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# Controlling the Health Budget: Annual Budget Implementation in the Public Health Area

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## ABSTRACT

Public health expenditure in Ireland has exceeded planned levels repeatedly in recent years. This *Analytical Note* examines the main sources of variation between the planned spending on public health and the final outturn, as distinct from the annual change in spending. The role of budgeting and expenditure management is examined, particularly the feedback between weaknesses in the planning and management stages by reference to the 'soft budget constraint'. An analysis across areas of Health Service Executive (HSE) spending identifies the hospitals and Primary Care Reimbursement Service areas as the largest and most persistent sources of deviation in recent years. Weaknesses in the organisational and procedural aspects of budget planning and implementation are identified in both areas.

## KEY MESSAGES

- Public health expenditure in Ireland has exceeded planned levels repeatedly in recent years. Continued health spending overruns could undermine the Government's ability to plan and prioritise in the medium-term and may also lead to problems in implementing policy. The most persistent sources of budget excesses in recent years have been in the hospitals and Primary Care Reimbursement Service (PCRS) areas.

- There is evidence that difficulties in budgeting and financial management and governance arrangements in the hospitals area create a tendency towards budget overruns. Improving these arrangements is particularly important given the proposed, more decentralised structure envisaged under the Government's *Future Health Strategy*.

- In the PCRS area, the main source of budget excesses is higher than planned average drugs costs, particularly in areas focussed on new drugs. While there are limits on the approval of individual new drugs, these controls are not linked to the overall budget and are not binding.

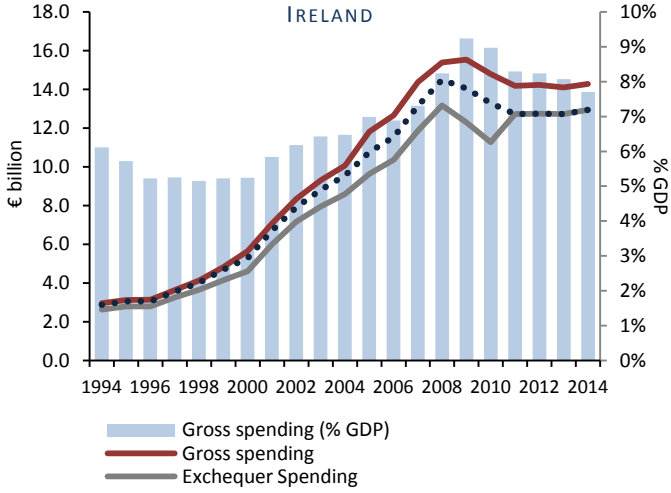
- Given known future challenges to the public health system, such as demographic change, existing financial planning and governance structures must be improved to ensure delivery of targets. The announcement of a new accountability framework for the HSE is one positive step in this regard.

- A transparent system to monitor the delivery of planned policy interventions should be put in place to address existing data deficiencies. The results of such analysis, and indeed analysis of proposed health policy and cross country comparisons, should be used to guide future budgetary and expenditure review processes.

## 1. Introduction

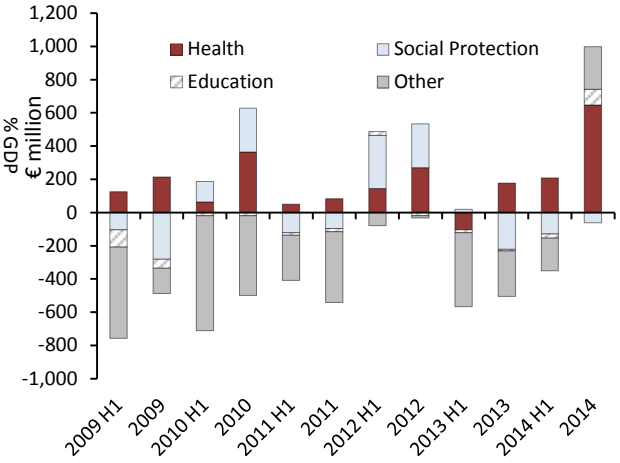
Fiscal policy since the beginning of the crisis has led to significant reductions in primary (non-interest) expenditure in Ireland to firstly slow and then reverse the growth of the budget deficit. Meeting the fiscal targets of both the EU/IMF Programme and the Excessive Deficit Procedure (EDP) necessitated significant reductions across all major areas of spending. Public spending on health has been reduced nominally and as a share of GDP since 2008, though the decline in both slowed since 2011 with nominal spending remaining relatively stable (see Figure 1a). As most other categories of expenditure have continued to fall, health spending has grown as a share of overall Departmental spending and now represents over a quarter of gross current spending. The health area has also been characterised in recent years by a failure to adhere to expenditure ceilings. Until 2013, this pattern was largely offset at the aggregate level by below budget spending by other Departments. However, in 2014 gross spending by all Departments ("voted expenditure") exceeded the budgeted allocations by €1 billion. This increased Exchequer spending by €841 million.[1] The largest single source of this overrun was the Health area, accounting for €647 million (76 per cent) of the additional Exchequer costs (Figure 1b).

Figure 1a: Public Health Spending in Ireland




*Source:* Departent of Public Expenditure and Reform databank and end-December 2014 Exchequer Returns.
*Note:* The difference between Gross spending and Exchequer spending is accounted for by Departmental receipts ("appropriations-in-aid"). The largest of these in the health area was the Health levy, which was abolished at the end of 2010; the dotted line excludes the Health levy from historical data for comparison purposes. These figures include both current and capital expenditure by the HSE and the Department of Health. While spending by the Office of the Minister of Children was included in the Health Group of Votes between 2006-2011 it is excluded for comparison puposes. The 2014 figure is adjusted to reflect the transfer of child and family services in the HSE to the new Child and Family Agency to ensure comparability with data for earlier years. This is a cash-based measure of expenditure.

Figure 1b: Cumultive Overruns in Exchequer Expenditure: Mid-Year and End-Year




*Source:* Exchequer Returns, end-June and end-December for 2009 to 2014.
*Note:* The above figures represent total net voted expenditure, i.e. excluding spending funded by Departmental receipts ("appropriations-in-aid") and including both current and capital expenditure. This is a cash-based measure of expenditure.

[1] The gross expenditure figure reflects expenditure by Departments and offices regardless of the source of funding. Exchequer expenditure, or net expenditure, is net of receipts received directly by Departments including the pension-related deduction, certain EU co-funding payments and pension contributions. It also excludes expenditure by the Social Insurance Fund and the National Training Fund financed through the 'own income' of the funds. The difference in 2014 is mainly accounted for by higher than expected PRSI receipts that reduce the Exchequer cost.

Figure 1b shows that health overruns have generally represented the largest and most persistent nominal deviations from budget as compared to the other large public expenditure sectors.[2]

In 2013, ceilings on both aggregate gross voted expenditure ("Government Expenditure Ceiling") and individual Departments' spending ("Ministerial ceilings") were established in law as a core part of Ireland's Medium-Term Expenditure Framework (MTEF). This MTEF is fundamental to maintaining control of the public finances in the medium term, as it creates a mechanism to formally link expenditure growth to the ability of the economy to sustain it.[3] An important factor in assessing compliance with these ceilings is that they are asymmetric in nature; Departments may target spending below the ceiling but should not exceed it.

The *Stability Programme Update 2015* plans for moderate increases to nominal Departmental expenditure over the medium term. As noted in the Council's latest *Fiscal Assessment Report* (IFAC, 2015), these increases leave very limited room for manoeuvre against the Expenditure Benchmark (EB) in 2016, even allowing for recent adjustments to the calculation. When a hard budgetary rule is in place, unplanned increases in spending, such as those identified in the health area, undermine medium-term expenditure planning and can lead to *ad hoc* reductions to expenditure within the budget year. In addition, such persistent budgetary excesses could lead to an *ex post* breach of fiscal rules and ultimately to sanctions. This *Analytical Note* examines deviations from the annual budget in the public health area in recent years to identify the sources of the largest and most persistent areas of overspending.

The next section outlines the framework for analysis used in this paper. Section 3 briefly discusses Exchequer health expenditure, including institutional and accounting arrangements, before examining the main sources of deviation from budget in Exchequer health spending. Section 4 analyses trends in the HSE and focuses particularly on the pay, hospitals and Primary Care Reimbursement Services (PCRS) areas. Section 5 looks at the impact of HSE receipts on Exchequer budget excesses. Finally, section 6 draws some overall conclusions.

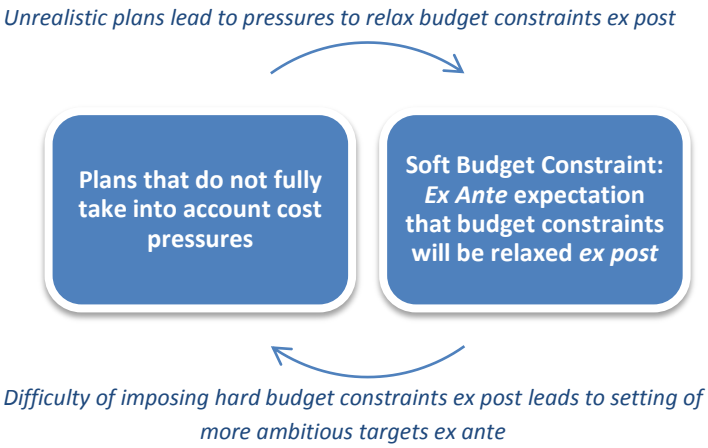
[2] The report of the Comptroller and Auditor General (2014a) shows that the HSE variations from budget are smaller than several other expenditure areas when expressed as a proportion of the original budget allocation. However, these other areas have relatively small budgets and consequently these excesses, while not desirable from an expenditure management perspective, do not represent the same level of risk to the overall fiscal position.

