 2014 - DAY CASE DISCHARGES, INPATIENT DISCHARGES AND ACUTE SPEND



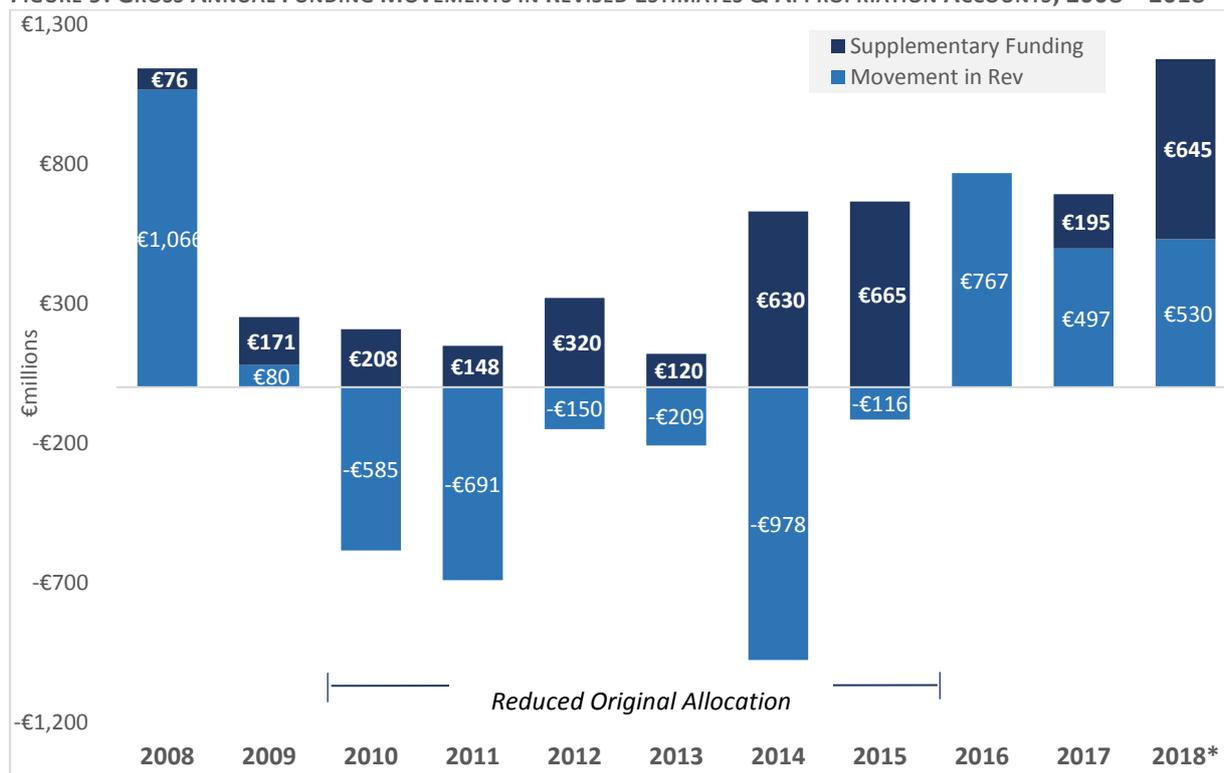
Source: Administrative Hospital Data. The graph assumes 2014 as the base year.

The graph above reflects a sharp and consistent increase in expenditure over the period 2014 to 2017. While the rate of the increase in day case procedures grew between 2014 and 2015, it then begins to taper off while spend continues to increase. In contrast to day case procedures and spend, inpatient procedures remained relatively flat over the period (Lawless, 2018).

Section 3: Budget Management and Planning

All Public Services must operate within the funding parameters available to them, therefore management and prioritisation is imperative to delivering more and improved services. The Budget allocations provided to key health services are assigned following substantial consideration and analysis of a range of factors. Despite this process, the health service has consistently failed to manage within its annual Budget allocation by significant amounts. See **Figure 9** below for gross annual funding movements and supplementary funding provided to health from 2008 to 2018.

FIGURE 9: GROSS ANNUAL FUNDING MOVEMENTS IN REVISED ESTIMATES & APPROPRIATION ACCOUNTS, 2008 – 2018*



Source: Revised Estimates 2008 – 2018 (annual movements - outturn versus estimate) and Appropriation Accounts 2008 – 2017 (supplementary estimates) *Disestablishment of the HSE Vote in 2014 resulted in €1bn health expenditure moving off Vote. This may account for the large expenditure decrease in 2014. In 2016, the original estimate was revised which provided an additional €500m to Health.

