JERSEY AUDIT OFFICE

Sustainable Healthcare Funding

23 JULY 2026

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Report by the Comptroller and Auditor General: July 2026

This report has been prepared in accordance with Article 20 of the Comptroller and Auditor General (Jersey) Law 2014.

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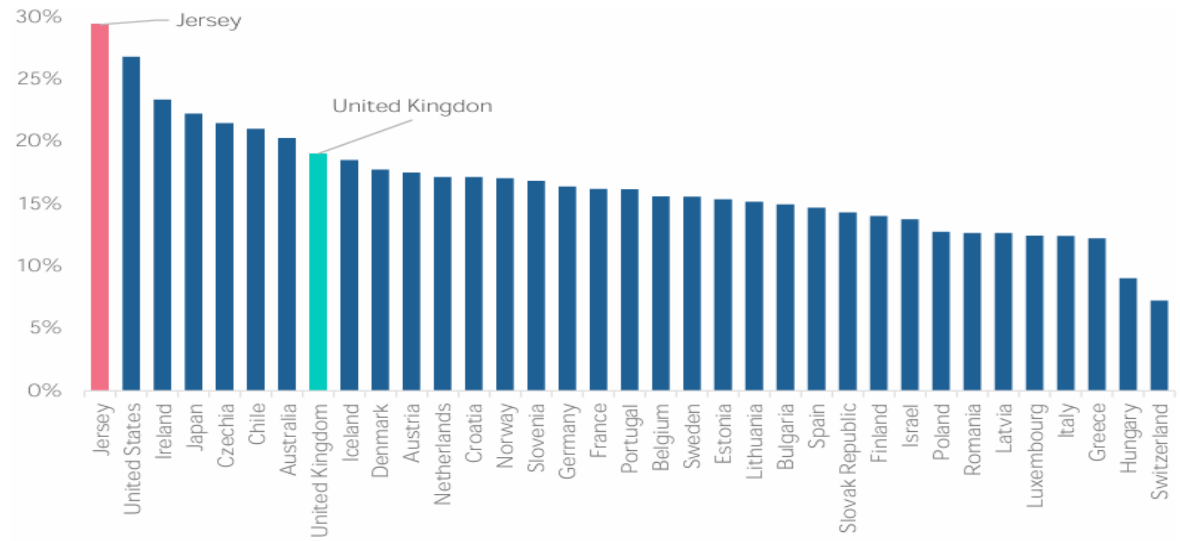
Summary

Introduction

1. The funding of healthcare represents a significant financial challenge to many jurisdictions. Jersey is no exception to this.

2. Using the Classification of the Functions of Government (COFOG) system, expenditure on health in 2024 was £515.7 million which represented 29% of total general government expenditure. In 2023 (the last year for which comparative data is currently available) the percentage of total general government expenditure on health was higher than any Organisation for Economic Co-operation and Development (OECD) country and was over 10 percentage points higher than the United Kingdom (Exhibit 1).

Exhibit 1: General government expenditure on health as a percentage of total expenditure 2023

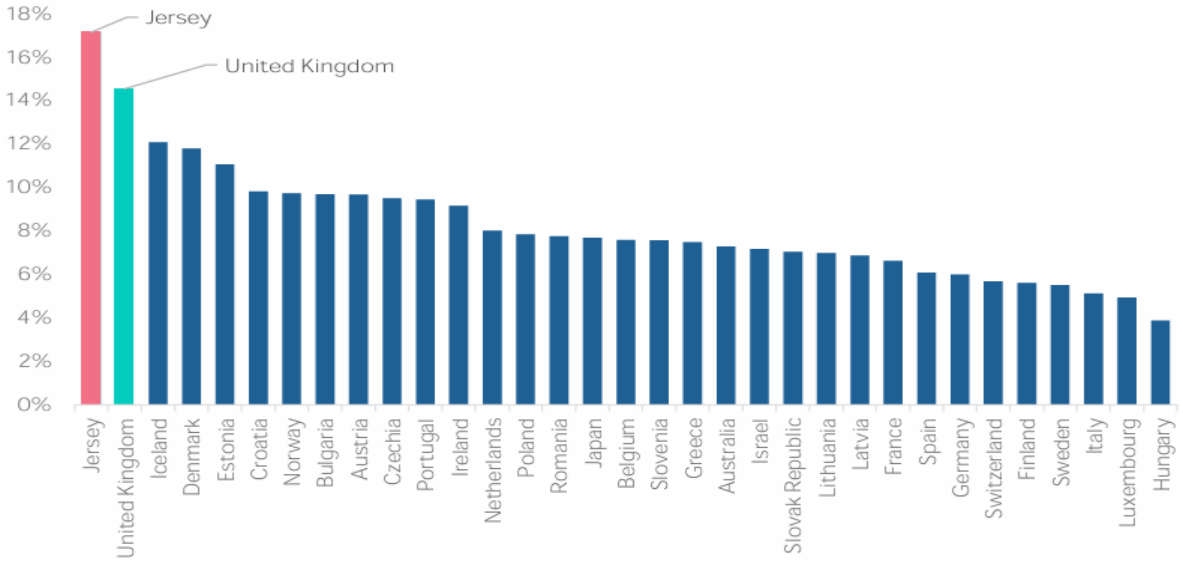


Source: Statistics Jersey Public Sector Spending Statistics 2024

3. The high level of expenditure in Jersey is driven primarily by the percentage of Government expenditure on hospital services being above all OECD nations (Exhibit 2).