[3] More specifically the MTEF should ensure compliance with the overall requirements of both domestic and European fiscal rules and is explicitly linked to the Expenditure Benchmark (EB). Recent changes to the operation of the EB will make the setting of multi-annual ceilings more difficult and will require a greater focus on the domestic MTEF and public expenditure management arrangements (see IFAC, 2015).

## 2. Overview of Analytical Framework

The focus of this Note is identifying the main factors leading to health spending exceeding the budgeted allocation in a given year, rather than an analysis of year-on-year growth and the drivers of health spending. There are potentially two causes of budget overruns, weakness in either the process of budget planning or in the process of budget implementation. In practice it may be difficult to disentangle the impact of these two issues and they may in fact reinforce each other (see Figure 2).

FIGURE 2: INTERACTION OF PLANNING AND MANAGEMENT STAGES




Weaknesses in budget planning may arise where the initial budget is set at a level that is not fully reflective of cost pressures at the planning stage. In the health area it may not be possible to anticipate all demands and consequently budget excesses may be unavoidable in certain specific circumstances.[4] However, aside from underlying service demands, poor planning may also be due to weak estimation of the impact of new policies, including planned efficiency improvements.

In relation to budget implementation, IFAC (2013) identified the 'soft budget constraint' (SBC) as a possible structural difficulty in managing health expenditure within the budget year. In the original formulation (Kornai, 1992) this theory posits that, notwithstanding *ex ante* threats to impose a hard constraint, the budget constraint is soft where the decision maker in control of day-to-day expenditure anticipates that the constraint is likely to be relaxed *ex-post* if the original constraint is not met. Where the budget setting process is weak, this may further 'soften' the constraint as the manager – knowing plans are poorly set – has less of an incentive to adhere to them. The existence of a SBC may also weaken the budget planning process where budget allocations have been persistently exceeded in the past and lead to ambitious targets being set. Where increased efficiencies are factored into budget

[4] For example in recent years the increased spending on Swine 'Flu vaccinations and related costs was not anticipated when setting the initial budget for HSE spending in 2009.

plans it may be particularly difficult to identify whether overly ambitious plans or poor implementation may be the cause of targets being missed.

## 3. Exchequer Health Expenditure

In broad terms, the Department of Health oversees health policy in Ireland, ensuring that Government policies are effectively implemented, while the Health Service Executive (HSE) provides all of Ireland's public health services in hospitals and communities across the country. Recent legislative changes aimed to create a more direct line of accountability between the HSE and Minister for Health and have imposed additional responsibilities on the Department of Health.[5]

In addition to funding from the Exchequer, public health spending is also funded by direct payments to the HSE and the Department of Health (see section 5 for more detail). Since its establishment in 2005 funding for the HSE has been identified as a separate 'vote' within the Exchequer accounts.[6] Within the Exchequer accounts, net expenditure is that funded solely by the Exchequer while gross spending is considered that funded by the Exchequer and other sources ("appropriations-in-aid"). From the beginning of 2015 Exchequer spending by the HSE is included in the Department of Health 'vote'. The HSE also produces its own set of annual accounts, which differ from the Exchequer format in a number of respects.[7]

This paper assesses health spending overruns in Exchequer terms. However, the presentation of much of the Exchequer data is by region rather than expenditure category, which impedes a more detailed analysis of the categories and schemes within HSE spending. This breakdown is a function of the existing regional financial management systems, which are in turn an artefact of the Health Board

[5] The *Health Service Executive (Governance) Act 2013* provided a framework for a new governance structure and associated administrative structures in the HSE. From the beginning of 2015 Exchequer funding for the HSE will be provided through the Department of Health. Consequently the head of the Department of Health is the Accounting Officer for this spending.

[6] The Revised Estimates for Public Services – the document presenting planned spending by Departments- shows expenditure for the following year broken into 'votes', with each Department comprising of one or more 'votes' (in 2015 sixteen Departments are made up of 40 'votes'). The Estimate for each 'voted' expenditure component is also presented by category (pay, pensions, non-pay, capital and also by main programme). These 'votes' are the units of funding actually voted on by the Oireachtas. This is also the format for the final, audited, Appropriation Accounts.

[7] Income and expenditure are accounted for on the accruals basis in the HSE's Annual Financial Statement, whereas 'cash' accounting is used as the basis of the 'vote' accounts, as required by Government Accounting rules. Net annual funding from the Exchequer, as reported in both the Annual Financial Statements and Appropriation Accounts, represents the HSE's net recourse to the Exchequer to fund payments made, as distinct from expenditure incurred in the reporting period. In addition, the final annual account on Exchequer expenditure (the appropriation account) does not require any explanations of the variances for subheads relative to their original budgeted amounts. Instead explanations are provided for significant variances between the amount appropriated (after supplementary estimate adjustments) and the final outturn.

system.[8] The presentation in the HSE's Annual Financial Statements and monthly performance reports allows for more detailed analysis of some areas of HSE spending and data from these sources is used in the more detailed analysis in Section 4. Table 1 compares the major components of HSE revenue and spending in 2014 under the Revised Estimates for Public Services presentation and the accounting treatment used in the HSE's Annual Financial Statement. In aggregate terms expenditure from these two sources is broadly similar but care must be taken when comparing categories under the different accounting arrangements.

TABLE 1: COMPARISON OF HSE REVENUES AND SPENDING FOR 2014

| | | Revised Estimates for Public Services | HSE Annual Financial Statement |
|---|---|---|---|
| | | *€million* | *€million* |
| Revenues | | **13,175** | **13,229** |
| | Exchequer | 11,843 | 11,843 |
| | Other receipts | 1,332 | 1,386 |
| | | | |
| Expenditure | | **13,175** | **13,220** |
| | Pay | 5,985 | 4,196 |
| | Pensions | 660 | 600 |
| | Other | 6,530 | 8,425 |
| **Balance** | | ***0*** | ***8*** |

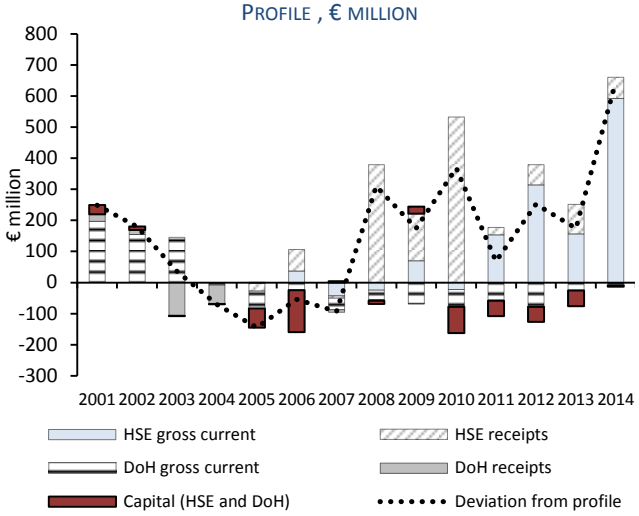
*Source*: HSE *Annual Report and Financial Statements 2014*
*Note*: Rounding may affect total

Figure 3a shows the deviations from budget in nominal terms while Figure 3b decomposes the percentage deviation from total budget into its main determinants. At an aggregate level, higher than expected gross current expenditure in the Health Service Executive (HSE) or shortfalls in HSE receipts, or both, have been the cause of the Exchequer health budget being exceeded in every year since the crisis began in 2008. HSE current spending is ahead of target in five of the seven years since 2008 (inclusive), with relatively large nominal deviations in each of the years from 2011. In most years these HSE deviations are at least partially offset by under-spending on the Department of Health current budget and the capital budget for both the Department and the HSE.[9] For 2008 to 2010 the deviations from profile were mainly driven by shortfalls in HSE receipts, whereas from 2011 HSE current expenditure overruns were the source of most deviation.

[8] The HSE replaced a system where services were provided by seven regional health boards and the Eastern Regional Health Authority (serving the Dublin area).

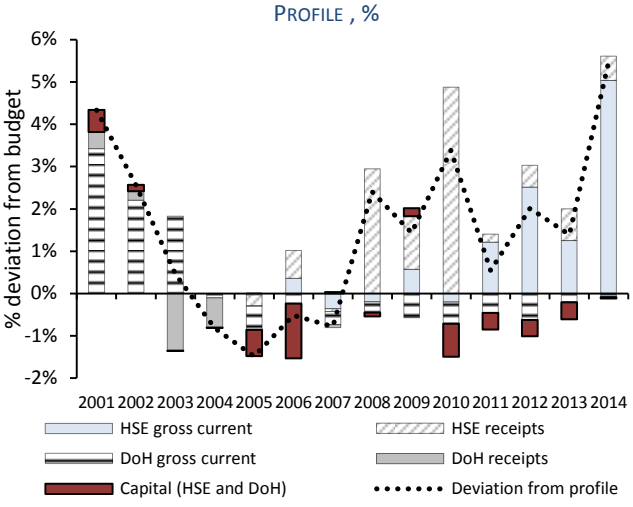
[9] Department of Health savings arose across a number of subheads, generally in respect of lower than expected payments from agencies and lower than anticipated drawdown on funds. Between 2006 and 2011 the Office of the Minister for Children and Youth Affairs was also included in the Health group of votes. This expenditure has been excluded from this comparison as it is now the responsibility of the Minister for Children and Youth Affairs.