From 2010 to 2015, the original Budget allocations provided to Health reduced the total funding available annually as a result of savings delivered through the implementation of a number of central measures. While the supplementary funding provided in both 2014 and 2015 was significant at over €600m, these were in the context of reduced Budget allocations for those years. **This is significantly different to the more recent position where from 2016 onwards the Budget allocation provided to Health was on average an additional €431m.** Despite the significant additional funding provided in these Budgets, **the health sector has continued to require supplementary funding. The supplementary funding has ranged from €195m to around €645m. This has resulted in the health sector receiving an additional €2.6bn between Budget 2016 and Budget 2018.**

There appears to be a change in terms of Budget management over the last 3 years. From 2010 to 2014 (excluding 2012) the Health Budget was reduced annually, despite these reductions when the final accounts were published there was a significant surplus reported ranging from €6m to €352m. From 2015 to 2017, the investment in health increased significantly however the annual surplus which had been experienced every year for the previous 7 did not materialise. If there are overspends in addition to the Supplementary Estimates illustrated in Table 3 these spill over into the subsequent year and reduce funds available for that year.

TABLE 3: TOTAL ANNUAL HEALTH ADDITIONAL ALLOCATION V'S FINAL ANNUAL ADDITIONAL SPEND 2008 - 2017

	2008	2009	2010	2011	2012	2013	2014*	2015	2016	2017
	€m	€m	€m	€m	€m	€m	€m	€m	€m	€m
Total Health Budget (incl. Supplementary Funding)	€1,142	€251	-€377	-€543	€170	-€89	-€348	€549	€767	€692
Final Additional Spend	€1,016	€134	-€729	-€612	€44	-€140	-€354	€553	€766	€691
Surplus/Deficit	€126	€117	€352	€69	€126	€51	€6	-€4	€1	€1

Source: Constructed based on Figure 2 and Figure 9. The trends for surplus/deficit are broadly in line with Appropriation Account.

Management tools: HSE National Service Plan

A key tool used for managing the HSE annual Budget is the National Service Plan (NSP). The main purpose of this plan is to set out the level of services that will be provided for the Budget across key areas. The HSE NSP is drafted in line with the net determination and the agreed Budget as published in the Rev. Both the requirements for the NSP and the drafting process are set out in the *Health Act 2004*. The primary requirement under this legislation is that the HSE must have regard to the net determination for the year when preparing the NSP. The legislation also sets out more specific key requirements for the NSP. **Over the last number of years, annual NSPs have not fulfilled all legislative requirements. See the table below for key legislative requirements for the NSP which have not been adhered to:**

Key legislative requirements for NSP
<ul style="list-style-type: none"> The service plan must contain estimates of the number of employees of the Executive for the period and the services to which they relate.
<ul style="list-style-type: none"> The HSE NSP is drafted in line with the net determination and the agreed budget published in the Rev.
<ul style="list-style-type: none"> The NSP must indicate the type and volume of health and personal social services to be provided during the period to which the plan relates.

1. NSP Aligned to Budget

As set out in the Health Act 2004, the HSE must have regard to the net determination for the year when preparing the NSP. The NSP 2016 and NSP 2017 set out the services to be provided within the allocations as agreed at Budget time. For these years, the service plans highlighted some challenges, but the scale of the challenges were presented as manageable and did not appear to seek additional funding. In addition, a detailed approach to managing these challenges was presented within the agreed allocation. The NSP 2018 sets out the allocations for the service areas as provided for during the Estimates process. However, in contrast to previous years, the NSP 2018 appears to imply a shortfall in funding. The plan specifically set out key risk areas and an associated saving requirement of €346m. Subsequently these savings were not delivered and has resulted in an overrun in 2018. The HSE is required to manage within its Budget, which implies that it has to base its plans on the most reasonable estimate of income and expenditure, thereby minimizing the financial risks of overrunning.

TABLE 4: REPORTED FINANCIAL CHALLENGE IN PAST NSP (CURRENT EXPENDITURE ONLY)

	Outturn €m	NSP Reported Financial Challenge	Savings underpinning NSP*
<u>2014 Add:</u>	11,728		
<i>Reported in NSP</i>		€1,038m	€129m
2014 Supplementary Estimate	630		
2014 Outturn	12,358		
<u>2015 Add:</u>			
Additional Resources allocated in Budget 2015	- 67		
<i>Reported in NSP</i>		€140m	€170m
2015 Supplementary Estimate	665		
2015 Outturn	12,956		
<u>2016 Add:</u>			
Additional Resources allocated in Budget 2016	242		
<i>Reported in NSP</i>		-	€186m
2016 Revised Allocation	500		
2016 Outturn	13,695		
<u>2017 Add:</u>			
Additional Resources allocated in Budget 2017	457		
<i>Reported in NSP</i>		€35m	€123m
Supplementary Estimate 2017	195		
Forecast Outturn 2017	14,347		
<u>2018 Add:</u>			
Additional Resources allocated in Budget 2018	490		
<i>Reported in NSP</i>		€881m	€346m
Additional resources allocated in REV 2018	40		
2018 Allocation	14,877		

* Savings beyond agreed Budget savings, these are mainly in the areas of Agency expenditure and hospital income.