Exhibit 2: Expenditure on hospital services as a percentage of total general government expenditure 2023

Source: Statistics Jersey Public Sector Spending Statistics 2024



4. The need to develop a long-term sustainable healthcare funding model, to support wider changes in the healthcare system, has long been recognised. Since 2022 the work that has been undertaken includes the development of a model to underpin future projections in healthcare expenditure.

5. The Budget 2026-2029 includes two new fees planned to be introduced in 2026 (use of the Emergency Department and Did Not Attend Fees) as well as investment in prevention measures and the digital health strategy. A period of public communications is required prior to the introduction of the Did Not Attend Fees and the Emergency Department Fees require further approval by the States Assembly prior to introduction.

6. My audit has assessed the:

   - assumptions underpinning the model being developed and the extent to which the model and supporting assumptions will enable effective options appraisal and decision making

   - design of the controls supporting the implementation of new fees; and

- extent of progress being made in the development of sustainable healthcare funding in Jersey including by taking learning from previous initiatives.

Key findings

7. In 2022, the Health Economics Unit (NHS Midlands and Lancashire Commissioning Support Unit) was commissioned to forecast future expenditure and revenue for healthcare provision, assess the drivers of the gap between the two and make recommendations on the way forward. The report produced in September 2023 concluded that by 2043 total healthcare expenditure (including public and private expenditure) was forecast to reach £1,296 million and to be 39.35% greater than the total healthcare revenue. The public financing gap was forecast to be £298 million by 2043.

8. During 2025 and 2026, Government officers have undertaken work to develop and update the 2023 model. This new model updates the starting expenditure baseline to 2026 and is intended to answer the question *'If nothing changes in how Jersey provides or funds healthcare, what will the future cost trajectory be?'*.

9. The approach taken to develop the model is sufficiently robust to provide a view of the underlying future cost trajectory, while accepting that it has some limitations and no long-term forecast can be exact, due to the evolving nature of demographics and healthcare delivery. At the time of my fieldwork, the model was due to be subject to external quality assurance and peer review processes which are now ongoing. The model provides a useful starting point for the consideration of future policy options that seek to put in place a sustainable healthcare funding solution.

10. Without consideration of future policy interventions and without consideration of any changes in cost profiles resulting from the operation of new healthcare facilities, the updated model reviewed as part of my audit showed a compound average growth rate in total healthcare expenditure of 2.97%. This percentage may change following the further external quality assurance and peer review processes that are ongoing.

11. It is clear from the output of the model that a range of policies and actions will need to be put in place beyond the Health and Care Jersey (HCJ) Financial Recovery Programme in order to fund public healthcare expenditure in a sustainable way.

12. The Government is developing a suite of 'charging' policies designed to change behaviour, target services in the right direction and reduce costs. These policies are intended to influence the choices that patients and carers make when accessing healthcare provision. They are aimed at encouraging the overall better use of healthcare resources and are not intended to generate significant funding.

13. Without firstly publicly explaining the wider strategic challenges facing the Jersey healthcare system over the next 20 years, this suite of operational policies risks being seen as a series of piecemeal initiatives, rather than part of a wider solution. This creates a risk that Islanders do not understand the importance of the suite of policies in contributing to financial, behavioural and cultural change.

14. Enforcement of the policies is planned to be relatively 'light touch' and there is a risk that implementation of the policies will not have the desired impact either financially or culturally.

15. In order to obtain the full benefits, future long-term funding (including possible reform) should go hand in hand with wider healthcare and social care reform, to ensure that the future monies spent deliver the best possible value for money. My audit has identified six key areas that need to be considered and addressed in conjunction with one another:

    - healthcare system constraints
    - social care system constraints
    - New Healthcare Facilities Programme
    - fragmented health and social care accountability
    - how change works in practice; and
    - capability and continuity of leadership.

Conclusion

16. The risk of ever rising publicly funded expenditure on healthcare has been known for a long time. It is not an issue that can be resolved by HCJ or the Government in isolation. The solutions that will be required will need a wider public consensus.

17. Prioritised action is now required in order to bring forward a range of options for future long-term funding hand in hand with wider healthcare and social care reform.

Objectives and scope of the audit

18. The audit has assessed the:

- assumptions underpinning the model being developed and the extent to which the model and supporting assumptions will enable effective options appraisal and decision making
- design of the controls supporting the implementation of new fees; and
- extent of progress being made in the development of sustainable healthcare funding in Jersey including by taking learning from previous initiatives.

19. The audit included consideration of the arrangements and strategies within and available to Health and Care Jersey (HCJ) and across the States of Jersey, including those which relate to current and future assumptions and modelling options.

20. The audit has not included an assessment of the New Healthcare Facilities Programme. I am undertaking a separate audit of the New Healthcare Facilities Programme in 2026.

21. The work undertaken has not included an audit of the Health Insurance Fund or the Long-Term Care Fund. I published a report on the Health Insurance Fund in February 2026. I published a report on the Long-Term Care Fund in February 2022.

22. Further information on the audit approach can be found in Appendix One.

Detailed findings

Developing a model to underpin future healthcare expenditure predictions

History of model development

23. The need to develop a long-term sustainable healthcare funding model has long been recognised. A proposition to the States Assembly in 2012 (P.82/2012) indicated that work would be undertaken to develop a long-term sustainable funding mechanism for Health and Social Services by 2014.

24. Additional funding was provided to the then Health and Social Services Department in both the Medium-Term Financial Plan for 2013-2015 and the Medium-Term Financial Plan for 2016-2019. This included a 2% investment in service standards and healthcare inflation.

25. The Jersey Care Model was launched in 2019 and, as part of this, the then Health and Community Services Department planned to continue to transform and modernise and to ensure that existing services were funded sustainably. The plan assumed the continuation of 2% annual growth funding.