FIGURE 3A: COMPOSITION OF DEVIATION IN HEALTH SPENDING FROM PROFILE , € MILLION




*Source:* Department of Public Expenditure and Reform Databank and Revised Estimates Volumes, various years.
*Note:* For comparison purposes the Office of the Minister for Children is omitted from the Health Group of Votes for the period 2006-2011.

FIGURE 3B: COMPOSITION OF DEVIATION IN HEALTH SPENDING FROM PROFILE , %




*Source:* Department of Public Expenditure and Reform Databank and Revised Estimates Volumes, various
*Note:* For comparison purposes the Office of the Minister for Children is omitted from the Health Group of Votes for the period 2006-2011.

In 2014, Exchequer spending on health was €645 million above profile, driven by gross overspending by the HSE of €591million and a shortfall in HSE receipts of a further €66 million. This was marginally offset by below-profile current spending by the Department of Health and by capital spending by both the HSE and Department of Health, but to a much less significant extent than in previous years.

A discussion focussing only on these headline aggregates can disguise considerable deviations in the sub-components of expenditure as large transfers of funding between different sub-components of gross HSE expenditure would not be evident in Figures 3a or 3b. For example, in 2007 Exchequer health expenditure was below budget in aggregate terms but funding of €250 million was transferred from the Residential Care Redress Fund to offset over-spending in relation to hospitals and medical card services.[10] Identifying significant and persistent sources of deviation from budget requires a more detailed analysis of the categories of expenditure, as follows in the next section.

[10] Large transfers of this type are typically undertaken by Technical Supplementary Estimate. The Revised Estimates for Public Services, published in December since 2013, represents the allocation of voted expenditure proposed by Government. It also contains more detailed financial and performance information. These Estimates are presented to the Dáil and are then referred to the relevant Dáil Select Committees for discussion and subsequently a vote in the Dáil. Where a significant change to the allocated expenditure for a particular Department or Office is required subsequent to this approval, a Supplementary Estimate (SE) must be presented to the Dáil. SEs are usually required to move significant funding between areas of the Vote ('technical') or to increase spending above the previously authorised level ('substantive'). The SE shows the proposed changes to the estimate and undergoes the same process as the original estimate with a vote in the Dáil required. SEs adjust the budgeted allocations for Departments and Offices but as they are typically voted on in November or December the final outturn is lower.

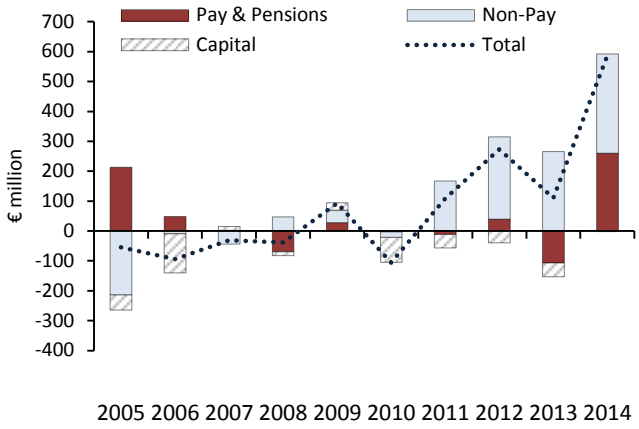
## 4. HSE Expenditure

In broad terms HSE expenditure is divided evenly between expenditure on pay and pensions and on non-pay spending (Figure 4a). With the recent exception of 2014, overruns on gross voted HSE expenditure predominantly arise in non-pay expenditure with particularly large spending above profile in the years since 2011 (see Figure 4b). This non-pay 'deficit' grew from €166 million in 2011 to €332 million in 2014. The significant pay and pension over-spend in 2014, in combination with the continuation of the persistent non-pay overrun, led to the largest HSE budget overrun since its establishment.[11] Capital expenditure has typically come in below allocation. Due to a large portion of Exchequer spending being disaggregated by regional rather than component this section uses both Exchequer and HSE expenditure data to identify the main issues driving overspends within and across areas in the HSE.

Figure 4a: Composition of Gross HSE Expenditure


*Source:* Department of Public Expenditure and Reform databank, Revised Estimates for Public Service.

Figure 4b: Gross HSE Expenditure, deviation from budget




*Source:* Department of Public Expenditure and Reform databank, Revised Estimates for Public Services.

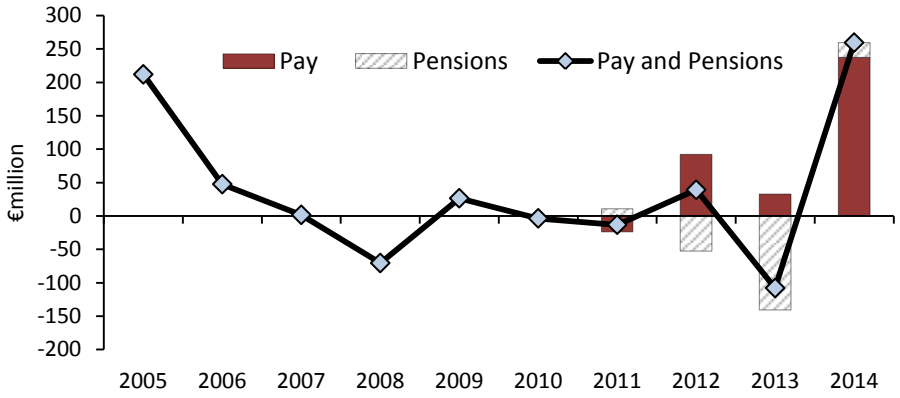
[11] The comparison of 2014 with older data is somewhat complicated by the recent amalgamation of the HSE within the Health vote, however this will mainly affect data comparability from 2015. The HSE Vote was 'disestablished' following the enactment of the Health Service Executive (Financial Matters) Act 2014. The expenditure of the HSE will now be met through a grant from the Minister for Health. The HSE is now to be funded on a net basis, i.e. expenditure funded from certain receipts, previously included as HSE appropriations-in-aid, no longer appears as gross spending in the published Estimates.

## 4.1 HSE Pay

A number of policies to reduce public service pay were introduced over the crisis period since 2008. Callaghan (2014) estimates that the gross savings from staffing reductions in the HSE and the impact of pay agreements since 2009 amount to a cumulative €1.2 billion in 2013.[12] This encompasses direct savings from rate changes, staffing reductions, and productivity measures arising from changes to terms and conditions (e.g. additional hours worked).

Given the analytical framework outlined in Section 2, the issue for this Note is the extent to which the planned savings were factored into the budgeted pay allocations for the HSE and if they were realised. Figure 5 disaggregates deviations from budgeted amounts in pay and pensions from 2011, the first year this breakdown is available on an Exchequer basis.

FIGURE 5: HSE PAY AND PENSIONS, DEVIATION FROM BUDGET




*Source:* Department of Public Expenditure and Reform databank and Revised Estimates for Public Services (various years).
*Note:* Figures shown are gross expenditure figures on an Estimates basis and do not include receipts from the pension-related deduction on public service remuneration (an estimated €333 million in 2014). A breakdown between pay and pensions is not available on an Exchequer basis prior to 2011.

While pay excesses were offset to differing degrees by pension 'savings' in 2012 and 2013, there was a significant pay over-spend in 2014 that was worsened by the above profile spending on pensions.[13] The deviations in pension expenditure may arise from difficulties in anticipating the pattern of retirements following the incentivised early retirement schemes introduced in the HSE in late 2009 and early 2014. Furthermore, pension expenditure can be more volatile due to the payment of lump sum payments at retirement. For example, lump sum payments fell by €100 million between 2012 and 2013.

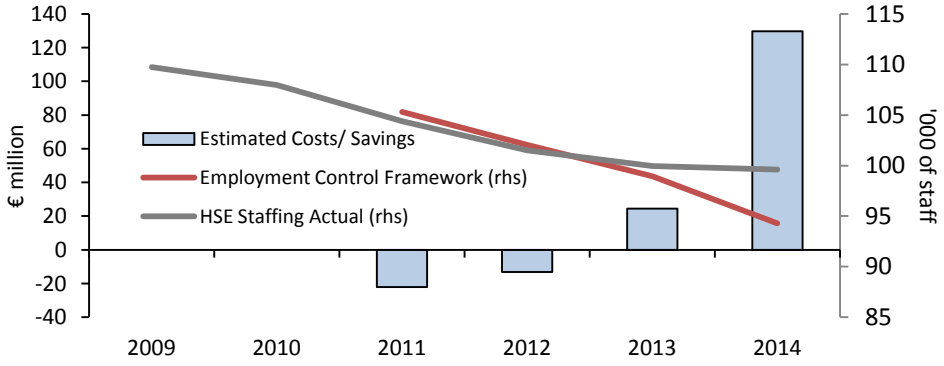
[12] As this is a gross estimate by definition it does not include any offsetting costs that may arise from the policy changes.

