Box B: Recent trends in public health sector staffing

Healthcare is very labour-intensive. As a result, a large driver of the increase in health spending annually is staffing costs. The pay bill accounted for, on average, 47% of the health vote costs from 2015 to 2021, but reached 52% in 2021. The number of workers in the health sector is also one of the main drivers of public sector pay more generally, as health workers make up 37% of all public sector workers.[25] For this reason, staffing levels in the health sector are an important indicator for the public finances. This box looks at the recent trends in public health sector staffing.

Health staff levels and demographics

Staffing levels in the health system are likely to reflect demand, including the impact of changing needs over the course of a person's life cycle; for example, in 2018, spending in public hospitals on people aged 65 and over, who account for only 14% of the population, accounted for 43% of the total spending. Therefore, changes in the number of people in these cohorts are a key driver in in explaining the demand for health services.

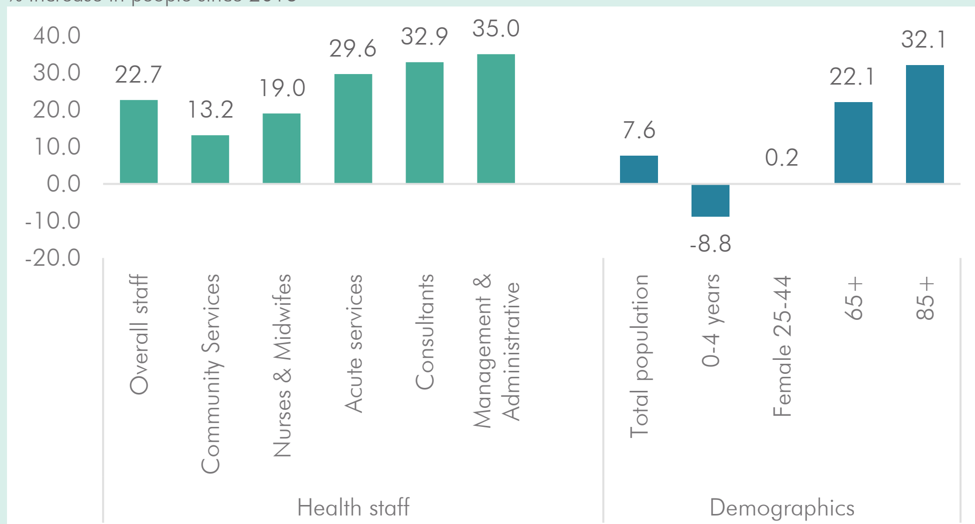
Comparing any increase in staff levels to the increase in these cohorts can be a useful indicator of a real expansion in the level of services in the health sector.

Figure B1 compares the changes in some key areas of staff levels in the health service since 2016 to the changes in some key demographic groups. Overall, the increase in the staffing levels in key health services broadly kept pace with the increasing number of older people. Since December 2016, the number of staff in the public health sector has increased by 25,000, or 22.7%, while the population over the age of 65 has grown by 22.1%.

The changes in the staff levels by area also provide an indication of recent policy priorities. There has been a large increase in the number of staff in Acute Services (29%), and Consultants (32.9%) in recent years. However, front-line services have not seen the largest growth in staff levels. Management and Administration staff have risen to more than 22,600, increasing by 35% since December 2016, more than other areas of the health service.[26]

Figure B1: Increases in key health staff have broadly matched demographic changes, but have been uneven across areas

% Increase in people since 2016



Sources: CSO; Health service personnel censuses; Health service employment reports, and Fiscal Council workings.
Notes: Demographic figures are taken from the Annual Population Estimates and compare April 2022 population to April 2016 population. Health staff figures compare December 2016 Whole Time Equivalents (WTE) figures to September 2022 WTE figures. Get the data.

[25] Data as of Q2 2022, taken from the Department of Public Expenditure and Reform Databank.

[26] This relatively large increase in Management and Administration staff levels is not just due to the Covid-19 pandemic. Staff levels in Management and Administration had grown relatively quickly (by 12.7%) even prior to the pandemic, with only Consultants growing faster (14%) between December 2016 and February 2022.