26. The Government Plan for 2021-2024 included an investment of £28.1 million in the Jersey Care Model. This investment was expected to deliver a net financial benefit from 2025 and was forecast at the time to avoid £23 million of the expected expenditure growth in Jersey's health and care system each year by 2036. Additional investment was approved in the Government Plan for 2022-2025 and a wider review of sustainable healthcare funding was planned to be undertaken during 2022.

27. Following the election in 2022, work on the Jersey Care Model was paused although some further work was continued in respect of the sustainable healthcare funding workstream.

28. Since 2022 the work that has been undertaken includes the development of a model to underpin future projections in healthcare expenditure. This

'Healthcare Forecasting Model' (the model) is intended to provide an estimate of Jersey's future healthcare expenditure over a 20 year horizon.

29. In 2022, a project commenced which focussed on reviewing healthcare expenditure to compile the Jersey Health Accounts based on internationally recognised definitions of the Organisation for Economic Co-operation and Development (OECD), the World Health Organisation (WHO) and Eurostat guidelines 'A System of Health Accounts 2011'. The Jersey Health Accounts provided a framework for analysing healthcare spending in Jersey and enabled comparisons with countries across the OECD, covering both public and private expenditure on health and long-term care. The Jersey Health Accounts were produced by the Health Economics Unit (NHS Midlands and Lancashire Commissioning Support Unit) using data from 2019 in order to avoid the distorting effects of the COVID-19 pandemic on international comparisons.

30. As well as producing the Jersey Health Accounts, the Health Economics Unit was commissioned to forecast future expenditure and revenue for healthcare provision and assess the drivers of the gap between the two and make recommendations on the way forward. The report produced in September 2023 concluded that:

'healthcare expenditure is expected to increase at a significant rate due to the elevated activity and price pressures currently observed in the healthcare sector and the anticipated shift in the size and structure of the ageing population of Jersey. By 2043, the total healthcare expenditure is forecasted to reach £1,296 million and to be 39.35% greater than the total healthcare revenue, resulting in a total financing gap of £366 million. This reflects financing gaps in both public and private funding schemes. Yet, the public financing gap increases faster and, by 2043, it comprises the largest part of the total gap at £298 million.'

Status of the model in 2026

31. During 2025 and 2026, Government officers have undertaken work to develop and update the 2023 model. This new model updates the starting expenditure baseline to 2026 and is intended to answer the question *'If*

nothing changes in how Jersey provides or funds healthcare, what will the future cost trajectory be?'.

32. The development of the 2026 model is being overseen by the Health Funding Reform Project Board. This has ensured that a degree of review and challenge has been built into the development process. Membership of the Board includes officers from HCJ, the Economy Department, the Cabinet Office, Revenue Jersey and the Treasury and Exchequer Department. In addition, review and challenge is being provided to the model by the quality assurance and the peer review processes that were ongoing at the time of my fieldwork.

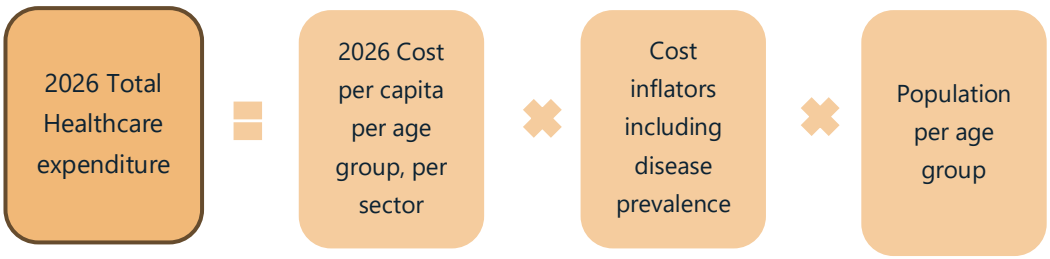
33. The updated model forecasts expenditure out to 2045 and reflects total spend on healthcare across the Island (including public and private expenditure). It shows expenditure by age group using the cost per capita (total expenditure of a specific age group divided by the number of people in the population of that age, in other words, the average cost for each year, for each person, in that age group) derived from the 2019 Jersey Health Accounts.

34. The 2026 cost per capita baseline is estimated by growing the 2019 cost per capita from the Jersey Health Accounts by three influencing factors between 2019-2026:

- population ageing and growth (Statistics Jersey published population projections)
- disease prevalence growth (estimated by Public Health, cost impact estimated variable); and
- net of underlying cost inflation, less cost efficiencies, as a combined balancing figure.

35. The 2026 cost per capita figure for each healthcare sector is then multiplied by each of the model's cost drivers and cost reducers, to give an inflated cost per capita for each of the forecast years. This is then multiplied by the age group population for each year for each healthcare sector, as shown in Exhibit 3.

Exhibit 3: Model calculation of total healthcare expenditure



Source: Government of Jersey

36. The result ensures that changes in each age group in population or disease prevalence is maintained, as they do not all grow in the same proportions. As the younger, less expensive population declines and the older population who use more healthcare grows, the model reflects this rather than using crude averages which can mask and understate the impact of change in population composition. The population is grouped into five broad age bands (Exhibit 4).