[13] €113 million in medical card probity savings was included as a savings measure in *Budget 2014*. The HSE's subsequent *National Service Plan 2014* (HSE, 2013d) determined that this level of savings could not be delivered in this area. One of the offsetting measures was a reduction of €63 million in the pension allocation.

While it is difficult to identify the specific cause or causes of the pay overrun in 2014, reports from the HSE over 2013 and 2014 indicate shortcomings in both the planning and implementation stages of the process of setting the pay allocation. The HSE indicates that a considerable portion of planned pay savings are outside of its direct control.[14] In mid-2014, Callaghan (2014) highlighted the potential addition of 1.5 million working hours per annum to the health system arising from the Haddington Road Agreement (HRA), implying that much of the problem arose from aggregate gains not being sufficiently leveraged into cost reductions. These differing views of how deliverable the HRA savings were, and the HSE's assertion that a large portion of pay savings were outside its direct control, highlight problems with the budget setting process and, in particular, with the allocation of responsibility for implementing at least some cost containment measures in this area.

Figure 6 compares the targeted end-year staffing levels with the actual outturns. The indicative costs and savings are based on the average pay per whole-time-equivalent in the HSE, which has seen a moderate increase since the reductions in pay rates in 2010.

FIGURE 6: DEVIATION FROM HSE STAFFING TARGETS (ECF) AND ESTIMATED SAVINGS/COSTS




*Source:* IFAC internal calculation based on data from Department of Public Expenditure and Reform databank, Revised Estimates for Public Services, various years.
*Note:* Both target /Employment Control Framework (ECF) and outturn staffing figures are for end-December. Estimated savings/ costs are calculated based on an average pay of €48,750 (used in IGEES, 2014) and assumes the deviation is spread equally throughout the year.

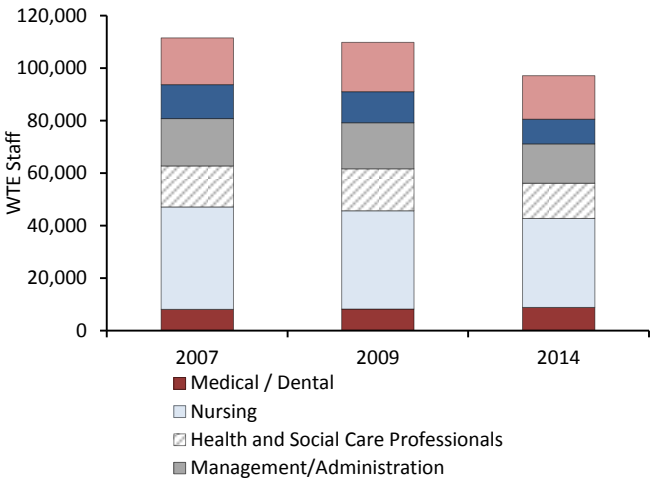
These estimates imply that while higher than expected staff exits yielded some unanticipated savings in 2011 and 2012, the slower than estimated decline for 2013 and 2014 likely caused additional cost

[14] Reported delays in the implementation of the agreement in 2013 led to shortfall of €46 million in savings to be delivered. An independent report from PA Consulting (2013) identified a 'stretch' target of €212 million in pay savings as compared to the planned €290 million in *Budget 2014*. The end-December 2014 HSE performance assurance report identifies €133 million of the pay-related expenditure overrun, including €111m in unspecified pay savings, as being "outside of [the HSE's] control and therefore not deliverable..."

pressures against targets. While somewhat crude, this approach suggests about half of the pay overspend in 2014 may have arisen from staffing levels being above target.[15]

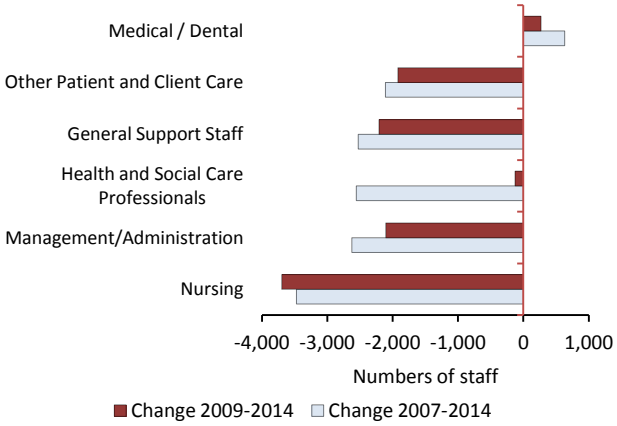
Figures 7a and 7b show that the largest staffing reductions have taken place in the nursing area with a 13.4 percent reduction since peak HSE employment in 2007.[16] While smaller in absolute terms, the reductions in the general support staff and administration/management categories over the same period represent larger proportionate decreases at 24.8 percent and 14.1 percent respectively. The only category of staff to expand over the period is medical and dental.

FIGURE 7A: COMPOSITION OF HSE EMPLOYMENT 2007-2014




*Source: Health in Ireland Key Trends 2014, HSE.*
*Note:* 2007 represents peak HSE employment while 2009 represents the peak of HSE pay expenditure and is included for comparison with other graphs. Figures are Whole Time Equivalents (WTE). Reclassification has occurred between the grade categories of Other Patient and Client Care and General Support Staff in the data in the above table. Student nurses are included in the 2007 and 2008 employment figures on the basis of 3.5 students equating to 1 WTE and in the 2009-14 figures on the basis of 2 students equating to 1 WTE. Agency staff are not included.

FIGURE 7B: CHANGE IN HSE STAFFING




*Source: Health in Ireland Key Trends 2014, HSE.*
*Note:* See note for Figure 7a.

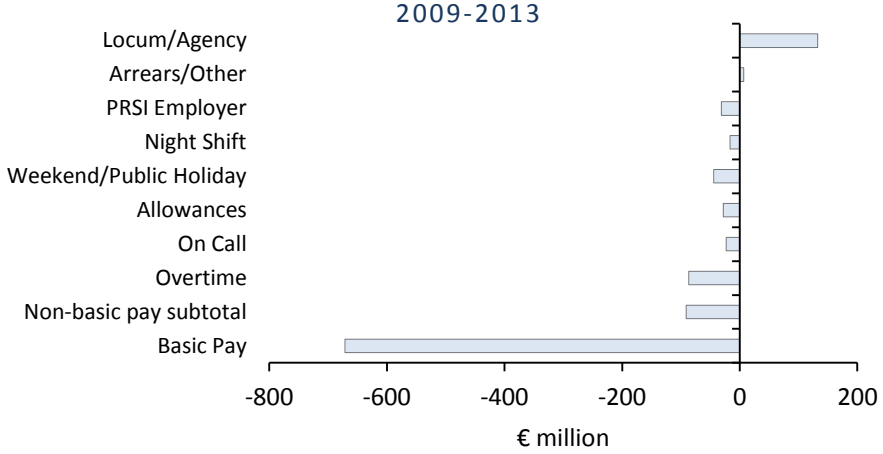
These staffing reductions were driven by the use of an Employment Control Framework (ECF), which sets individual Departmental targets on end-year Whole-Time Equivalent staffing levels (WTE). These top-down targets were to be delivered through non-replacement of retiring staff, redeployment and the use of increased productivity measures agreed through successive pay deals. The use of this explicit limit on staff was effective in reducing the number employed by the HSE but may have led to increased costs in other areas – such as overtime and agency spending – where the planned

[15] This approach is based on WTE staffing levels and average pay rates and consequently does not reflect the composition of exiting staff. It also assumes that staff exits are linear through the year.

[16] Student nurses are included in the 2007 and 2008 employment figures on the basis of 3.5 students equating to 1 WTE and in the 2009-14 figures on the basis of 2 students equating to 1 WTE. As the treatment of student nurses is not clear for the period pre-2007, it is assumed that the 3.5 to 1 ratio applied.

productivity gains (additional hours) implied by successive pay deals did not sufficiently meet service demands. Figure 8 shows the change in the components of pay between peak HSE pay in 2009 and in 2013. The increase in agency and locum costs over the period offsets a large portion of non- core pay reductions.[17] These additional locum and agency costs are considered non-pay expenditure in Exchequer terms, as it does not represent pay to public service employees, and consequently account for some of the non-pay overrun on the Exchequer side.

FIGURE 8: CHANGE IN COMPONENTS OF HSE PAY, 2009-2013



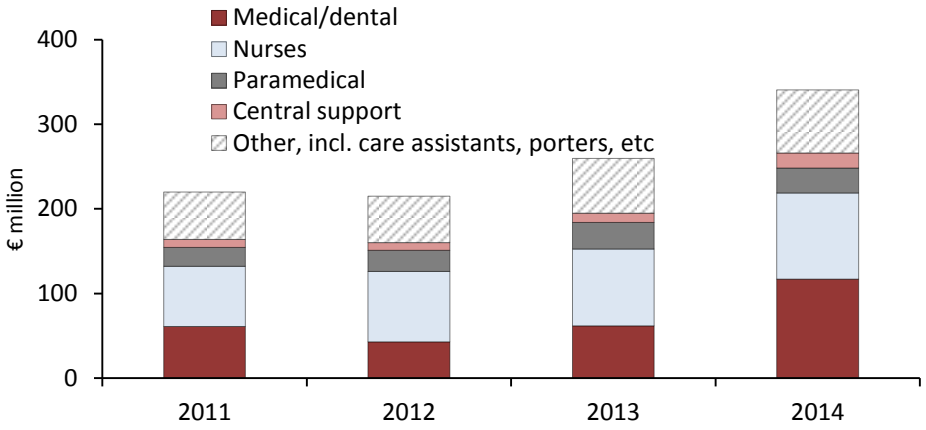

*Source: IGEES Working Paper HSE Pay.*

Callaghan (2014) noted that the increased core staffing level in 2014 did not slow the trend in increasing agency costs. The implementation of the EU Working Time Directive limits the hours junior doctors are permitted to work and appears to be pushing up staffing levels in the medical area, leading to increased agency spending (Figure 9).[18] Furthermore, the 2012 EU Directive on Temporary Agency Work requires that agency workers have equal treatment in basic working and employment conditions as directly employed staff. This change implies that, in the short-term, there is no difference in cost between meeting service demand with HSE or with agency staff.