Recent staffing levels and targets

Figure B2 shows the trend in overall staff levels in the public health sector since December 2016. The HSE National Service Plan for 2022 outlined a minimum target of 137,410, with an upper limit of 141,690 staff by the end of 2022. While the National Service Plan provides a minimum target, funding had been provided and plans developed on the basis of the upper limit: "The NSP works to the maximum target as the HSE is fully committed to deliver to the greatest extent the maximum of the range, acknowledging the significant and unpredictable challenges to workforce supply in 2022" (HSE, 2022).

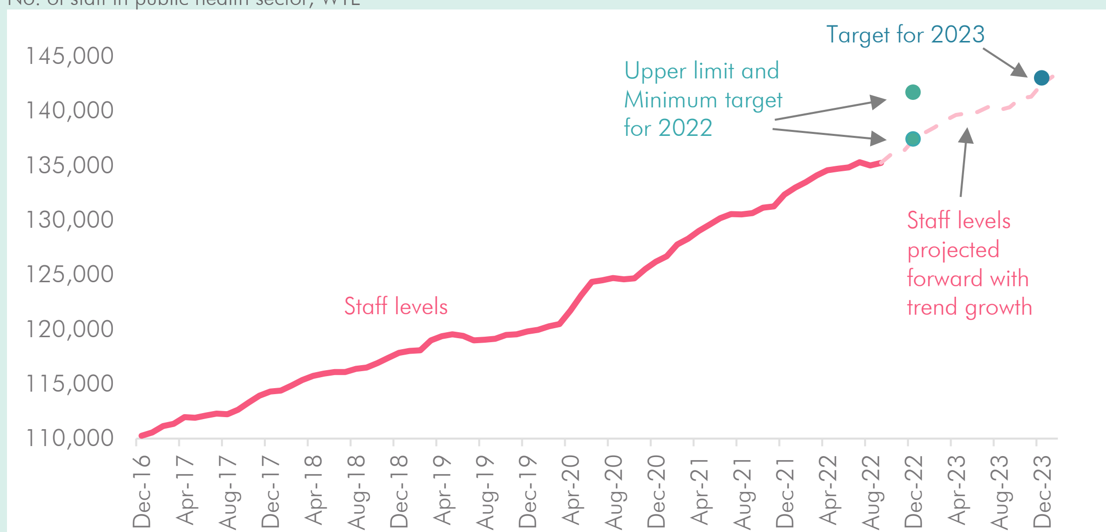
By September 2022 around 135,240 Whole Time Equivalents (WTE) were employed in the public health sector. This implies that the total number of staff in the health sector was 2,170 people shy of the minimum end-2022 target. However, some areas of the health service were already above the minimum target. The number of staff in Acute Services, such as hospitals and ambulances, was above the minimum target for 2022 by 860 people.

Community Services were almost 3,000 below the minimum end-2022 target, and almost 5,900 below the upper limit the National Service Plan worked towards.[27] This shortfall is mainly driven by Primary Care, which is 1,950 staff below the minimum target, but Mental Health (390), Disabilities (590), and Older People (660) were also all below the minimum target by the end of September.[28]

Figure B2 projects forward the level of staff based on recent trend growth in staff. Using this projection, the level of staff numbers by the end of 2022 would fall just shy of the minimum target by 130 staff and more than 4,400 below the upper limit that the HSE's National Service Plan worked towards.[29] Looking further ahead, the *Expenditure Report 2023* sets a target of an increase to 143,000 staff by the end of 2023. Based on the trend growth rate, staffing levels might just meet this target.

Figure B2: Staffing levels likely to just meet minimum target this year

No. of staff in public health sector, WTE



Sources: Health service personnel censuses; Health service Employment Reports; Expenditure Report 2023; HSE National Service Plan 2022 and Fiscal Council workings.

Notes: All figures are on a WTE basis. Upper and minimum target limits for health staff are taken from the HSE National Service Plan 2022. The target for 2023 is taken from the Expenditure Report 2023. Trend year-on-year growth is based on the data from December 2016 to September 2022. The average year-on-year growth in staff levels since December 2016 was 3.75%. Get the data.