Exhibit 4: Average cost by age shown in the model

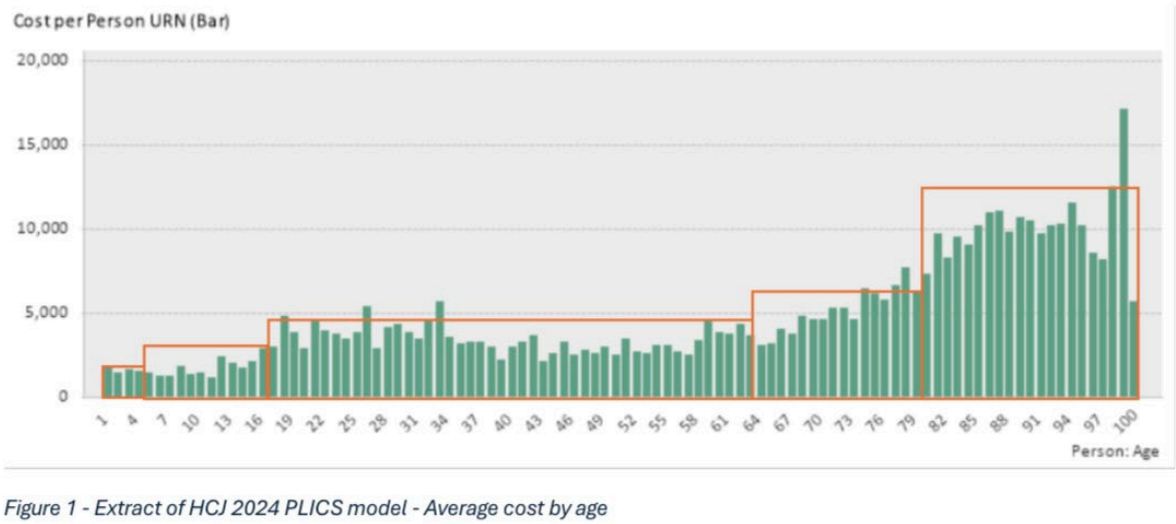


Figure 1 - Extract of HCJ 2024 PLICS model - Average cost by age

Source: Government of Jersey

37. The Government has identified a number of limitations in the updated model. These include:

- the approach adopted assumes that the cost per capita within each age bracket from 2019 to 2026 has not changed. However the COVID-19 pandemic occurred during this period and both temporarily and

permanently shifted certain trends due to the disruption in things like screening programmes, waiting lists and treatment times

- where the 2026 expenditure for healthcare sectors outside of Government control is not known, the 2019 expenditure has been grown in the same proportion as Government healthcare spend. This approach infers that all healthcare sectors have experienced the same cost growth as the Government. No data is held to confirm or adjust this theory

- some sectors of healthcare resources have been considered out of scope for the model, though acknowledged as important aspects of the wider Island economy and serving healthcare needs. These include:

    - long-term care – 'social only' element of care costs; and

    - non-cash/unpaid carers; and

- the use of broad age bands (0-4, 5-16,17-64, 65-79 and 80+) limits the model's ability to forecast costs for more granular changes in the population size and structure. In addition, costs driven by projected gender-specific demographic changes have not been included in the model as gender-specific data does not exist in the Jersey Health Accounts.

38. In addition to the identified limitations, the updated model makes certain key assumptions including:

- the model does not attempt to model transformational policy options, including the costs of the New Healthcare Facilities Programme and split site working for the new facilities. It maintains the existing position and does not consider potential changes such as major healthcare service redesigns, innovation and new treatments including new drug technologies and genetics, public health prevention initiatives, and digital transformation; and

- while the model assumes that the Jersey healthcare system will be 0.65% more productive each year, it does not make any assumptions on future efficiency savings, including cash releasing savings.

39. Only a full repeat of the Jersey Health Accounts modelling would provide evidence to support the following assumptions that have been adopted in the model:

- the cost per capita within each age bracket has not changed since 2019; and
- where the 2026 expenditure for healthcare sectors outside of Government control is not known, the 2019 expenditure has grown in the same proportion as Government.

40. The scope of the current modelling project has not included a full repeat of the Jersey Health Accounts modelling due to the significant capacity and timeframes required to complete such an exercised. I have been informed that HCJ's long term financial analytics strategy includes aspirations to develop systems that produce this information in routine and regular production subject to resource availability.

41. Long-term care 'social only' care costs are excluded from the model (as the model only includes healthcare costs). While this assumption is reasonable, healthcare and social care costs are inextricably linked. An independent actuarial review of the Long-Term Care Fund is expected to be published during 2026.

42. At the time of my fieldwork, the model was due to be subject to external quality assurance and peer review processes which are now ongoing.

Output from the model at the time of my audit

43. Despite the acknowledged limitations noted earlier, the model provides a useful starting point for the consideration of future policy options that seek to put in place a sustainable healthcare funding solution.

44. Without consideration of future policy interventions and without consideration of any changes in cost profiles resulting from the operation of new healthcare facilities, the updated model shows a compound average growth rate in total healthcare expenditure of 2.97%. This percentage may change following the further external quality assurance and peer review

processes that are ongoing. Exhibit 5 summarises the output from the updated model.

Exhibit 5: Updated model healthcare expenditure projections

Sector	2026 £m	2030 £m	2035 £m	2040 £m	2045 £m
Government healthcare services	402	449	509	572	642
Health Insurance Fund	66	73	81	90	100
Long-Term Care Fund	99	117	137	161	192
Social Security Fund	3	4	4	5	6
Payments from private health insurers	51	57	64	71	79
Services provided by charities	17	18	20	21	23
Employers occupational health schemes	1	1	2	2	2
Public out of pocket	148	169	192	221	251
Total healthcare expenditure	**787**	**888**	**1,009**	**1,143**	**1,295**

Source: Government of Jersey

45. It is clear from the output of the model that a range of policies and actions will need to be put in place beyond the HCJ Financial Recovery Programme in order to fund public healthcare expenditure in a sustainable way.

