Irish Fiscal Advisory Council

The path for Ireland's health budget

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DEW 17th Sep 2022

Two observations

1) Health spending in Ireland has far outpaced economic growth (2% national income in mid-1900s; now 8%).

   This is likely to continue as population ages and as Sláintecare reforms are implemented.

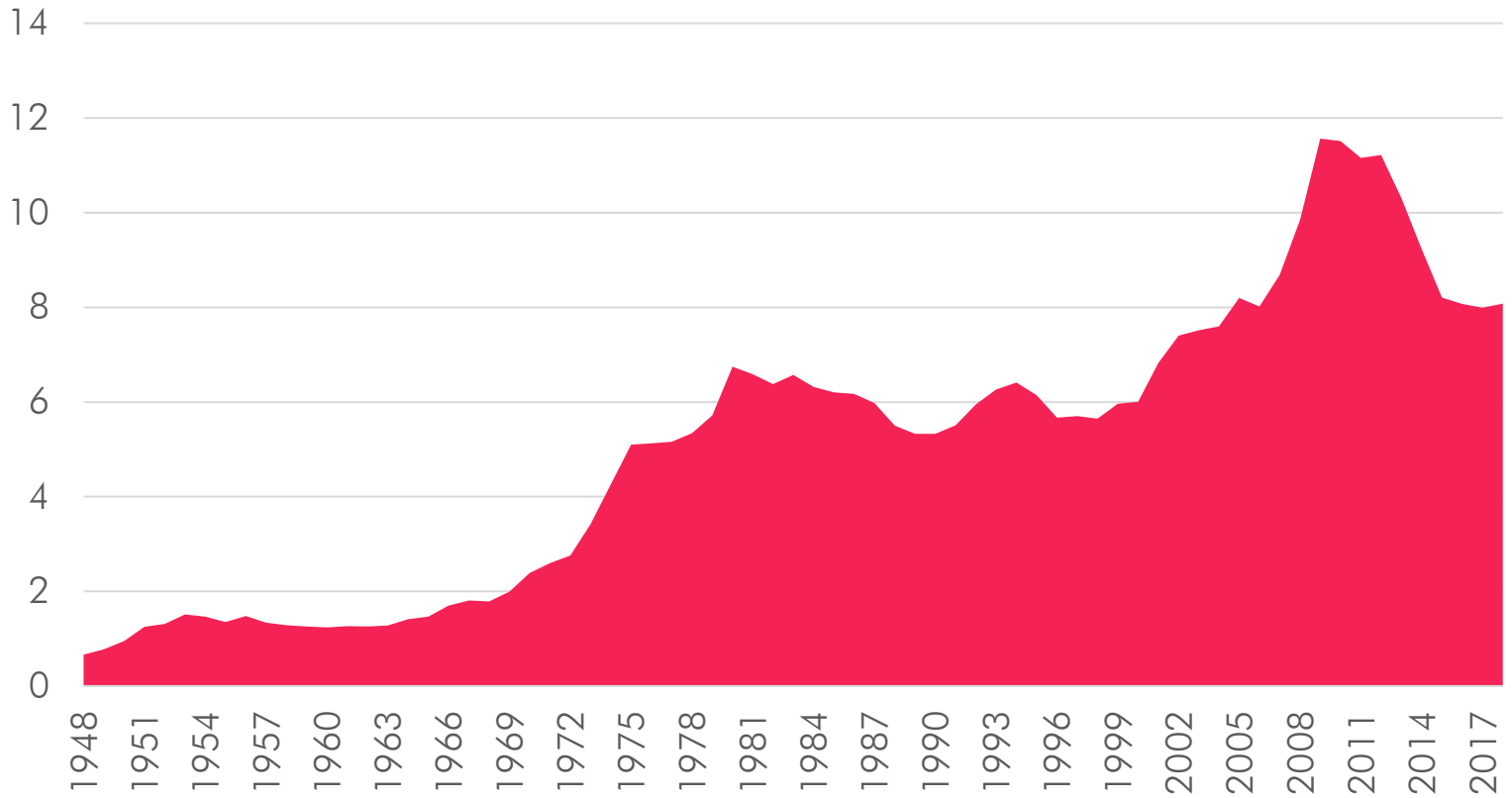
2) Much of the recent increases have not been budgeted for. The poor planning and weak spending controls we see put the wider public finances at risk.

A long–term view

From 2% to 8% of national income

Public health spending has outpaced economic growth

% GNI*

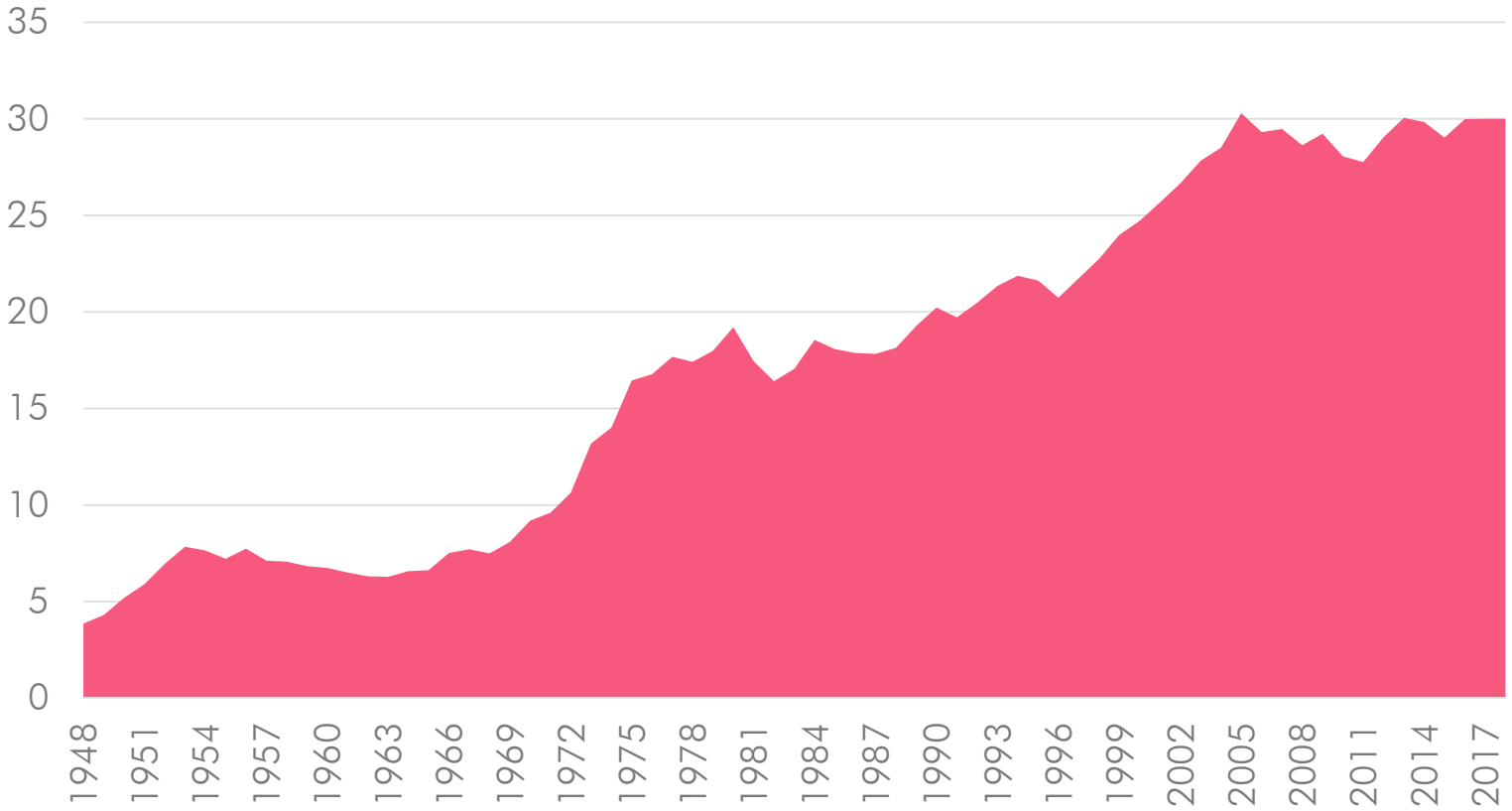


Sources: Barbieri and Bewley (2022)