[17] The *HSE Annual Report 2012* (HSE, 2013c) highlights rising agency and overtime expenditure as a cause of the hospital overrun in 2012, identifying the then ongoing negotiations for the HRA as a potential means of reducing these costs; "In addition, the impact of retirements has seen an increase in overtime and agency costs. Funding of €162m was applied from the Supplementary Estimate to address the 2012 deficit in acute hospital services. The use of agency and overtime will be much reduced if there is a successful conclusion to the negotiations, being led by the Department of Public Expenditure and Reform, surrounding the new Public Service Agreement 2010-2014 (Croke Park)."

[18] There is also evidence regular working hours in this area were at, or in excess, of those agreed under the HRA, so further cost reductions through planned productivity gains were limited.

FIGURE 9: COMPOSITION OF AGENCY SPENDING IN THE HSE




*Source: Department of Public Expenditure and Reform.*
*Note: Detailed decomposition of agency spending is only available from 2011.*

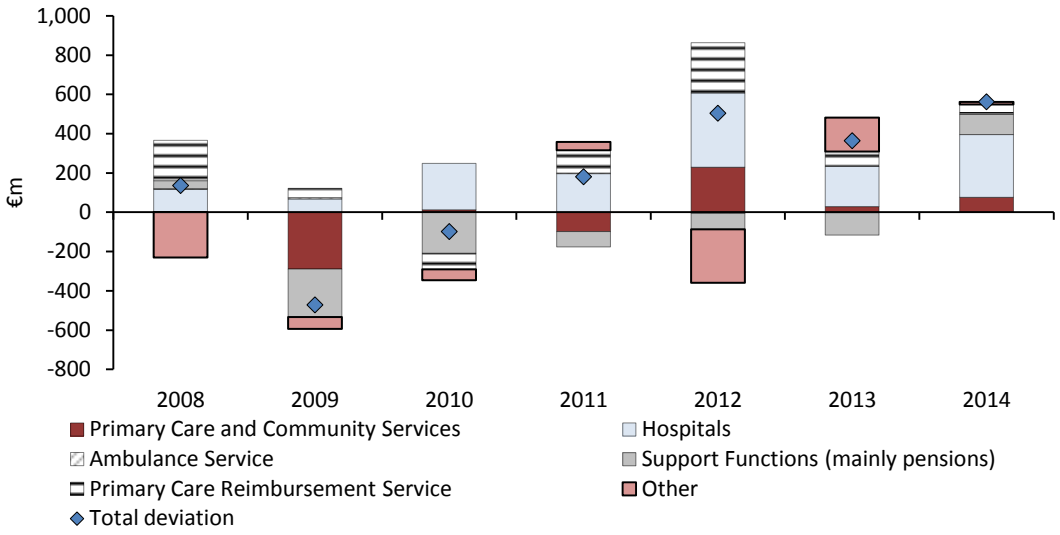
Delivering payroll reductions through reform of working practices rather than direct pay reductions is relatively more complex due to the necessity for ongoing local level reforms - for example changes to rotas and overtime arrangements – and support from all levels of management. However, as noted by the IMF (2014), while "wage and employment freezes can be effective in the short run they cannot substitute for deeper reforms that address genuine staffing needs and efficiency..." (p. 23). Aside from the greater reliance on more complex working practice reforms to deliver savings , the apparent disconnect between planning and implementation of pay policies in the health area also seems to have been an issue in delivering budgeted pay savings in 2014.

From 2015, the ECF approach to managing numbers has been replaced with a cap on total wages within each Ministerial ceiling.[19] This greater autonomy allows for individual organisations to better match staffing composition to service needs but will also put greater pressure on internal monitoring and management structures. The broader issue of budget planning and implementation is discussed in relation to the hospital sector in the next section.

Moving beyond pay, a picture of the sources and scale of deviations in total HSE expenditure across the main categories and schemes can be established using the profiles published in the HSE's monthly performance reports (Figure 10).

[19] In his Estimates Statement in October 2014 the Minister for Public Expenditure and Reform announced that, "From next year I am pleased to announce that Departments will have discretion over staffing levels within an overall pay framework."

FIGURE 10: PERFORMANCE AGAINST PROFILE
HEALTH EXPENDITURE BY CATEGORY




*Source:* HSE monthly *Supplementary* and *Data Management* reports.

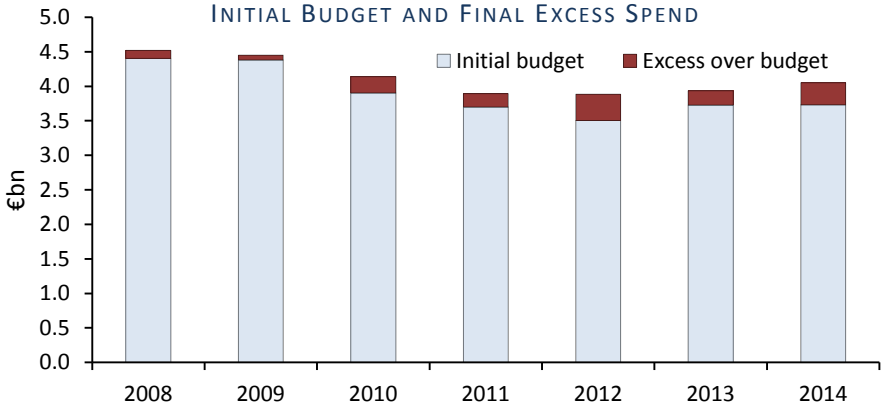
The most persistent driver of gross HSE overspending is the hospitals sector, while the Primary Care Reimbursement Service (PCRS) exceeded its initial budgetary target in five of the last six years. These two areas accounted for over half all HSE spending in 2014 and will be the focus of discussion for the remainder of this *Note*.[20]

[20] The primary care and community services area is also shown to have exceeded its budget for the last three years, however, the largest deviation in 2012 appears to arise primarily from a re-allocation of funding between primary care for older people and the 'Fair Deal' (within the 'other' category'). As this re-allocation was undertaken after the formulation of the initial profile it is reflected as a deviation in Figure 9. A more detailed assessment of deviations within this area should be the subject of future work.

## 4.2 Hospitals Expenditure

It is notable that despite adjustments to the initial hospital budget allocation over the last four years the final outturn figure has remained broadly the same (Figure 11).

FIGURE 11: HOSPITAL EXPENDITURE
INITIAL BUDGET AND FINAL EXCESS SPEND




*Source:* HSE monthly *Supplementary* and *Data Management Reports.*
*Note:* These figures include pay, non-pay and capital expenditure.

Any assessment of acute hospital expenditure must take into account the fact that pay represents about 70 per cent of spending for most years and has followed the same broad trajectory as the overall HSE paybill. As highlighted in section 4.1, problems with the 2014 overrun arise from issues related to the process of setting the budget and implementing policy in line with plans. In the hospitals sector, this weakness in budgetary systems is also evident for non-pay expenditures.

Broadly speaking, a failure to meet budgetary targets arises from: (i) misestimation of demand for hospital services; (i) misestimation of the efficiency of service delivery; (iii) the net impact of cost containment measures being lower than planned; or (iv) some combination of these factors. Forecasting demand for hospital services is a complex task given the range of drivers. Notwithstanding this, the processes of budget setting and in-year financial management in the HSE have been subject to a number of criticisms. PA Consulting (2013) examined the budget setting process for 2012.[21] In setting the aggregate allocation for health the analysis found that the process was extremely 'top-down' in nature and failed to take sufficient account of demand forecasts.[22,23] In fact, the report

[21] This report was commissioned by the Department of Health to examine financial management within the HSE.

[22] The Office of the Comptroller and Auditor General's Report on the Account of the public services 2012 (C&AG, 2013) assessed budget management in the HSE in 2012. While acknowledging the inherent uncertainty in budgeting for future periods, this report also drew attention to deficiencies in the process of budget setting in the health area, particularly a failure to sufficiently account for the underlying cost drivers in some key expenditure areas.

[23] This is consistent with a statement by the HSE Accounting Officer in relation to the HSE budgeting process that "the HSE does not set its own Vote allocation and a number of variables affect the final amount allocated. The amount

determined that National Service Plan priorities do not align with the budgetary allocations. Within the HSE allocation process regional budgets – including hospitals' budgets – are based on the previous year's budget, rather than outturn data, leading to additional allocations being incremental in nature. This failure to reflect expected activity levels and costs at local level can result in targets and cost containment measures for particular areas that are unrealistic and undeliverable.[24] The Report found that this perpetuates year-on-year inefficiency and drives a lack of ownership for financial performance at an operational level.