Recommendations

R1 Update the Jersey Health Accounts on a periodic basis such as every four years to improve strategic and operational healthcare decision making.

R2 Publish the results of the actuarial review of the Long-Term Care Fund and ensure that the results and impact of the review are considered as part of the wider healthcare funding options.

R3 Undertake an exercise to model social care costs (including the impact on the Long-Term Care Fund) to ensure the full estimation of health and care costs is available for future policy decisions.

Implementing new policies, fees and charges

46. During 2017 and 2018 two reviews were commissioned of user charges and the primary care payment model. The review of user charges identified that charges could help shape behaviour and improve use of resources by discouraging unnecessary demand, encouraging use of the most appropriate care setting, and addressing perverse incentives in the system. The primary care payment model review found that different payment models for primary care would drive better value and patient outcomes.

47. The Government is currently developing a suite of policies designed to change behaviour, target services in the right direction and reduce costs. The policies that are being developed and/or implemented include:

- Emergency department fees
- Treatment and interventions priority policy (implemented)
- Off Island travel and accommodation policy
- Publicly funded healthcare eligibility policy (implemented)
- Patient Choice policy (implemented); and
- Did Not Attend charges.

48. These policies are intended to influence the choices that patients and carers make when accessing healthcare provision. They are aimed at encouraging the overall better use of healthcare resources and are not intended to generate significant funding.

49. Without firstly publicly explaining the wider strategic challenges facing the Jersey healthcare system over the next 20 years, this suite of operational policies risks being seen as a series of piecemeal initiatives, rather than part of a wider solution. This creates a risk that Islanders do not understand the importance of the suite of policies in contributing to financial, behavioural and cultural change.

50. Enforcement of the policies is planned to be relatively 'light touch'. The policies are planned to be enforced with supporting appeals processes, and

exemptions to criteria, that allow for HCJ to take account of individual's personal and clinical circumstances. There is a risk however that implementation of the policies will not have the desired impact either financially or culturally.

Emergency department fees

51. Officers estimate that around 30% of emergency department attendances are low acuity and potentially inappropriate. Freeing time within emergency department would enable it to concentrate on the more complex cases better suited to its services.

52. An option that remains under consideration is the introduction of a charge for people who attend the emergency department who are triaged as being 'primary care appropriate' but who refuse to access appropriate primary care services (such as general practitioners or dentists). The policy may include differential charges between residents and non-residents with payment requested by card in the emergency department.

53. The States Assembly require detailed, evidence-based proposals (including but not limited to ensuring that free access for genuine emergencies is not compromised and the safety and wellbeing of health care staff is maintained) to be presented and approved prior to the introduction of the charges. Officers intend to develop a full proposal for the introduction of this charge for consideration by incoming Ministers and, if approved by Ministers, consideration by the States Assembly.

54. The planned enforcement procedures for the policy reviewed as part of my audit appear weak. As a consequence, there are risks that the implementation of a charging policy:

- would not result in the desired behavioural change from patients
- may not result in emergency department resources being available for people with genuine emergencies and not conditions that could be treated in primary care; and
- could cost more to implement than the fees generate.

Treatments and interventions prioritisation policy (TIPP)

55. TIPP aims to create a decision-making framework for treatments, drugs and technologies to deliver consistent outcomes that are evidence based and will contribute to better resource management. Having been presented to the HCJ Advisory Board a number of times during 2025 TIPP has its support.

56. TIPP is a new policy providing a process for modernising treatment, balancing health outcomes, cost control and innovation in a disciplined and evidenced way – this has not been in place before. The approvals and discussion structures are designed to be evidence driven so decisions can be evidence based and the reasons clear to all parties. A decision-making framework is now available and should be an effective contribution to good use of resources.

57. However, despite some data being available, a lack of good quality data across the full scope of the policy may prevent rigorous application of the policy in practice.

58. In order to implement the policy in a robust way there is a need for accurately coded clinical data. In common with other jurisdictions, there is a shortage of clinical coders in Jersey which has resulted in a two year coding backlog that is estimated to require 9-12 months to resolve.

59. Other issues that will need to be addressed in order for the policy implementation to be effective include:

- clinician accountability – mechanisms need to be in place to dissuade clinicians from ignoring the policy processes, especially in situations where clinicians may not be basing decisions on a firm evidence base

- developing and implementing a consistent methodology for considering policy exceptions particularly if no central fund is planned for new and novel therapies (although such a fund is under consideration). While the board and committee structure put in place to oversee the TIPP is relatively new and looks appropriate I note that it has approved all the submissions put to it as exceptions so far. While this reflects the limited

range of areas TIPP has been assigned to, wider deployments will call for nuanced and evidence based decisions to be taken

- public perception in an environment where some treatments may be heavily promoted by third parties but may not deliver what the public expects; and
- the need for a published overarching strategy for healthcare unpinned by other related strategies.

Off island travel and accommodation policy

60. This policy could re-introduce a means tested system to determine eligibility for travel costs and out of hospital funding. The aim of the policy would be to target funding where need for support is the greatest. The policy is estimated to have the potential to yield around £260,000 each year. The plan would be to use existing declarations to Revenue Jersey and some self-assessment to test means and determine funding eligibility.

61. The policy was presented to the HCJ Advisory Board in February 2026. It is planned to be considered further by the Minister for Health and Social Services now that the election period has concluded.

Publicly funded healthcare eligibility policy

62. This policy is aimed mainly at tourists with the expectation that their costs are covered either by reciprocal agreements or insurance.