From <10% to 30% of total spending

Health 30% of all government spending

% total government spending

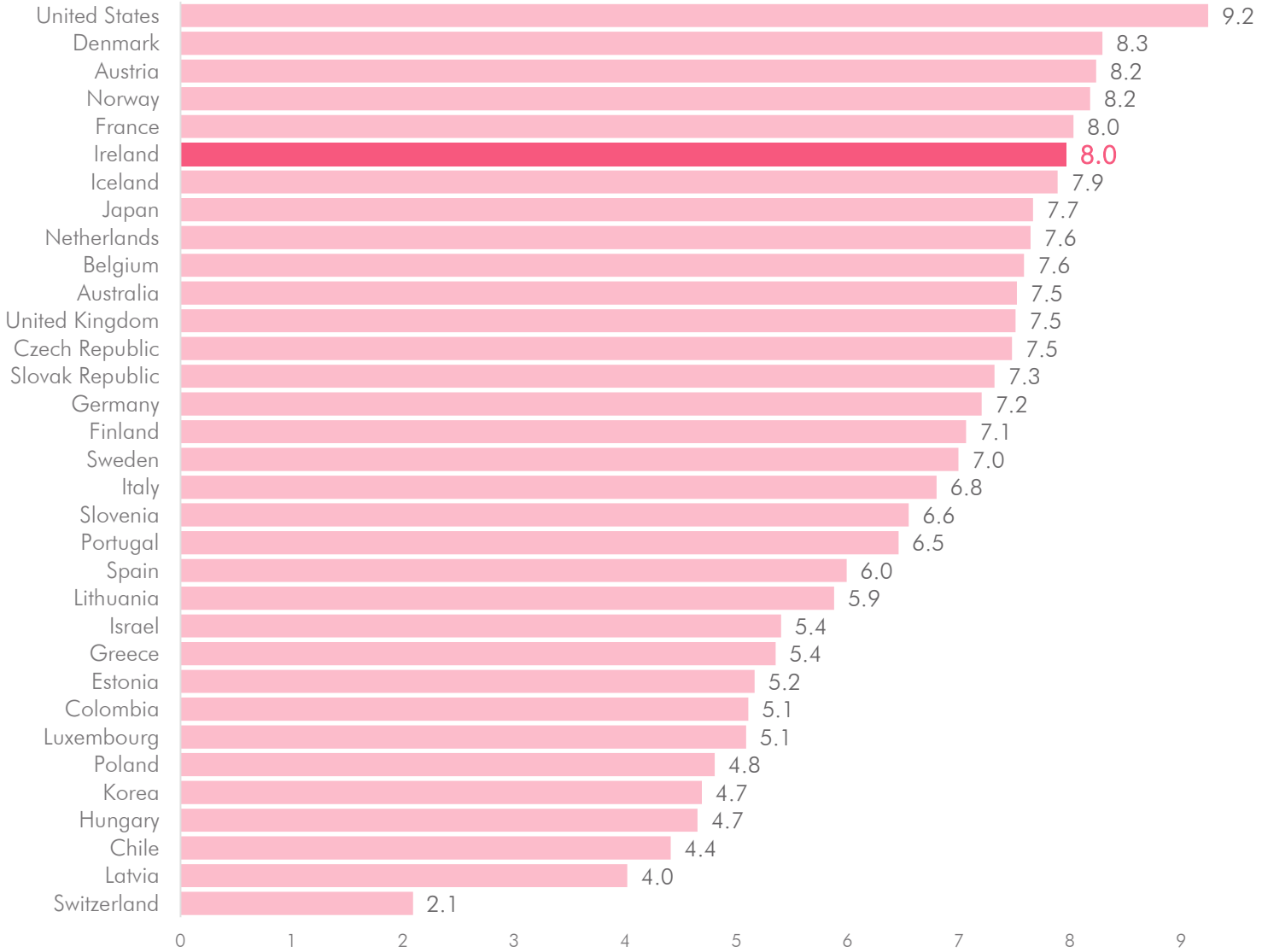


Sources: Barbieri and Bewley (2022)

High relative to peers

Irish Fiscal Advisory Council

% GDP (GNI* for Ireland), 2018 data



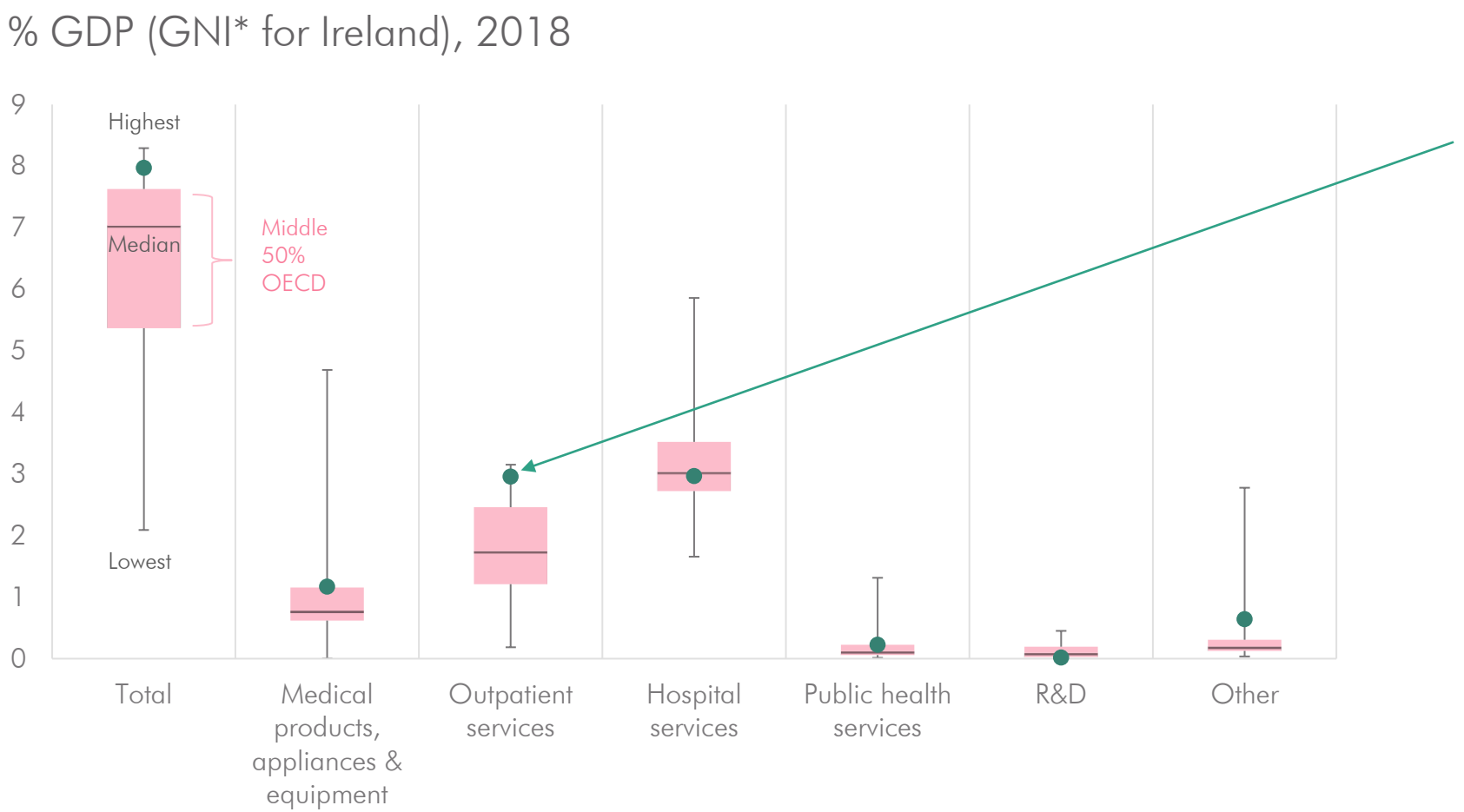
Of the 33 OECD countries where comparable data are available, Ireland ranks as the 6th highest for government spending on healthcare

Sources: OECD; CSO; and own workings.
Notes: The data shown are for general government health spending in 2018, using the COFOG classification, relative to national GDP or, in Ireland's case national income (GNI*).