[27] There were 56,790 staff in Community Services at the end of September 2022.

[28] For context, at the end of September 2022, Primary Care had 12,150 staff, Mental Health had 10,400 staff, Disabilities had 19,670 staff, Older People had 13,780 staff. At the end of September, Primary Care was 3,130 staff below the upper limit that the National Service Plan worked towards; Mental Health was 670 staff below the upper limit; Disabilities was 1,160 staff below the upper limit; and Older People was 1,550 below the upper limit.

[29] This also follows on from a shortfall of 3,300 staff in 2021 from the end-December target in the HSE National Service Plan 2021.

Implications of a shortfall in staffing

As funding had been made available for the increase in staffing levels, the struggle to meet even *minimum* targets suggests supply constraints in the healthcare labour force. One example of such constraints was highlighted in a recent *Spending Review* paper showing that recruitment in nursing has become heavily reliant on recruiting nurses who have been educated abroad (Caulfield *et al.,* 2022). In 2021, 69% of newly registered nurses had been educated outside Ireland, up from 26% in 2014. The paper also highlighted that domestic supply gaps were likely to persist and that recruitment from abroad would continue to be required. This is despite Ireland committing to the ending of active recruitment of health personnel from developing countries (Caulfield *et al.,* 2022). The paper recommended the expansion of student nursing places.

Given the commitment to end the practice of recruiting from developing countries, the reliance on recruitment from abroad to cover domestic supply gaps and the difficulties in retention of staff in the health sector pose challenges to expanding the number of staff in the health sector.

All else equal, a shortfall in staff would see a lower level of services being provided than originally planned. This is particularly the case in Community Services, which requires an additional 1,000 staff per month for the remainder of the year to meet the minimum target (almost 2,000 per month to meet the upper limit). This target is therefore unlikely to be met. This has implications for the implementation of Sláintecare reforms as many of the reforms centred on shifting towards a community-centred approach and rely on expanding staff levels in Community Services: "The Committee's preferred design is a model where the vast majority of healthcare is provided in the community".[30] As Figure B1 shows, staff in Community Services have grown by only 13.2% since 2016 — a much lower increase than those in other areas. The shortfalls in staffing levels in this area will delay the implementation of the Sláintecare reforms.

In terms of the public finances, a lower level of staffing than planned should see underspends in Health. The savings from the lower level of staff were estimated by the Department of Health to be between €350 and €510 million this year.[31] However, it seems likely that this underspend will be used to cover overspends in other areas, with areas such as Covid-19 measures, waiting lists, the winter flu programme, and pay restoration flagged as areas to which this money might be diverted.[32]

The use of funds to cover spending in areas not originally intended is an indication of poor planning. The inability to expand the supply of the healthcare workforce to meet policy aims also highlights the lack of planning in the healthcare system. Planning could be better facilitated if the HSE finalised its annual *Pay and Numbers Strategy* in a more timely way.[33] A comprehensive, strategic medium-term workforce plan — in line with key policy goals — would better facilitate managing staff levels, particularly if the planned expansion in staff over the medium term is large. This medium-term strategic plan is necessary as there needs to be a corresponding expansion in domestic university places in healthcare ahead of any planned increases in health staffing, as well as policies to ensure the retention of staff.

---

[30] See Committee on the Future of Healthcare (2017).

[31] See reporting by the *Business Post*: https://www.businesspost.ie/news-focus/dear-stephen-mcgrath-told-donnelly-health-overspend-was-of-great-concern/.

[32] See reporting by the *Business Post*: https://www.businesspost.ie/news/e350m-hse-surplus-from-under-recruitment-will-fund-covid-costs-and-pay-restoration/.

[33] Connors (2018) outlines how the HSE only submitted the revised 2016 *Pay & Numbers Strategy* to the Department of Public Expenditure and Reform in December 2016, the final month of the year in question. The 2017 *Pay & Numbers Strategy* was only submitted to the Department of Public Expenditure and Reform in November 2017. Connors (2018) argues that "[t]hese timelines result in the Strategy having no impact on the planning and monitoring process".