63. Identifying those liable for charges is not expected to be challenging. All patients requiring emergency treatment will be automatically treated. Eligibility for charging will then be assessed. Those not from countries with reciprocal agreements will be expected to have insurance in place so they will either pay and reclaim or arrange for the insurer to pay direct.

64. As there is no intention of withholding emergency care there is a risk that people will refuse to pay after their treatment especially if they have no travel insurance or other suitable insurance in place.

65. For those with travel insurance the policy seeks to reduce the risk of insurers refusing to pay for the emergency element of wider private insurance packages on the basis that Government published policy is that emergency care is free.

66. Limited consideration has been given as to potential longer term sanctions for individuals refusing to pay.

Patient Choice policy

67. The Patient Choice policy seeks to address the issue of delayed transfers of care caused where an adult patient is medically fit for discharge but they (or their carer) refuse the proposed onward transfer options. 'Bed blocking' is a serious issue and by effectively charging people for remaining in hospital when fit to be discharged the aim is to change behaviour. The policy has been introduced by a Ministerial Order approved in March 2026.

68. The charging mechanism is underpinned by a new, detailed policy which includes multiple points of flexibility. Examples include through exceptions to the 5-day rule, multi-disciplinary team judgement, best-interest decision making and escalation routes. As the policy is implemented it will be important to be clear where the flexibilities in the policy do and should exist. Without this clarity there is a risk of complaints of prejudice and unfairness.

69. While legal powers are in place to enforce the charges proposed there are no legal power to evict people from hospital. There is also a risk that charging people for hospital accommodation will not encourage them to move on but will instead encourage self-funders to stay on the basis they are paying for and receiving a service.

70. It will therefore be important to ensure that discharge planning procedures are enhanced from the point of admission, particularly in terms of anticipating the difficulties of patients who have dementia, including alongside a condition which has required acute healthcare. Without effective procedures in place there is a risk that both current and planned inpatient facilities will continue to experience additional pressures of acting in effect as care homes as well as providing acute and community services.

71. Demographic changes and a predicted increase in the prevalence of dementia both globally and on the Island suggest that there is a growing risk that there is not adequate provision for safe transfer of care, regardless of how patients or their carers behave. There needs to be a broader approach to solving this problem, looking particularly towards the community to solve some of the issues. Dementia cases are expected to increase significantly over the next 12 years globally and the provision for such cases on Island is already inadequate.

Did Not Attend charge

72. The Did Not Attend charge is the proposed introduction of a charge if a patient fails to attend one hospital appointment - without notifying the hospital of their non-attendance – to be levied on arrival to the second appointment. The introduction of the digital Patient Knows Best app is planned to support this policy as the patient will have been more closely involved in setting the date of the appointment. The charge will not be introduced until the app is fully available. At the time of my fieldwork the app was estimated as having a go-live date in the first quarter of 2027.

73. There are a number of risks to the successful implementation of this policy including promoting and ensuring widespread use of the Patient Knows Best app. A reliable alternative will need to be in place for people who for any reason do not use the app. As a comparison only 85% of the English adult population use the NHS app. Without a reliable alternative there is a risk of inequality of access for certain groups.

74. As part of the policy implementation some safeguards are planned for important treatments. At the time of my fieldwork however there were limited enforcement procedures planned for patients who do not pay the charge and there was a limited focus at that time on the likely financial benefits of introducing the policy. Both of these matters should be considered as the policy is developed.

75. Whether the policy will contribute to more efficient use of hospital appointments and less Did Not Attends will be partly dependent on how well the Patient Knows Best app is taken up after it is launched.

Recommendations

R4 Implement a formal communications campaign to explain the reasons for and support implementation of all fees and charges policies.

R5 Undertake a system-wide review of discharge planning policies and procedures to identify and implement systems improvements.

R6 Identify some high profile early adopters of the Patient Knows Best app to support a successful launch of the app, share experiences and encourage its widespread adoption.