In terms of in-year financial management, the report criticised the evaluation process and systems for monitoring and evaluating the HSE financial performance, the lack of capacity in financial management within the system and the lack of incentives within the system for managers to remain within budget. This criticism of budget formulation in the health area and particularly in relation to the lack of incentives to maintain budget allocations, and also to the lack of ownership of financial targets, would appear to facilitate an environment conducive to creating a soft budget constraint. The lack of incentives to manage costs effectively was identified as one of the main problems in the health board system by the so-called Brennan report (2003), which predates the establishment of the HSE.

The Office of the Comptroller and Auditor General (C&AG, 2013b), in assessing 2012 budget management within the HSE, noted the introduction of a new approach to expenditure planning in the hospitals area proposed for 2013. This aim was to move away from the incremental annual process to a new system with annual hospital budgets to be related to projected spend. Furthermore, new service level agreements were put in place to ensure hospitals stayed within their annual budget. The purpose of this process was to "ensure no hospital plans for a budget overrun in 2013" (Office of the Comptroller and Auditor General, 2013b). It subsequently appears that while this process was undertaken for 2013, the existing 'block grant' approach remained in place with the new approach being undertaken in a parallel 'shadow funding' exercise.

In a response to a Parliamentary Question, the Minister for Health confirmed that implementation of the new 'Money Follows the Patient' model (MFTP) began in 2014. The MFTP approach is designed to ensure hospital funding is based on planned, case-mix adjusted activity.[25,26] One short term

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allocated in relation to HSE expenditure is developed against a backdrop of national budgetary objectives. [...] the final estimate provision, in many cases, is imposed following the conclusion of the budgetary process." (p. 233, Office of the Comptroller and Auditor General, 2013b)

[24] For example, there is evidence of increased activity in the number of day case discharges between 2008 and 2012, but broadly flat activity levels in inpatient discharges and emergency admissions. However, this does not take account of the care needs associated with each patient.

[25] PQ 30468/2014

implication in moving away from the existing block grant system is that there may be an initial increase in aggregate hospital spending when funding is linked entirely to activity, particularly in light of the recent reductions in health spending. To mitigate possible increases in aggregate costs, the proposed approach introduces budget caps to limit spending. In principle, if a hospital falls short of its planned activity level it will only receive funding for the output delivered, while if activity is in excess of the agreed level the hospital will receive no additional funding. Under the reformed budgetary framework, including the Medium-Term Expenditure Framework (MTEF), any over-spending can be applied as a charge against future budget allocations. The MTEF should also bring more certainty to medium-term resourcing in the public health area and allow for better strategic planning. However, without implementing sanctions or incentives, it may be difficult to break the cycle of over-spending in this area.[27] A further reform in the hospital area is the creation of independent hospital groups. The rationale behind this reform is that these Groups can deliver high quality, safe patient care in a cost effective manner. While the composition of the hospital groups have been identified by the HSE, the process appears to have not yet moved beyond this initial stage.

The MFTP approach is not designed to resolve the governance and accountability issues raised in this section. Indeed, the successful implementation of MFTP would require significant reform of these areas.[28] The EU Commission (2014) identifies improved financial management systems as one reform on which the successful implementation of MFTP is dependant. The *National Service Plan 2015* (HSE, 2014) included a new accountability framework for the HSE. In addition to managers being held accountable for patients' access to services and the quality and safety of those services, this framework is designed to hold managers accountable for delivering these outcomes within available financial resources.

The MFTP approach and creation of hospital groups are part of the Government's wider *Future Health Strategy* (2012). The stated aim of this strategy is to move to a single tier health system in Ireland.

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[26] 'Case-mix' refers to the approach of 'weighting' activity and costs based on the complexity of conditions being treated. The *Report of the Commission on Health Funding* (1989) first proposed that hospital budgets be based on case-mix based cost of meeting agreed activity levels. This has been applied in a limited way in the HSE. Until the end of 2013 the budgets of acute hospitals were adjusted by up to 3 per cent in line with the case-mix approach on an Exchequer neutral basis. This approach requires close auditing of categorisation to ensure the case-mix reflects activity levels correctly.

[27] In his statement on the 2014 Supplementary Estimate for the HSE, the Minister for Health stated, "In terms of financial control, there is a stronger incentive than ever for the HSE and hospitals to stay within budget. In recent years savings had to be delivered in order to reduce the central Government deficit. Now, more and more, savings above a certain level can go back into the health service and into services. I hope that is an incentive to drive savings more in the future."

[28] While not an issue for this *Analytical Note*, as it does not directly impact on health overruns, it has been noted that the while the MFTP system is best practice in terms of quantifying costs it does not address the relatively high level of hospital unit prices in Ireland relative to other EU countries.

Underpinning this aim are two key structural reforms; the introduction of Universal Health Insurance and of universal primary care, including free GP care. The overall fiscal impact of these reforms is not yet clear and their introduction is currently under review by the Department of Health.[29]

An important consideration in this regard is that, despite the savings achieved in the health area over the period since 2008, public health expenditure remains well ahead of norms in the EU, representing 8.7 per cent of GNI, or 7.1 per cent of GDP, in 2012 as compared to the EU average of 7.3 per cent, while output and outcomes are comparable to the average (EC, 2015). However, further increases in the efficiency of health expenditure will likely require reforms of a more structural nature than have been implemented in recent years (see Burke et al, 2014). This is particularly the case given increased demographic pressures (see IFAC, 2015) and other challenges to reform in this sector.[30] While budget targets should be ambitious to ensure effective and efficient use of resources, they must be deliverable if future budget overruns are to be avoided. By setting ambitious but achievable targets, and ensuring a framework is in place to deliver on these targets, the aims of both fiscal and health policy can be better pursued.

## 4.3 Primary Care Reimbursement Service (PCRS)

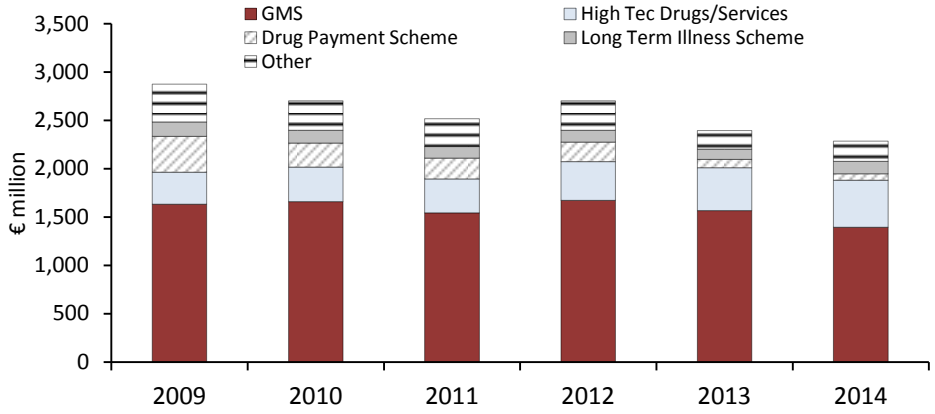
Higher than budgeted expenditure on the Primary Care Reimbursement Service (PCRS) has been the second major driver of expenditure overruns in the HSE. The function of the PCRS is to manage payment services to primary care service contractors, such as General Practitioners, Pharmacists and other health professionals, who provide free or reduced cost goods and services to the public. It does not include payments to primary care professionals employed directly by the HSE.[31] PCRS expenditure comprised about one-fifth of the HSE gross voted budget in 2014. The four largest schemes are the General Medical Service (GMS), Drug Payment (DP), Long-term Illness scheme (LTI) and High Tech Drugs (HTD) schemes (see Figure 12).

[29] There is some evidence to suggest spending through bureau programmes - where spending is allocated through an organisation such as a national health service - is easier to limit than entitlements based spending - such as social insurance or government insurance based systems (see White, 2014).

[30] For example, Nolan *et al.* (2014) indicate questioning by senior health service decision-makers whether there was sufficient political will to implement health reforms. In addition they noted further organisational challenges including, "the capacity to use evidence to drive policy, a noted lack of management capacity to deliver on efficiency and reform targets, and a lack of integrated management systems."(p. 28)

[31] Primary care provided by direct HSE employees – e.g. public health nurses and occupational therapists - is funded under the Primary Care Group heading.