There are some caveats around this but picture seems to remain the same

- Wren and FitzPatrick (2020): Ireland still a relatively high spender on health, even when controlling for differences in how spending on social care is allocated. Cite high prices, and notably high wage costs.
- Some long-term care, such as assistance services that enable a person to live independently, is classified as health spending in Ireland. However, in many other countries that report to the OECD, this can be classified as social spending.
- Wren and FitzPatrick (2020) find that Ireland's ranking for public spending in the EU15 drops from 5th to 6th when combined with *social* spending on health.

Ireland seems to spend relatively more on outpatient services



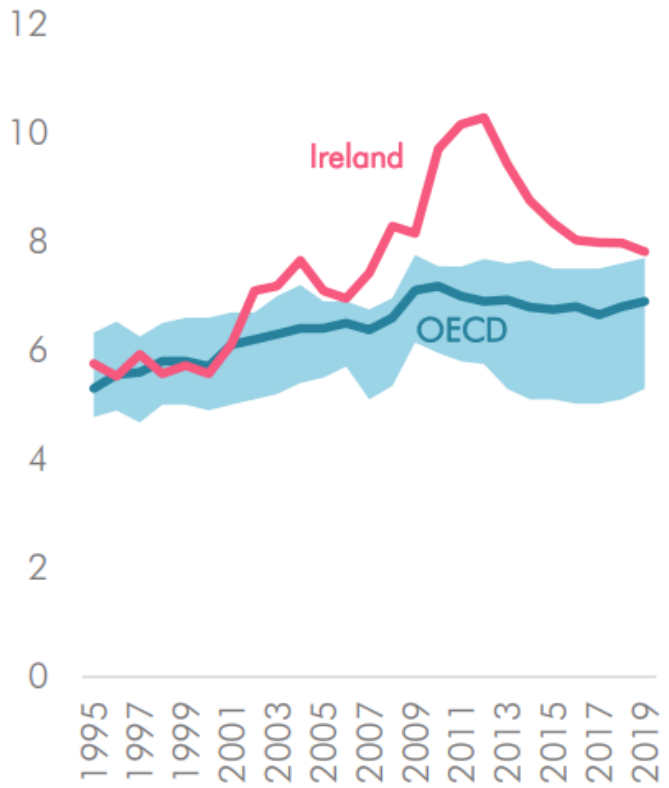
Outpatient services are basically hospital services for a day (not overnights or longer-term hospitalisations).

Health warning on data here

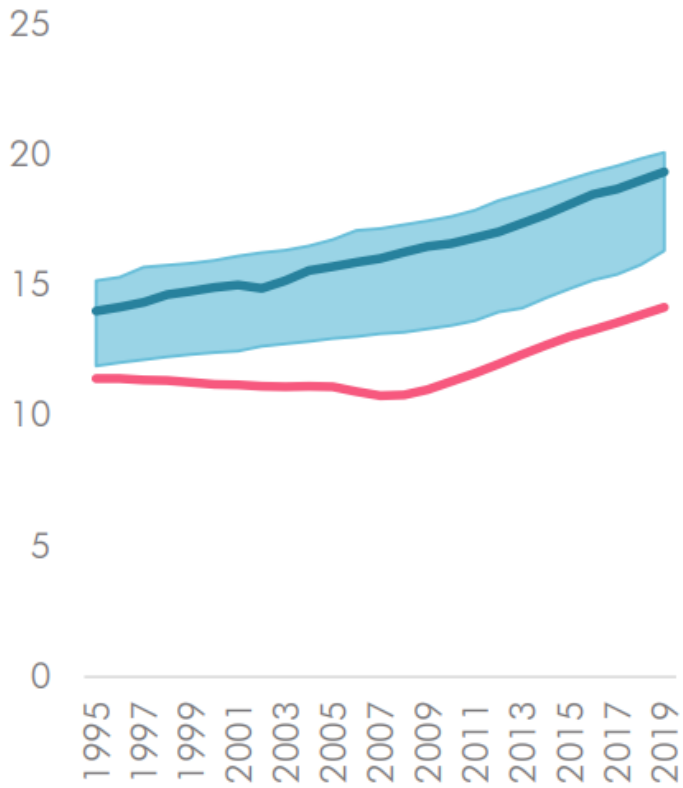
Sources: OECD; CSO; and own workings.
Notes: The data shown are for general government health spending (using the COFOG classification) relative to national GDP or, in Ireland's case national income (GNI*).

Health spending has risen fast by international standards

A. Health spending as share of economy
% GDP (GNI* for Ireland)



B. Elderly population
% population over 65



Sources: OECD; Eurostat; CSO; and Fiscal Council workings.
Notes: OECD shows the median for OECD countries where data are available and the middle 50% range (inter-quartile range). Data are available from the OECD directly for 2007 onwards, but are extended back to 1995 using Eurostat data for a subset of the OECD countries.

Why is it rising fast?

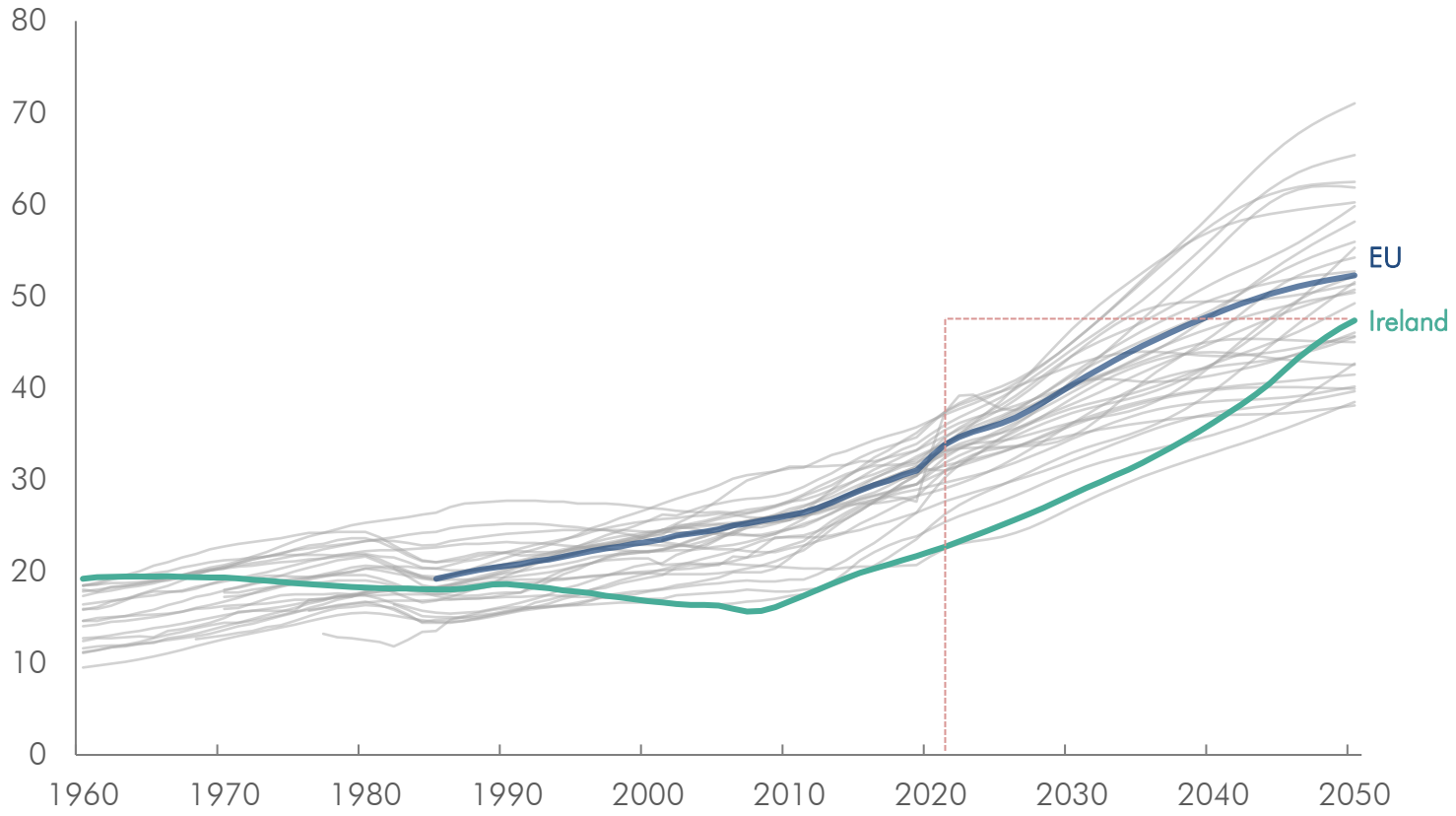
- Not easy to answer this
- Two key factors usually cited in the literature for international increases:
  - ageing
  - general rise in people's incomes: health seen as a "luxury good" — a demand rises faster for it relative to incomes.
- Studies often look at 65+ age cohort and GDP per capita (Newhouse 1977; Kleiman 1974).
- We re-examine for past five decades, with a similar specification
  - We find incomes and ageing are positive and significant drivers of healthcare spending over time
  - But these approaches are blunt and have shortcomings. Adding a simple time trend or lag, which is appropriate, => two drivers less important.

