Joint Committee on Health

Challenges relating to budgetary and staffing matters in the HSE.

18 November 2026

Chair and Members, thank you for the invitation. My name is Rachel Kenna, Chief Nursing Officer/Assistant Secretary with responsibility for strategic workforce planning and the National Patient Safety Office and I am joined by colleagues Siobhán McArdle, Paul Flanagan, Louise McGirr, Michael O'Leary from the Department of Health and my colleagues from the HSE.

As Chief Nursing Officer at the Department of Health and Head of the National Patient Safety Office, I know the excellent work our healthcare workers do daily, providing safe, compassionate care to our patients. I also understand the pressures they face with rising demand and the very real pressures experienced across our health service.

More care is being delivered across both hospital and community settings. This progress matters but increased investment must also translate into more capacity, improved productivity and, most importantly, better and more timely access to care for patients across the whole health service. As our population grows and ages, we must deepen our commitment to reforming how we deliver healthcare.

Unprecedented investment has supported this expansion. Since 2019, health funding has increased by approximately €11.9 billion and staffing by more than 33,000. Health now accounts for nearly one quarter of Exchequer expenditure.

That investment matters. But it carries a responsibility to deliver better access, better outcomes and better value for patients.

This is not a choice between investment and financial control, or staffing and reform. A sustainable health service requires all of them: the ability to meet patients' needs today while maintaining the funding, workforce and capacity to meet growing demand in the years ahead.

Demand is changing

Ireland's population is growing and ageing: from 5.3 million in 2023 to potentially 7 million by 2057. The proportion over 65 is expected to rise from one in seven in 2023 to one in five by 2040 and one in four by 2050. This group accounted for 60% of hospital bed days in 2023.

These pressures are already here. We cannot meet them indefinitely by adding expenditure and staff to existing care models. The response must therefore combine continued investment with reform, rather than treating either as a substitute for the other.

Since 2019, real acute hospital expenditure has increased by 52% and staffing by 33%, against activity growth of 14% over broadly the same period. Direct comparisons do not capture the full impact of increased patient complexity, new and expanded services, or enhanced quality and safety requirements. Nevertheless, this level of investment brings a clear responsibility to maximise productivity and demonstrate tangible improvements in access and outcomes for patients.

There is already evidence of this different approach working. More than 90% of patients participating in structured chronic disease management now receive their routine chronic disease care in community settings. This illustrates how general practice and integrated community services can support patients without relying on hospital-based care for every stage of treatment.

Financial control

We must be equally direct about the financial position.

At the end of September, HSE expenditure was growing at almost 9%, against funded growth of approximately 5%. By the end of October, cash drawdown was €781 million above plan.

Medicines, pensions, State Claims, inflationary costs, lower private-patient income and above-budget pay, including agency and overtime, have contributed to pressures. They do not explain the full position.

Good financial governance is not separate from good healthcare. It enables us to sustain and improve healthcare. Service planning, workforce planning and budgets must align. Every additional commitment needs a clear service purpose, an identified workforce requirement and sustainable funding.

Controls introduced during 2026 aim to reduce expenditure above budget and prevent unfunded commitments, while protecting essential services and opening funded capacity.

There is no blanket recruitment freeze. In addition to circa 4,000 staff recruited by the HSE this year, under the revised sanction arrangements, the Department of Health has approved staffing proposals certified by the CEO for 644.5 whole-time equivalent

posts (as of 16:00 17th November), including all graduate nursing and midwifery posts submitted for sanction.

Most approvals involve replacing agency staff or overtime with directly employed staff, improving continuity for patients while reducing reliance on more expensive agency cover. Most remaining applications are also agency-conversion proposals and are under review. Urgent patient-safety and service-continuity risks have an expedited consideration route and the Department has written to the HSE for an urgent update on critical posts relating to urgent and emergency care posts.

Staffing and reform must come together

We need to know not just how many people we recruit, but where and when they are needed, what improvements they will deliver and how posts will be sustainably funded.

The Framework for Safe Nurse Staffing and Skill Mix provides a practical example of this. It is now in place across all 26 adult Emergency Departments and 39 acute hospitals, with 96% of identified baseline requirements delivered. It assesses staffing against patient dependency, complexity and care needs, matching staffing levels to the patients being treated. This provides an evidence base to inform safe staffing levels across sites, reflecting the needs of the patients being treated.

We must reduce avoidable reliance on expensive agency and overtime where substantive recruitment offers a safer, more sustainable solution. Graduate recruitment should be planned earlier and tracked from offer to commencement.

Reform cannot mean simply asking stretched staff to do more. It means organising care differently. Our aim is to support staff to deliver care safely and effectively, not to diminish the very real pressures they experience. In Cavan and Monaghan, integrating acute and community audiology services reduced the paediatric waiting list from 159 children to 17 in three months. A central referrals office in Dublin and the North East reduced referral-processing times by more than 80%. These examples show how service redesign and simpler administration can improve access and move referrals through the health service more quickly.

Productivity and efficiency must be central to this reform: improving timely access and outcomes from the resources available, while maintaining quality and safety. This is not simply about increasing activity or reducing costs. It is about reducing avoidable delays, duplication and administrative burdens, so that staff can spend more time delivering patient care.

Practical opportunities include the work being led by the Chief Clinical Officer with clinical teams on theatre capacity, for example, extended theatre working at Connolly Hospital enabled six additional elective patients to be treated each week, while Saturday gynaecology theatre sessions in Drogheda enabled six additional patients to be treated per session. Progress should be measured through shorter waits, better patient outcomes and experience, and demonstrable improvements in the use of staff time and funded capacity—not activity alone.

Our surgical hubs are being opened to protect planned treatment from emergency pressures. Mount Carmel's surgical hub illustrates the benefits of this approach. It delivered more than 8,000 procedures between February 2025 and August 2026, with

average waits in participating specialties falling from eight and a half months to four.

Virtual wards are now operating in every Health Region and have cared for more than 5,300 patients. They enable patients to receive care at home with clinical oversight, avoiding admission or supporting earlier discharge while preserving hospital capacity for those who need it.

Chair, our responsibility is twofold: protect safe, high-quality care today and reform our health service for a sustainable tomorrow. The public rightly expects existing investment to be used effectively.

Neither responsibility can be set aside: sustaining services depends on financial discipline, and financial discipline must support the safety and quality of those services.

Financial control is not simply about bringing expenditure closer to budget. The test is greater financial discipline while protecting essential services, opening funded capacity and improving timely access to safe, high-quality care. That is the accountability we owe patients, our workforce and the public whose investment makes our health service possible.

Thank you, Chair. We welcome the Committee's questions.