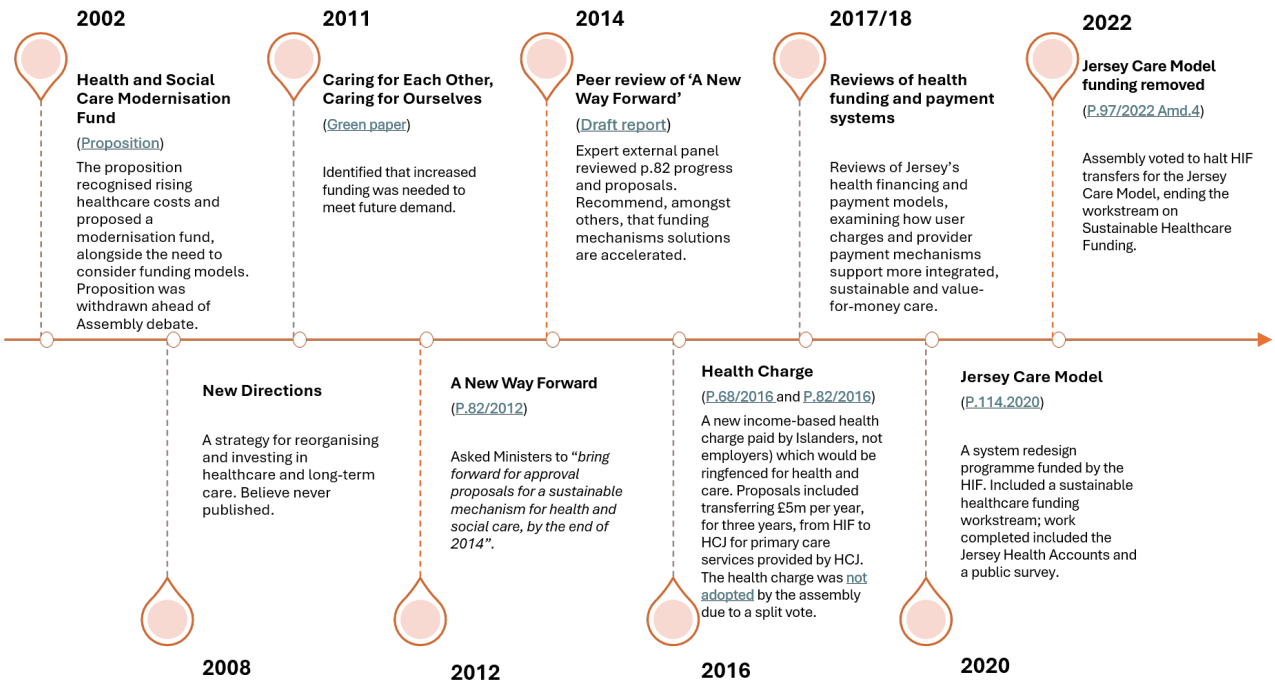
Area for consideration

A1 Consider whether legislation should be brought forward to facilitate the eviction of medically fit people, whose capacity to make decisions is safeguarded, from a hospital or community bed, where there is a refusal to transfer to a suitable facility.

Development of sustainable healthcare funding options

76. There is a long history of both published and not published policy papers that have considered future Jersey healthcare funding models (Exhibit 6).

Exhibit 6: History of sustainable healthcare funding policies



Source: Government of Jersey

77. It is clear therefore that the need to take action on the future funding of healthcare has been known for a considerable amount of time. There is not however a single document that pulls together all of the reflective learning of the projects since 2008 that have commenced and subsequently ceased or not fully delivered.

78. The updated model that is currently being finalised confirms that significant long-term increases are expected in total Jersey healthcare expenditure (Government and privately funded). These increases will need to be funded and the big challenge is how. Options that could be available to the States include:

- raising general taxes

- raising specific hypothecated taxes – for example a general healthcare fund like the Long-Term Care Fund or the Health Insurance Fund
- prioritising and potentially rationing the healthcare services that are publicly paid for; and
- the introduction of a form of compulsory health insurance scheme.

79. I have considered the progress being made in identifying and implementing options for sustainable healthcare funding, including by taking learning from previous initiatives.

80. In order to obtain the full benefits, future long-term funding (including possible reform) should go hand in hand with wider healthcare and social care reform. My audit has identified six key areas that need to be considered and addressed in conjunction with one another:

- healthcare system constraints
- social care system constraints
- New Healthcare Facilities Programme
- fragmented health and social care accountability
- how change works in practice; and
- capability and continuity of leadership.

Healthcare system constraints

81. Some of the current constraints in the healthcare system that need to be addressed are:

- commissioning practices - while HCJ does commission some services, it does this for money spent externally and it does not commission services against the large amount of money it spends internally. As a consequence, there is limited assurance that funds are allocated to the right services within HCJ, or that clinical pathways are the best they can be. I have identified some areas of improvement including the approval in 2026 of a Commissioning and Partnership model, a Palliative strategy, and a Mental

Health strategy. An overarching Clinical Strategy is in draft. Implementation of robust commissioning practices across the Health Insurance Fund and Long-Term Care Fund spending decisions would also support increased assurance that funds are allocated to the right services

- how to motivate and incentivise primary care – the draft Clinical Strategy refers to integrating care and developing services in the community (as did P.82/2012 and the Jersey Care Model). My report *Health Insurance Fund* (February 2026) recommended that the Government prepare a detailed plan to ensure the longer-term viability of primary care and pharmacy services which are currently funded by the Health Insurance Fund

- diagnostic capacity – there is evidence of long waits for, in particular, General Practitioner requested diagnostics (for example over six months for ultrasound). There is a risk that patients may access hospital care directly (through the Emergency Department) to obtain speedy results. This is one operational service issue example but is one that can impact on behaviours creating unintended consequences

- high levels of hospital bed occupancy and high levels of delayed transfers of care – there is a risk that current and future acute facilities will have reduced patient flow and will not operate efficiently if this is not addressed; and

- workforce engagement and motivation including the relationship between publicly and privately funded work.

Social care constraints

82. In order to address the ageing demographic and the expectation of a rise in people living with dementia there is a need to develop an overarching strategy for nursing and care home provision and, in doing so, ensure there is sufficient high acuity capacity available. My Report *Long-Term Care Fund* (February 2022) recommended that the Government '*prepare a detailed plan to implement a range of initiatives to reduce demand on the LTCF in the future. This plan [ ] should include shifting emphasis of care provision to prevention and domiciliary care*'.

83. The Government's audit recommendations tracker shows this recommendation as closed as the action was included in the work on the Jersey Care Model. However, when the work on the Jersey Care Model stopped the work to implement this recommendation was not completed.

New Healthcare Facilities Programme

84. The business case for the New Healthcare Facilities Programme makes a number of assumptions that have an impact on estimated costs of future healthcare provision. These include assumptions regarding the costs associated with operating from multiple sites as well as an assumption that additional capacity will lead to fewer Islanders being sent to the UK mainland for care leading to associated cost savings. However, based on experience from other organisations there is a risk that the new healthcare facilities will increase publicly funded on-Island healthcare costs, as patient demand can be stimulated by new healthcare infrastructure investments.

Fragmented health and social care accountability

85. The health and care system is split across three funds (consolidated fund, Long-Term Care Fund and Health Insurance Fund), two Ministers (the Minister for Health and Social Services and the Minister for Employment, Social Security and Housing) and three ownership models (private, State run and not-for-profit sector). This creates fragmented accountability and adds an additional complexity to implementing health and social care change on the Island.