Why is it rising fast?

- Instead, other drivers more difficult to model may be playing a crucial role.
    - **Baumol's cost disease**: health wages tend to rise faster—and more in line with wages elsewhere—than productivity advances in health (higher costs for same output)
    - **Technological advancements** increase spending, including on new drugs, treatments, machines, and tests
    - **Specific policy reforms:** think Sláintecare

Ireland is ageing rapidly

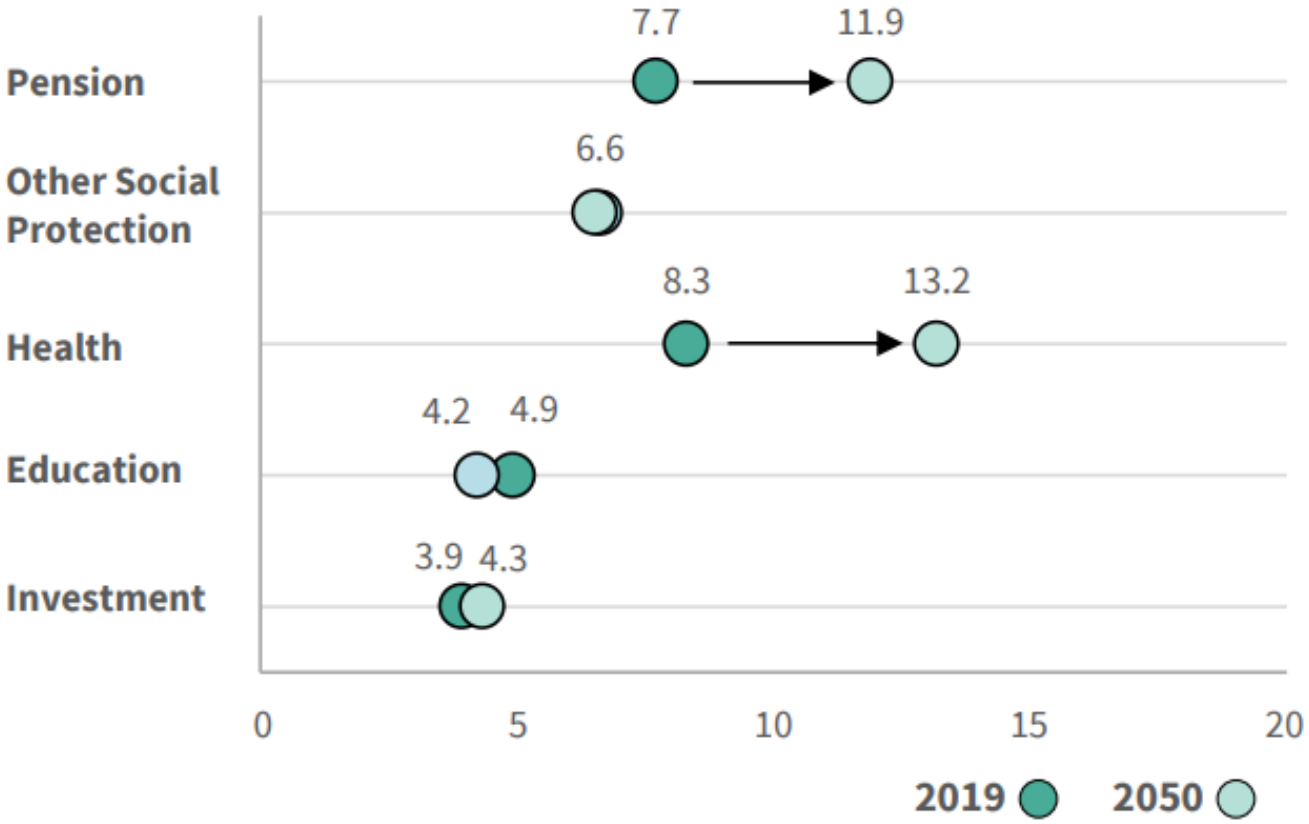
Ages 65+ as % of population aged 15–64



Source: Fiscal Council Long-term Sustainability Report (2020)

Ageing will lead to higher Health and Pension spending

% of GNI* (general government basis)