FIGURE 12: PCRS EXPENDITURE 2009-2014



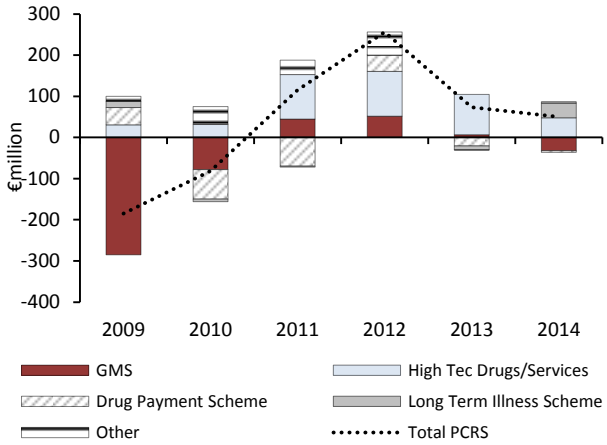

*Source: HSE Monthly Performance Management Reports.*

Figure 13a shows the deviation in spending by scheme in the PCRS area. Budgeted PCRS expenditure for both 2009 and 2010 demonstrated some conservatism when compared to the outturn.[32] However from 2011 'optimism' errors have crept into the forecast, with overruns evident in this area for each of the last three years. The High Tech Drugs scheme in particular has consistently spent in excess of budget in recent years. Figure 13b shows that most of the above profile spending over the period is driven by expenditure on drugs and medical appliances rather than fees and allowances. This indicates that the forecast error lies on the side of medical goods rather than services. However, given that drug and medical appliance costs make up about 70 per cent of the spending in the PCRS area, it is unsurprising that the most significant nominal deviations in PCRS expenditure from budget are found in this area.[33]

[32] In some cases savings arising from policy measures do not appear to have been fully factored into allocations, "Targets are based on trend lines in the last quarter of 2009 and are based on the assumption that the implementation of policy initiatives e.g. introduction of a prescription charge for GMS / LTI, extended DPS co-payment limit etc will not impact on 2010 targets figures."(HSE, 2010a)

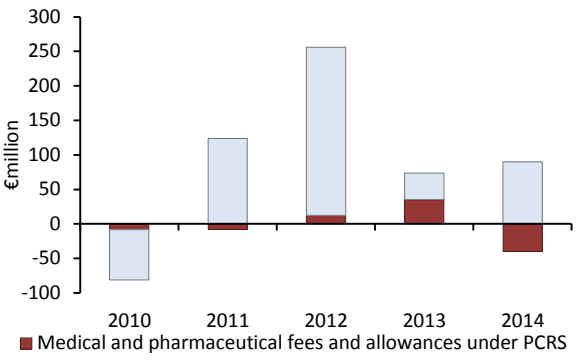
[33] While drug costs also impact on non-pay hospital expenditure, and higher than expected drug and medical equipment expenditure may account for some of the overrun in that area, the PCRS area accounts for about 84 per cent of the public drugs bill.

FIGURES 13A: PCRS PERFORMANCE AGAINST PROFILE




*Source: HSE Monthly Performance Management Reports.*
*Note:* Profiles shown are the inital profile published in each year and are from the January reports for all years with the exception of 2010, which is taken from the May 2010 report.

FIGURES 13B: PCRS PERFORMANCE AGAINST PROFILE




*Source:* IFAC calculations based on *Monthly HSE Performance Reports*
*Note:* Profiles shown are the inital profile published in each year and are from the January reports for all years with the exception of 2010, which is from the May report.

The potential explanations for this higher than expected spending are; (i) greater demand for services than initially expected, (ii) underestimation of unit costs, including through the misestimation of savings arising from policy changes.

The forecasts for the number of medical and GP visit card holders have been relatively conservative since 2011. Of course, both the split between GP visit cards and Medical Cards and the age composition of claimants can also affect overall costs in this area.[34] However, the relatively small forecast errors on medical and pharmaceutical fees and allowances, which are linked to costs arising from Medical and GP visit cards, indicates that these factors are reflected in the forecasts.[35]

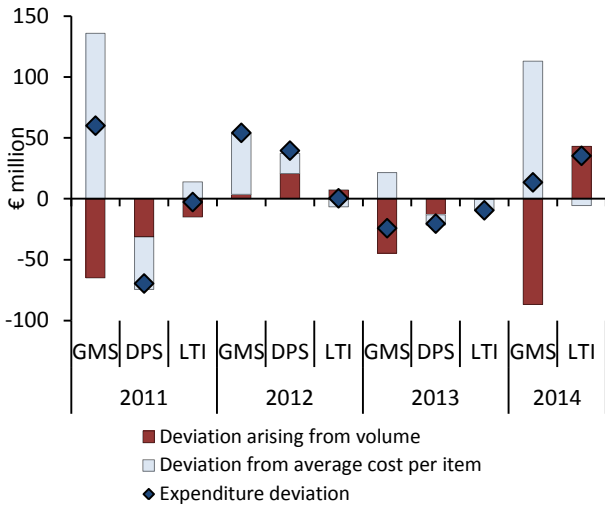
Broadly speaking, the deviation on drugs expenditure may arise from either larger than expected demand (the volume) or a higher than expected average unit cost (the price). Figures 14a and 14b disaggregate the overrun on drugs and medical appliances across the four main PCRS schemes into the elements driven by misestimating the volume and the price. Figure 14a estimates the volume of demand across schemes by reference to number of individual items prescribed and Figure 14b estimates volume using the number of claims and prescriptions. While less granular, an examination of the unit cost per claim rather than per item prescribed is important as it allows the HTD scheme to be

[34] The increase in medical cards over the crisis period was predominantly driven by the increase in unemployment among the working age cohort. This group tend to have the lowest average cost per card.

[35] A full medical card covers both medical services and drug costs while GP Visit cards (GPV) covers only the services component. GPV card holders also claim under schemes such as the DPS to offset drug costs.

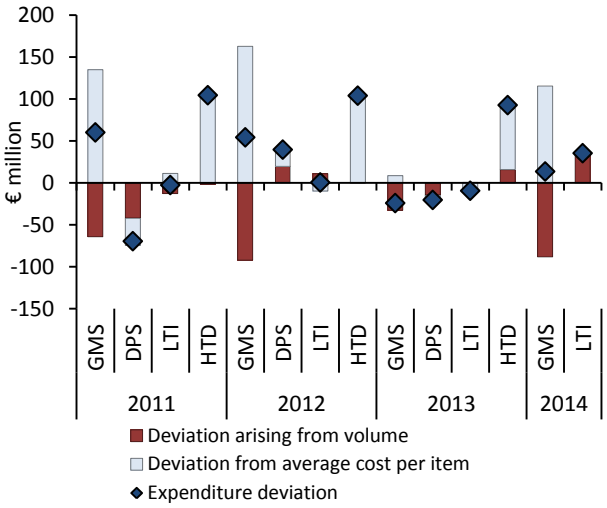
included in the analysis.[36] These measures differ as an individual claim/prescription may have multiple prescribed items associated with it.

FIGURE 14A: DECOMPOSITION OF DEVIATION IN MAIN DRUG SCHEMES
BY NUMBERS OF ITEMS PRESCRIBED




*Source:* IFAC calculations based on HSE monthly Performance Assurance reports.
*Note:* 2014 Profiles were not published for the Drug Payment Scheme..

FIGURE 14B: DECOMPOSITION OF DEVIATION IN MAIN DRUG SCHEMES
BY NUMBERS OF CLAIMS / PRESCRIPTIONS




*Source:* IFAC calculations based on HSE monthly Performance Assurance reports.
*Note:* 2014 Profiles were not published for the High Tech Drugs Scheme or the Drug Payment Scheme.

On the basis of this breakdown the majority of the overruns arise from underestimating the average unit cost of drugs. There appears to be some conservatism in the volume estimates which partially offsets the price effect in most years.

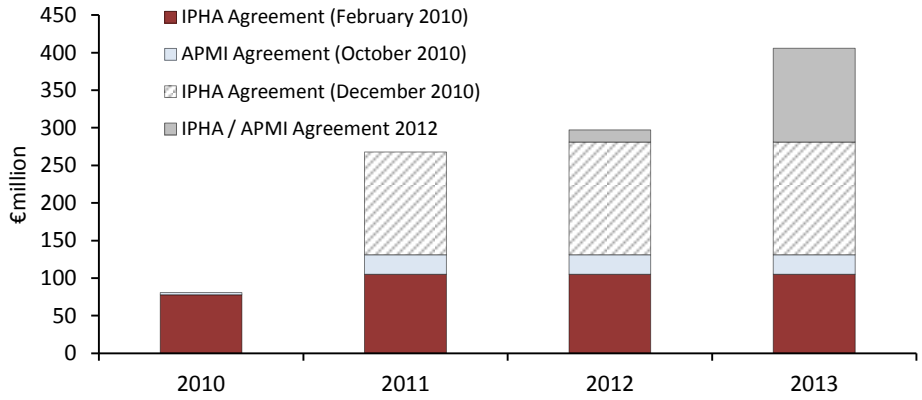
In recent years the price of drugs in Ireland has been driven largely through agreements with the main industry representatives. In Ireland 48 per cent of drugs by volume are on-patent or 'branded', while this proportion increases to 76 per cent by value. Drugs prices paid by the State have been determined by negotiations with the main industry representative groups: the Irish Pharmaceutical Healthcare Association (IPHA) for on-patent drugs and the Association of Pharmaceutical Manufacturers of Ireland (APMI) for off-patent drugs.[37] There have been a number of agreements in recent years yielding an estimated €400 million in full year gross savings, excluding the cost of new drugs (Figure 15). The introduction of reference pricing and the reduction in drug mark-ups within the GMS were also

[36] Volume data on the HTD scheme is only available by the number of claims in the monthly reports.

[37] Brick et al (2013) highlight four main elements determining the price of new pharmaceuticals; (i) price charged by the patent holder in a basket of other countries ("external reference pricing"), (ii) the formula for using this price information, (iii) the frequency with which this information is updated, and (iv) for drugs likely to have a significant budgetary impact a pharmacoeconomic assessment. The Health Act 2013 increases the discretion available to the Department of Health in setting drug prices beyond the industry agreements, including by reference to the overall resources available to the HSE.

designed to lower drug costs.[38] These policy changes appear to have had some impact in reducing drug costs but there is scope to further reduce overall drug costs through the introduction of policies designed to change prescription practices with a greater substitution of lower-cost, generic drugs where appropriate.[39] As the overrun on drugs expenditure appears to arise primarily as a result of misestimating the average drug cost, this suggests that there is either a failure to (i) fully realise the planned savings from the agreements with the pharmaceutical industry representatives and/or (ii) slower than expected behavioural change on the part of practitioners or patients in switching to lower cost substitutes.