2. Number of Employees

As set out in the legislation, the NSP should also outline the number and type of staff the HSE expect to recruit throughout the year within the Budget available. **Since 2013, the NSP has made no reference to the number of staff the HSE expect to recruit throughout the year and the associated cost of these staff.** The management of staff is a fundamental part of overall Budget management as pay related spend accounts for almost half of total health spend, the pay component equates to around 47% of total spend. Therefore managing recruitment is critical to overall Budget management.

Other workforce planning tools include:

1. HSE Pay and Numbers Strategy

The HSE are required to produce a Pay and Numbers Strategy each year. This strategy should set out the number of staff that will be hired throughout the year across grades and service area. This should also set out the amount expected to be spent on different components of the pay bill such as, direct pay, agency pay, overtime and allowances.

In 2016, the *HSE Pay & Numbers Strategy* allowed for the HSE to increase staffing levels by 2,512 WTEs throughout the year. However, the HSE failed to stick to their plan and the end 2016 outturn was 689 WTEs above the expected end of year position in the plan. Further to this, the HSE submitted a revised 2016 Pay and Numbers Strategy in December 2016, the final month of the year. This looked to increase the end year 2016 number by 1,036 WTEs, despite not having the resources to increase staffing levels beyond the original agreed strategy. For 2017, the *HSE Pay & Numbers Strategy* was only submitted to the Department of Public Expenditure and Reform in November 2017. Similarly in 2018, the *HSE Pay & Numbers Strategy* was only submitted in August 2018. These timelines result in the Strategy having no impact on the planning and monitoring process.

2. Department of Health Workforce Plan 2017

The Department of Health published a workforce plan in 2017 titled *Working Together for Health: A National Strategic Framework for Health and Social Care Workforce Planning*⁷. This plan sets out a detailed five step approach to workforce planning, these steps include identifying needs, assessing demand and supply, identifying and implementing solutions, monitoring and evaluating outcomes. The plan sets out the approach to workforce planning however it makes little or no reference to available resources. There is no consideration of what current resources are being spent on or what can be delivered in the future within a sustainable level of funding.

⁷ <https://health.gov.ie/wp-content/uploads/2017/06/WFP-Framework-Consultation-Report.pdf>

Conclusion

In the early part of the decade 2007 to 2017, expenditure fluctuations were reflective of changes in the economic environment. Health expenditure reached a peak in 2009 and from this point fell considerably until 2013 as a result of the economic downturn. The reductions in health expenditure were primarily delivered through changes in pay policy, these included reductions in numbers and the use of Financial Emergency Measures in the Public Interest (FEMPI). **However, since 2014 expenditure on health care has increased significantly from €13.8bn to €15.6bn in 2017.** This has also resulted in health sector continually requiring supplementary funding in addition to the original Budget provided.

Recommendations for Budget Management:

- Over the last three years the health service has been provided with significant increased funding levels as part of the annual Budget process.
- Despite significant increases in annual Budget allocations, the health sector has continued to overspend and require supplementary funding. The supplementary funding provided has ranged from €195m to around €645m. **This has resulted in the health sector receiving around €2bn between Budget 2016 and Budget 2018.**
- One of the key planning tools available to the HSE is the annual NSP. Under legislation, there are a number of requirements which this document must include. However, in recent years the NSP has not fulfilled all of these legislative requirements. See table below:

Key legislative Requirements for NSP	Included in Published NSP
1. Must contain estimates of the number of employees of the Executive for the period and the services to which they relate.	<ul style="list-style-type: none"> • Since 2013, the annual NSP has not included estimates of the additional staff expected to be recruited that year.
2. Must be drafted in line with the net determination and the agreed budget published in the Rev.	<ul style="list-style-type: none"> • The NSP has not been drafted in line with the agreed Budget. • Since 2014, there has consistently been savings assumptions underpinning the NSP. These have led to the Health Service overspending on the Budget allocation when these savings don't materialise.
3. Must indicate the type and volume of services to be provided during the period to which the plan relates.	<ul style="list-style-type: none"> • The NSP includes a list of Key Performance Indicators (KPIs) for a selected number of areas. There is little detail linking the type and volume of services that are expected to be delivered to the available Budget.

- In recent years it appears that unrealistic planning assumptions were created from the outset to give additional headroom to spend beyond available funding. This additional expenditure must be funded by Government as areas where assumptions are made tend to be critical service areas. This has resulted in health overruns and the provision of supplementary funding.
- At its simplest level, Budget management and health sector planning could be significantly improved if the annual NSP fulfilled all legislative requirements. This would also provide greater transparency and improve the performance monitoring process.

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Quality assurance process

To ensure accuracy and methodological rigour, the author engaged in the following quality assurance process.

✓ Internal/Departmental

- ✓ Line management
- ✓ Peer review (IGEES network)

✓ External

- ✓ Other Government Department