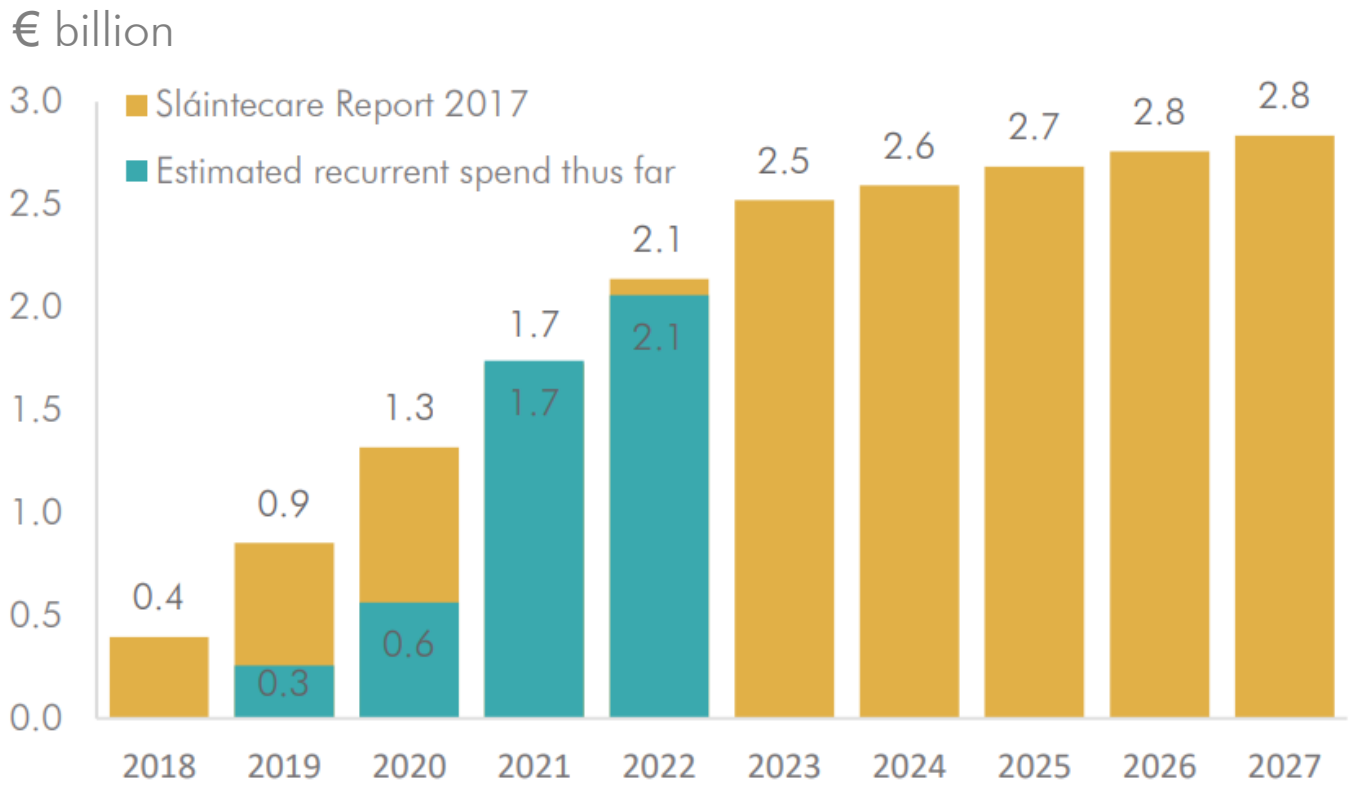


Two-thirds of the increase would be due to demographic pressures (including ageing and population increases)

One-third due to price and wage pressures

Source: Fiscal Council Long-term Sustainability Report (2020)

Sláintecare costs out of date and no clarity on progress

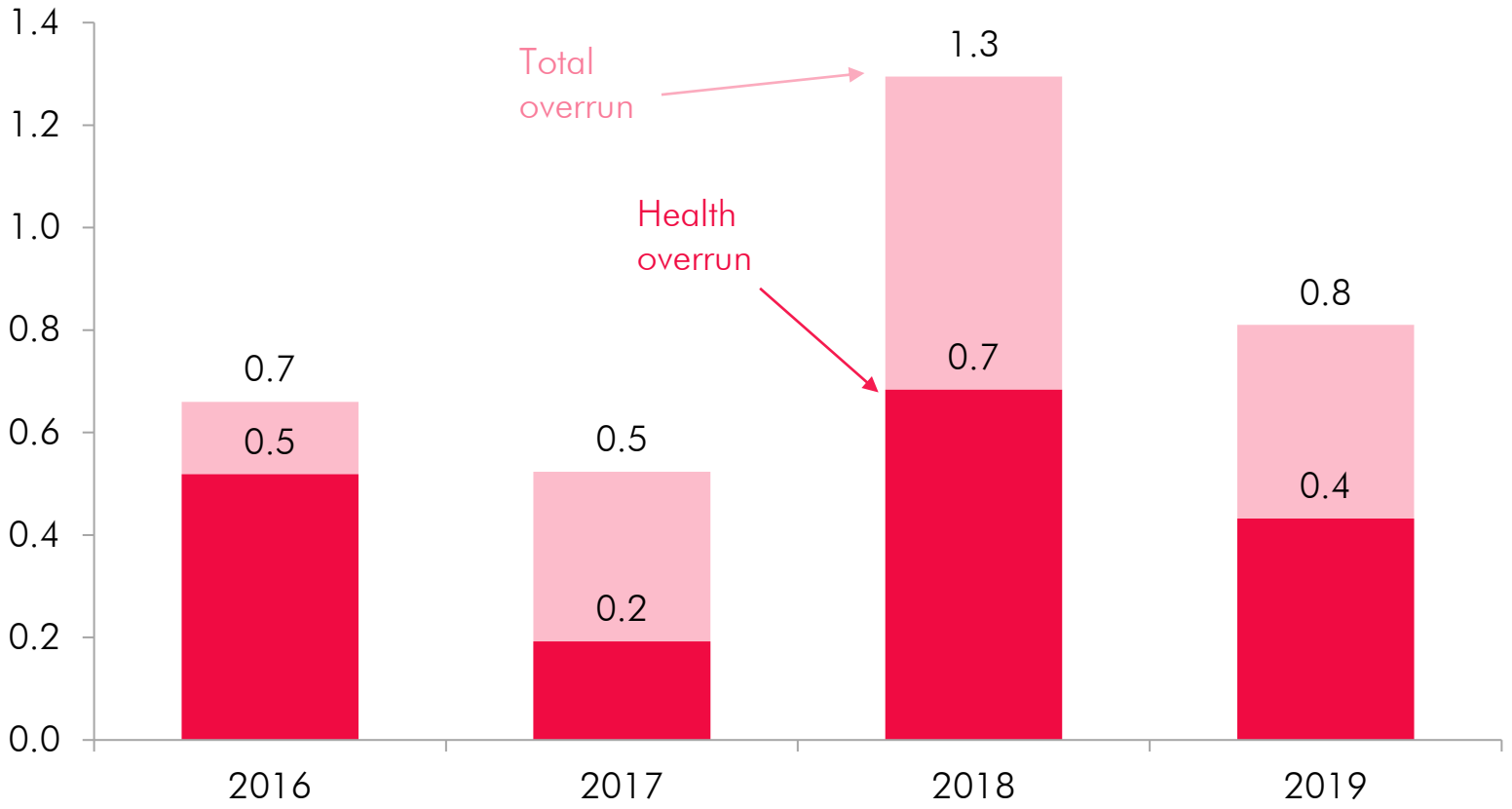


Sources: Sláintecare Report 2017; Department of Health; and own workings.
Notes: The "estimated spend thus far" represents the increase in recurrent annual health spending that is associated with Sláintecare as derived from budget day plans. The actual increases may vary, however, as these are plans rather than outturns, and the figures are not precise, in that costs tend to be mixed in with the costs of other more general expansions in publicly provided health services.

Recent budgeting problems

Health accounted for more than half of recent overruns

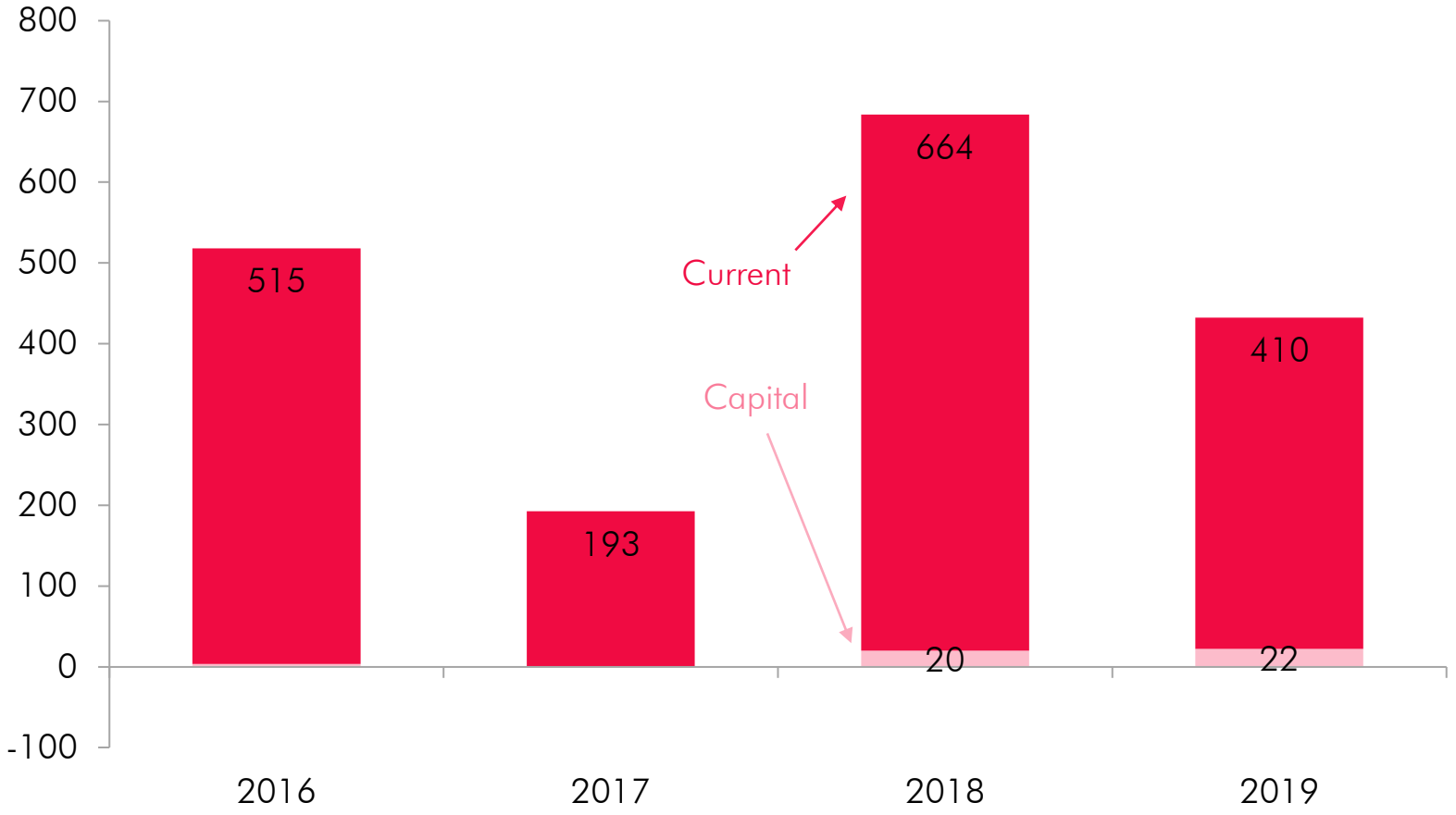
€ billions, government spending overruns