FIGURE 15: INTRODUCTION OF REDUCED DRUG REIMBURSEMENT




*Source:* Department of Health submission to the Comprehensive Review of Expenditure 2015-2017.

On introduction, new drugs likely to have a significant budgetary impact are subject to a cost effectiveness threshold requiring that for each Quality Adjusted Life Year (QALY) the drug in question must cost no more than €45,000.[40] This threshold was established formally in 2012 as part of the agreement between the IPHA and the Department of Health and the HSE. Prior to this there was no explicit threshold. However, a notional threshold was used by Irish cost-effectiveness advisory bodies. Initially this was €45,000 per QALY but this was subsequently revised down to €20,000 in 2009, apparently reflecting the changed fiscal circumstances (O'Mahony and Coughlan, 2014). The current

[38] 'Reference pricing' is the practice whereby groups of interchangeable off-patent drugs are defined and the state sets a single reference price for all drugs in the group. This is usually based on the price of a particular drug in this group, usually the lowest.

[39] Recent changes have been introduced to address prescription practices, mainly the Preferred Drugs Initiative in the Medicines Management Programme, which recommends the prescription of lower cost drugs in a therapeutic group. See also Brick *et al* (2013, p. 104-114)

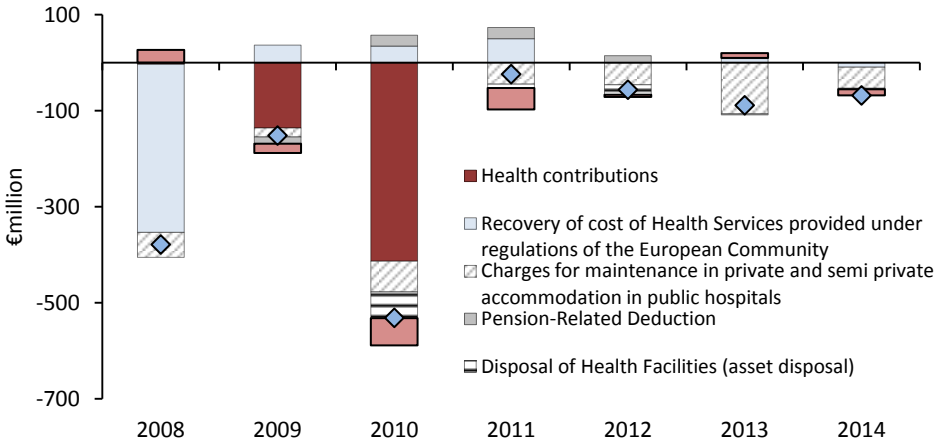
[40] A QALY takes into account both the quantity and quality of life generated by healthcare interventions. It is the arithmetic product of life expectancy and a measure of the quality of the remaining life-years and is used as a common method to compare medical intervention across many areas. See Barry (2008).

€45,000 threshold is higher than the comparable cost threshold in the UK.[41] Drugs not meeting this criterion may still be introduced subject to other criteria related to medical outcomes. There is evidence that the use of such discretion within the approval process for new drugs can lead to a higher effective threshold (see Brick et al, 2013; Dakin et al, 2014).[42] Typically the process for approval of pharmaceuticals exceeding the threshold of €45,000 has not been fully transparent. As this process applies to new, branded drugs it is likely to impact mainly on the High Tech Drug scheme and may contribute to the over-spend in recent years. While there is a financial threshold applying to new drugs it is not set by reference to the overall budget and can still lead to excess spending above the aggregate allocation.

## 5. HSE Receipts

The majority of payments received by the HSE are not directly influenced by Government policy. Following the merging of the HSE 'vote' into the Department of Health 'vote' from 2015, a significant portion (just below 80 percent) of HSE receipts previously identified as appropriations-in-aid will be used to reduce the net grant paid by the Department of Health to the HSE. In effect this reduces both gross public health spending and receipts, while leaving net Exchequer spending on health unchanged.

Figure 16: Deviation of HSE Receipts from estimates




*Source: Revised Estimates, Department of Public Expenditure and Reform databank* and the Department of Public Expenditure and Reform.

[41] Claxton et al (2013) report that the UK threshold of £20,000 to £30,000 is too high as they estimate an additional £13,000 of NHS resources adds one QALY to the lives of patients. This analysis estimates the threshold by reference to the cost effectiveness of healthcare displaced by the adoption of new drugs.

[42] The evidence for Ireland is partial due to the confidential nature of 'patient access agreements', which are negotiated between the State and manufacturers for individual new drugs. However, it suggests that in some cases pharmaceuticals are reimbursed even though the €45,000 threshold cost per QALY is exceeded (see Brick et al, 2013).

Figure 16 shows the deviation in annual HSE receipts from target from 2008. The deviation in 2008 was a one-off event arising from the renegotiation of an agreement with the UK.[43] The large deviations from profile in 2009 and 2010 are due to forecast error on the Health levy, which arose due to errors in the macroeconomic forecast for the indicator used to predict receipts. The most persistent source of underperformance since 2011 is in recovering the costs associated with private and semi-private beds in public hospitals. This underperformance reflects a failure to meet income collection targets, generally as a result of misestimating the impact of policy and procedural changes.[44] In 2013, the legislation required to implement the measure included in *Budget 2013* providing for the charging of private patients in public beds was not enacted.

In addition, income that was 'accelerated' into 2012 from insurers reduced the amount payable to the HSE in 2013.[45] It was assumed that a similar arrangement would apply in 2013 and bridge this gap, but this did not occur. While this type of cash-flow management may reduce the requirement for Exchequer drawdown in a given year, it disguises underlying problems.

## 6. CONCLUSION

A continuation of the recent trend for health spending to exceed its annual budget undermines the Government's ability to plan and prioritise in the medium term and may also lead to problems in implementing policy. Two main areas are identified in this analysis as being persistent sources of the increasingly large health overruns in recent years: hospitals and PCRS. In both areas there are evident weaknesses in certain organisational and procedural aspects of budget planning and implementation.

At the budget planning stage, in the hospitals area the number of actors involved in the process can lead to a diffusion of responsibility and ultimately a failure to meet targets. The clearer accountability arrangements proposed under the new HSE accountability framework may resolve some of these

[43] The shortfall in receipts under 'Payments made under the recovery of costs of health services under EU regulations' relates to lower than expected payments made by the UK authorities under the UK-Ireland Healthcare Reimbursement Agreement. The interim agreement put in place for 2008 considered the results from surveys completed during 2008 and updated costing information. This information was used to assess both the liability in respect of 2008 and the 2007 payment which was made on account pending the availability of new survey results and further review.

[44] The deviations in 2008 and 2009 are largely the result of an overestimate of the additional income accruing from changes to the long-stay charging regime. The budget estimates for 2010, 2011 and 2012 in this area were based on an acceleration of payment income from insurers; however these accelerated cash targets were not achieved. This was based on an estimate of the level of payments where patients incurred charges from treatments in acute hospitals but claims had not been finalised. Similarly in 2012, while a significant increase in incomes was achieved from accelerated collection (€50 million), the target was not met. (Appropriation Accounts, 2008-2013, Comptroller & Auditor General) The speed of claim processing has been highlighted as a contributing factor to lower than expected receipts for a number of years, with delays in sign off by consultants a particular issue (Office of the Comptroller and Auditor General, 2013b).

[45] In December 2012 the HSE statutory hospitals received accelerated payments totalling €49.8 million representing the insurers' estimate of amounts due to the HSE where the claim process had not been finalised.

issues. In addition, increased use of evidence and outturn data in budget setting and increased involvement at local management level would encourage greater coherence between high-level budget constraints and individual hospital and sectoral targets. Improved financial, accountability, and governance arrangements are particularly important given the proposed, more decentralised control associated with the introduction of hospital groups under the *Future Health Strategy*.

In the PCRS area, the main source of budget excesses is higher than expected average drugs costs, mainly relating to new drugs. While there are financial limits on the approval of individual new drugs, these controls are not linked to the overall budget limits and can be subject to individual discretion. The impact of this is evident in the High Tech Drugs scheme, where the budget allocation has been exceeded in each of the last six years.

While direct pay measures appear to have delivered savings targeted, recent overruns suggest that efficiencies to be delivered through other reforms have not materialised to the extent initially estimated. It also appears that targeted net savings in relation to drugs costs may not have fully materialised. Data deficiencies are highlighted by the difficulty in assessing the extent to which planned savings have actually been delivered. A transparent system to monitor the *ex post* delivery of planned policy interventions should be put in place. The results of such analysis, and indeed analysis of proposed health policy and cross country comparisons, should be used to guide future budgetary and expenditure review processes.

Given future challenges to the public health system such as demographic change, existing financial planning and governance structures must be improved to ensure delivery of targets. While budgets should be set to encourage more efficient and effective expenditure policy, they must also remain realistic if future budget overruns are to be avoided. Resolving such issues allows scope for the more effective pursuit of both fiscal and health policy aims.

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