Sources: Department of Public Expenditure and Reform; and Fiscal Council workings. Notes: The figure shows within-year spending increases. These are based on gross voted spending outturns as compared to forecasts. The forecast vintages used are: Budget 2015 for 2015; Budget 2016 for 2016; Budget 2017 for 2017; SPU 2018 for 2018 (due to the reclassification of spending on water services into the Department of Housing); and Budget 2019 for 2019.

Overruns are mainly on recurrent spending

€ millions, government spending overruns



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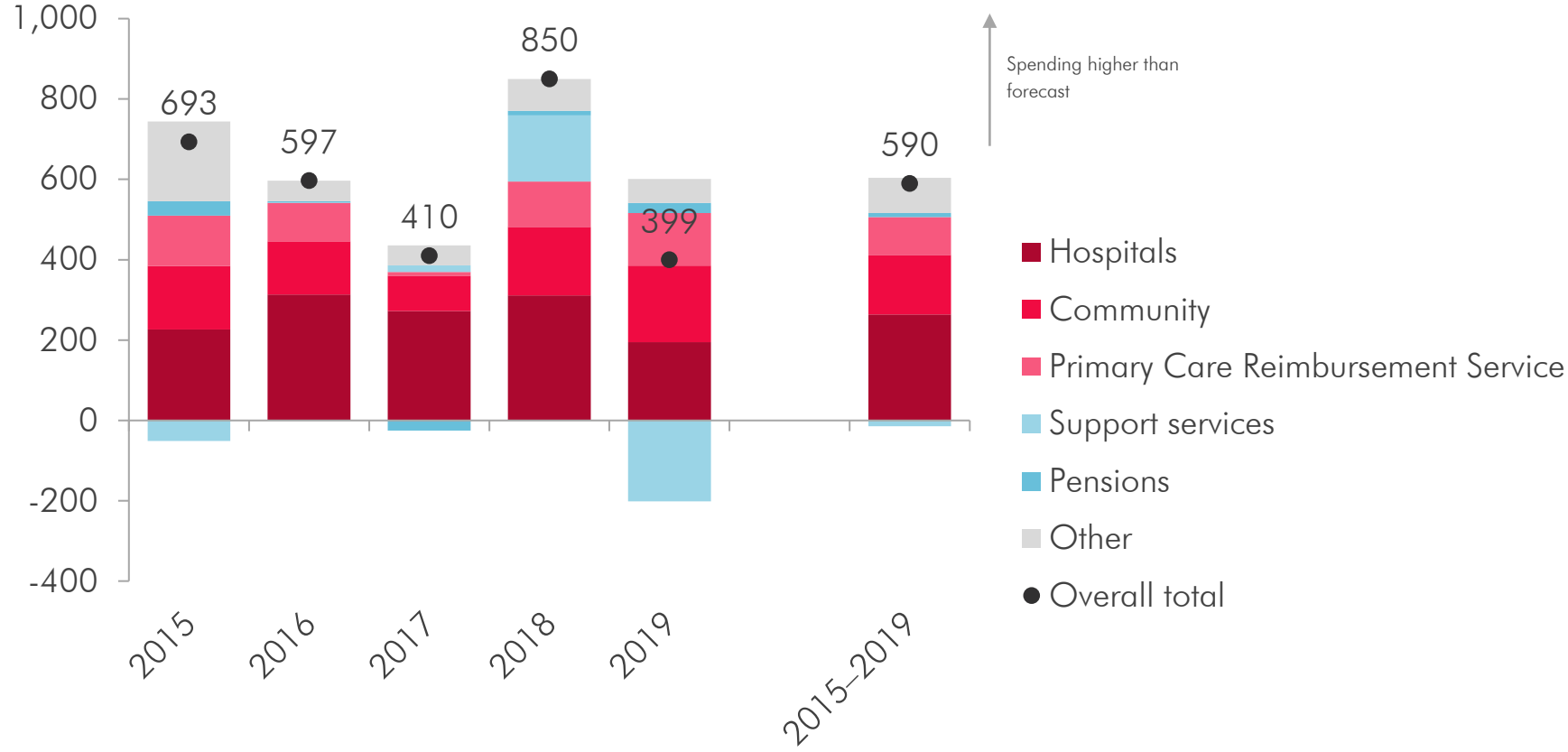
HSE overruns mainly due to hospitals and primary care

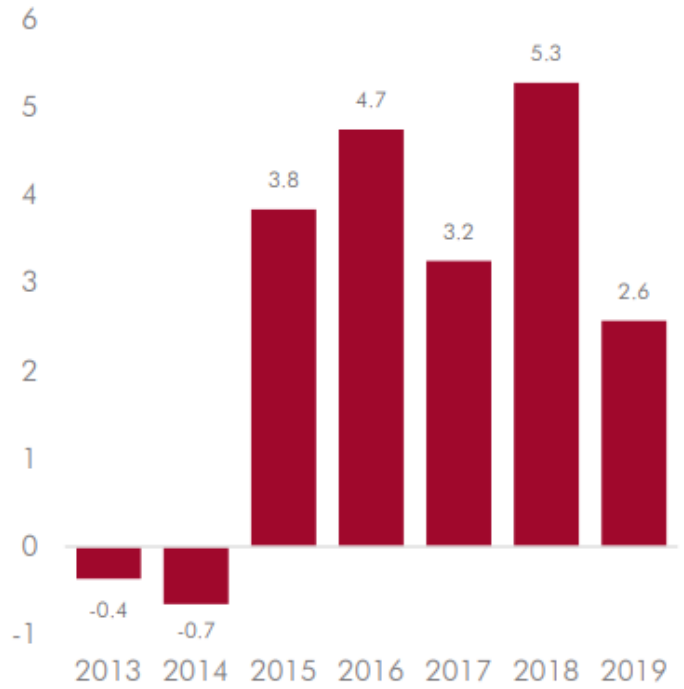
€ millions, government spending overruns (+) / underspends (-)



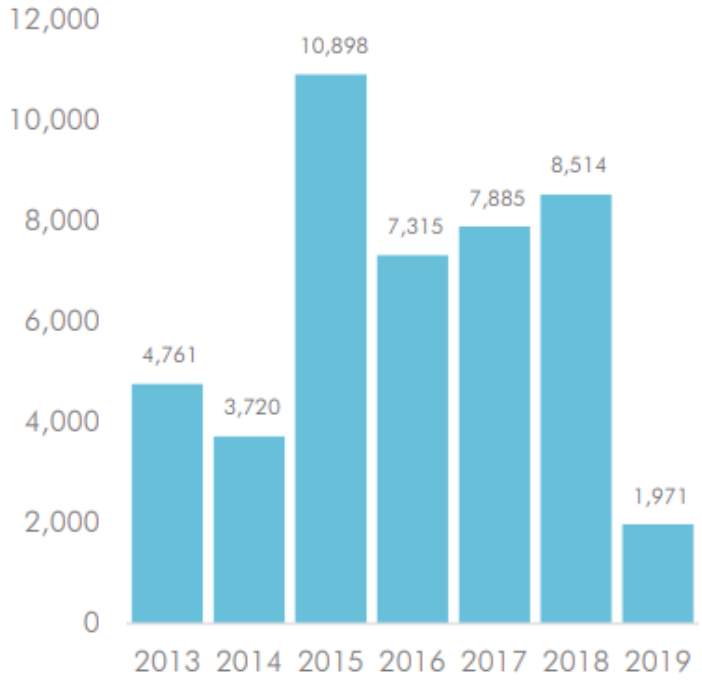
Sources: Health Service Executive performance reports; and own workings.
Notes: Forecasts taken from the end-January Performance Reports; outturns from end-December. Hospitals includes includes acute hospitals + ambulances. Community includes Community Healthcare Organisations, Regional/National (Primary care, mental health, older persons care, disability services). The annual average is shown for 2015–2019 in the last bar.

Forecast errors in pay and staffing levels have been large

A. Pay bill errors have been large
Error as % of forecast pay bill



B. Staffing levels persistently above forecasts
No. of people over forecast staff levels



Sources: Various Expenditure Reports; Public service numbers databank and own workings.
Note: Staffing figures are on a whole-time equivalent (WTE) basis.

Biggest overspends are not in fast growth areas and should be fairly predictable

		2016	2017	2018	2019	Average 2016-2019
Hospitals	Actual % y/y	5.0	6.6	7.1	7.7	6.6
	Budgeted % y/y	-2.2	0.6	0.7	4.0	0.8
	Error pp	7.2	5.9	6.4	3.7	5.8
	Error €bn	0.3	0.3	0.3	0.2	0.3
Community	Actual % y/y	4.8	5.0	6.6	5.7	5.5
	Budgeted % y/y	2.1	3.3	3.4	2.3	2.8
	Error pp	2.7	1.7	3.2	3.4	2.7
	Error €bn	0.1	0.1	0.2	0.2	0.1
Primary Care Reimbursement Service	Actual % y/y	5.0	2.1	5.1	3.8	4.0
	Budgeted % y/y	1.0	1.7	0.7	-1.1	0.6
	Error pp	4.0	0.4	4.4	4.8	3.4
	Error €bn	0.1	0.0	0.1	0.1	0.1
Support services	Actual % y/y	5.0	11.6	81.3	-4.8	23.2
	Budgeted % y/y	4.7	6.2	32.0	28.3	17.8
	Error pp	0.3	5.4	49.2	-33.1	5.4
	Error €bn	0.0	0.0	0.2	-0.2	0.0
Pensions	Actual % y/y	31.6	16.6	9.1	24.3	20.4
	Budgeted % y/y	30.0	24.4	6.1	18.2	19.7
	Error pp	1.6	-7.8	3.0	6.1	0.7
	Error €bn	0.0	0.0	0.0	0.0	0.0
Other	Actual % y/y	6.0	13.4	-23.9	14.4	2.5
	Budgeted % y/y	-1.5	6.5	-33.6	4.8	-5.9
	Error pp	7.5	6.9	9.7	9.6	8.4
	Error €bn	0.1	0.0	0.1	0.1	0.1
Overall total	Actual % y/y	5.5	5.9	6.6	6.5	6.1
	Budgeted % y/y	0.8	2.8	0.6	3.9	2.0
	Error pp	4.7	3.0	5.9	2.6	4.1
	Error €bn	0.6	0.4	0.8	0.4	0.6

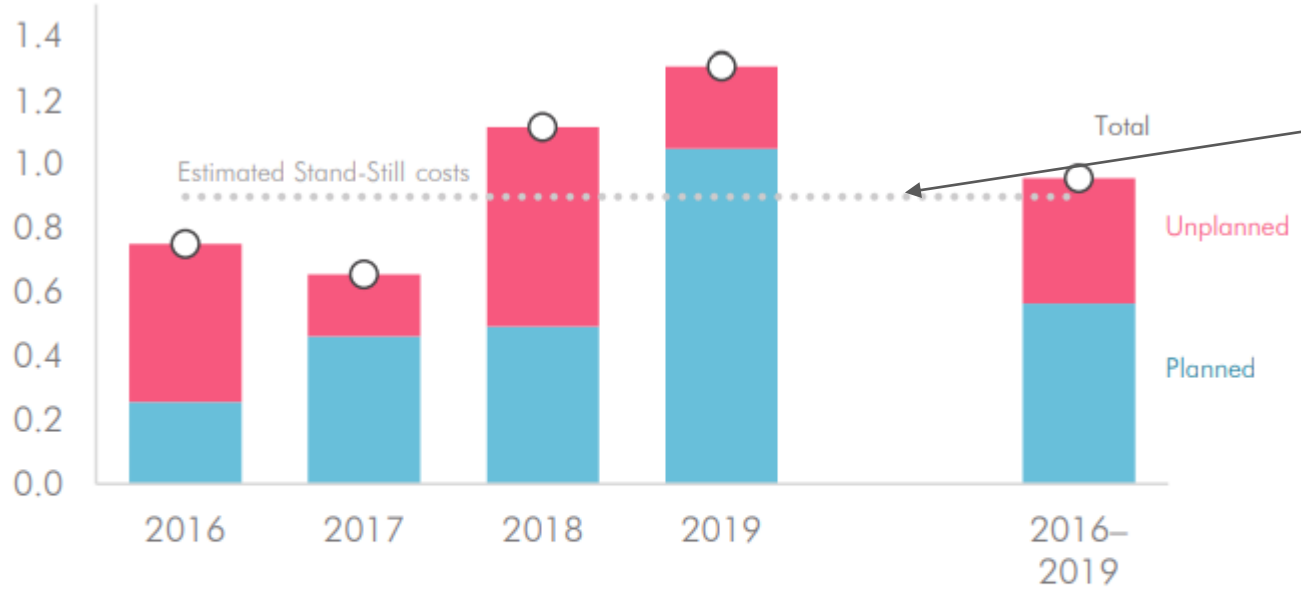
Hospital spend rose by 6.6% on average

But health budget was initially increased by just 0.8%

Providing very limited budget increases appears to have set the scene for spending overruns.

Eventual increases fairly predictable and nearly twice what was planned

€ billion increases in annual health budget



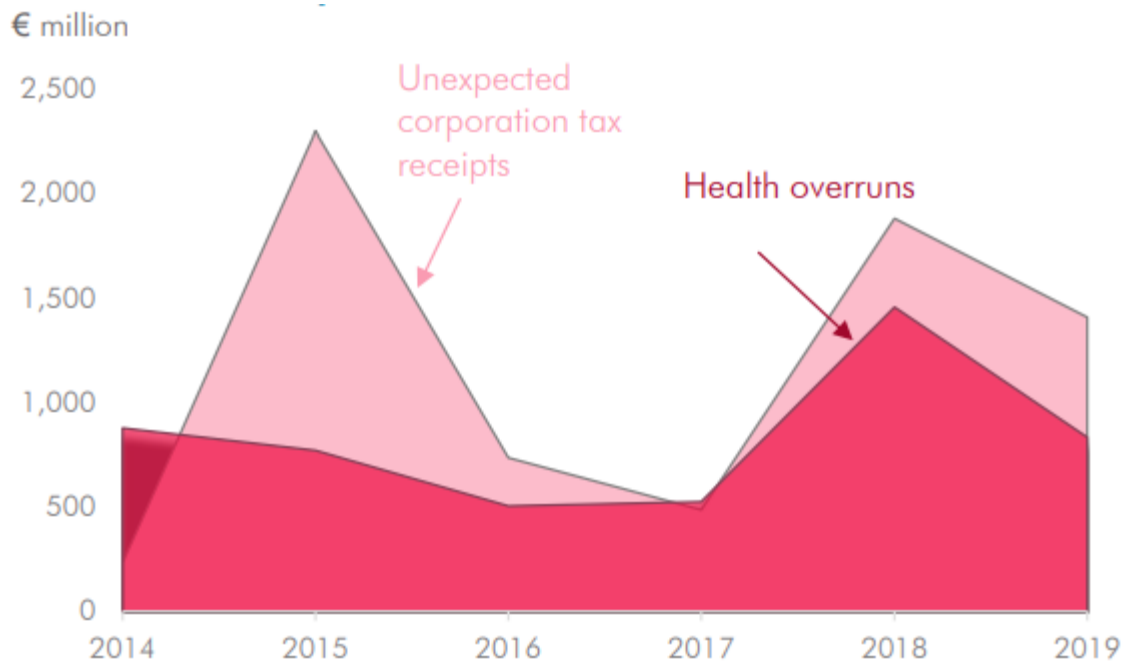
Sources: Department of Public Expenditure and Reform; and own workings.
Notes: The data shown are for Exchequer gross voted current spending in health. Planned increases are defined as the forecast for a given year made one year ahead (t+1) minus the previous periods' outturn (t), while unplanned increases are the difference between that forecast for year t+1 and the actual outturn in year t+1. The Stand-Still cost estimates averaging €900 million per annum are based on a once-off back-casting exercise that was performed for the period 2014–2017. These estimates have tended to rise over time as healthcare spending expands.

Just standing still – that is, allowing for price and ageing pressures – would suggest increases of €900m each year are needed

Plans often much less than that

Overruns therefore seem inevitable

Unexpected corporation tax receipts have masked the health overruns



Sources: Budgets 2014-2019; Expenditure reports 2014-2019; Department of Finance databank; Department of Public Expenditure and Reform databank.
Notes: Figures show gross voted current spending overruns of the Health vote, as well as corporation tax receipts in excess of forecast.

Conclusions

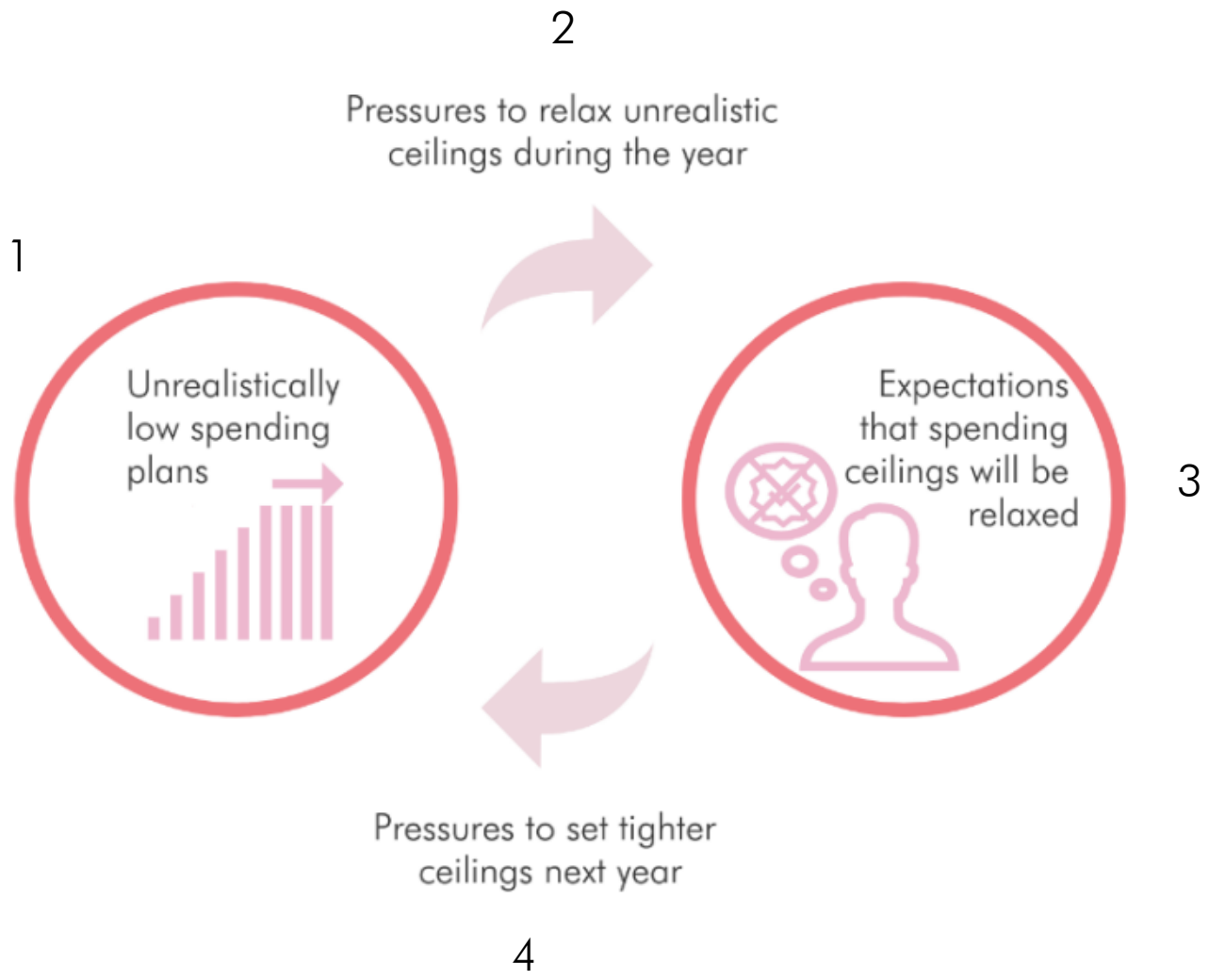
Why are we seeing this?

- Planning in public healthcare is flawed, leading to repeated overruns
- Basic plans are not made in a timely manner
- We now have a well-entrenched “soft budget constraint”

Basic plans lacking

- HSE is required to produce a "Pay and Numbers Strategy" every year – how many staff it needs
  - These tend to be submitted towards the **end of the year they actually refer to.**
  - For example, a revised version 2016's was submitted in December 2016. This looked to significantly increase staffing but with no explicit plans for funding this.
  - In 2017 strategy submitted in November
  - In 2018, submitted in August
  - In last two years, came in Q1 (still within year itself!)
  - This year, reports are that it had not arrived near end of Q2

How the "soft budget constraint" works



Ceilings are a longstanding issue

- PA Consulting (2013):
  - Health ceilings extremely "top-down" in nature
  - Fail to take sufficient account of demands for healthcare
  - Regional budgets, including hospitals, based on previous year's budget, not outturn data
  - Failure to reflect expected activity levels and costs at local level can result in **unrealistic targets and measures to contain costs that are unlikely to be delivered on**
  - This perpetuates year-on-year inefficiencies and drives a **lack of ownership** for financial performance at an operational level

Many reports, some two decades old

- C&AG (2013):
  - HSE ceilings don't take sufficient account of underlying cost drivers.
  - Unrealistic ceilings for hospital budgets and unrealistic expectations for cost reductions
  - Significant underfunding making overruns "inevitable"
  - It concluded that ceilings should be underpinned by realistic assumptions. It also noted that there was scope for the HSE to carry out more thorough analysis of the demand for services, and of the associated costs, and of underlying trends.
- Brennan report (2003): lack of incentives to manage costs effectively one of the main problems in health

How to fix it?

"You go up by stairs
but come down by the lift"

- Trust takes time to build

- If there are earlier plans, and more evidence that needs are identified carefully in advance, this will make it easier to raise ceilings for the next year. Higher ceilings would be easier to meet and would allow for inevitable ageing + price pressures.