86. The Health Partnership Board met informally for the first time in April 2026. This Board provides an opportunity to enhance the integration of services in the Island. However there is a need to manage conflicts of interest at the Board.

How change works in practice

87. Future change needs to learn the lessons of previous large scale change initiatives that have failed. Exhibit 6 provided an illustration of previous programmes that were commenced and then were subsequently ceased. Key lessons from such programmes going forward include:

- ensuring that stakeholders view the policy development as being led by and 'made in' Jersey
- setting out a clear strategic direction and then introducing policies individually (after consultation) that contribute in a coherent way to the overall strategic direction. This approach would enable areas of policy that have a consensus to be implemented more quickly
- engaging and consulting more formally with a broader range of stakeholders at all stages of development and implementation of policy changes; and
- ensuring that there are well developed action plans being implemented in areas of known potential challenge. A core example is ensuring that HCJ demonstrates effective financial management through successful implementation of the financial recovery plan.

Capability and continuity of leadership

88. Crucial factors in implementing change in a sustainable way include the capability and continuity of leadership. The Government has not seen continuity of leadership over recent years at corporate or HCJ departmental level (Exhibit 7). From 2017 there have been five Chief Executives in position and five leaders of HCJ. These changes have been accompanied by new Ministerial appointments in 2018, 2022 and 2024.

Exhibit 7: Changes in corporate and departmental leadership

Chief Executive position	HCJ leader
John Richardson to November 2017	Julie Garbutt to June 2018
Charlie Parker – November 2017 to February 2021	Interim – June 2018 to December 2018
Paul Martin (interim) – February 2021 to February 2022	Caroline Landon – early 2019 to March 2023
Suzanne Wylie – February 2022 to July 2023	Chris Bown (interim) – April 2023 to September 2024

Chief Executive position	HCJ leader
Andrew McLaughlin (interim then fixed term) – September 2023 to December 2026	Tom Walker (interim) – September 2024 to present time

Source: Jersey Audit Office analysis

Recommendations

R7 Consolidate all the learning from the various funding options papers (going back to 2008) into a concise view on healthcare funding options.

R8 Establish a Ministerial Health Funding Reform Group to ensure collective consideration of and accountability for policy reform proposals. Ensure this Group includes the Ministers for Health and Social Services, Employment, Social Security and Housing and Treasury and Resources.

R9 Review and enhance strategic and operational practices for managing difficult complex change programmes. The enhanced practices should include more formal structured engagement conversations with a broad range of stakeholders on key reform proposals.

R10 Ensure that robust programme management disciplines are in place to implement the Clinical Services Strategy when it is finalised.

R11 Alongside the Clinical Services Strategy, develop and implement an integrated health and social care strategy that provides a road map to the future of integrated care and prevention on the Island.

R12 Ensure robust succession planning is in place for known and expected changes in leadership.

Area for consideration

A2 Consider whether one Minister should be made accountable for Health and Care Jersey, the Health Insurance Fund and the Long-Term Care Fund.

Appendix One

Audit Approach

This audit used a combination of a result-oriented and system-oriented approach.

The following criteria were used to assess relative performance during the audit:

Model effectiveness:

- formula and logic correctness and consistency
- technical assumptions including data availability and the reasonableness of assumptions; and
- data quality and integrity

Implementation of new fees:

- effectiveness of the process being adopted for implementation; and
- effectiveness of proposed controls in respect of fee collection

Progress in development of sustainable healthcare funding:

- effectiveness of current and planned programme governance arrangements including linkages to overall health governance arrangements
- alignment of healthcare strategies including digital strategy, service strategies, commissioning strategy, financial recovery programme and workforce strategy
- robust financial forecasting and management arrangements
- activities adopting an appropriate balance across prevention and treatment, and optimising patient empowerment and stakeholder involvement; and
- collection and assessment of relevant data and evidence to support current and future decision-making.

The approach included the following key elements:

- Document request followed by review and analysis, and

- Interviews with key officers and contractors

The documents reviewed included:

- Jersey Health Accounts (Government of Jersey and Health Economics Unit, 2023)
- Sustainable Health Care Funding Model for Jersey: Forecasting of health care revenue and expenditure (Health Economics Unit and NHS Midlands and Lancashire Commissioning Support Unit, 2023)
- Sierra North Consulting outputs on future Jersey health funding options (2023)
- Updated Health Demand Model, version 1.4 (Government of Jersey, 2026)
- Notes to explain updated Health Demand Model, version 1.2 (Government of Jersey, 2026)
- A proposed new system for Health and Social Services (KPMG, 2011)
- Caring for each other, Caring for ourselves (Government of Jersey, White Paper, 2012)
- Health and Social Services: A New Way Forward (States of Jersey, P.82/2012)
- Jersey Care Model (States of Jersey, P.114/2020)
- Review of the Jersey Care Model: Minister for Health and Social Services (States of Jersey, R.166/2022)
- Affordable access to primary care scheme (States of Jersey, P.125/2019)
- Health and Community Services Financial Recovery Plan (Government of Jersey, September/October 2023)
- Future of Jersey 2017-2037 (Government of Jersey, 2017)
- Review of HCS Clinical Governance Arrangements within Secondary Care (Professor Hugo Macie-Taylor, 2022)

- Health and Care Jersey Advisory Board, various papers (Government of Jersey website, Advisory Board created 2023)
- Health and Care Jersey Advisory Board and Partnership Board (States of Jersey, P.52/2025)

The following people contributed information through interviews or by correspondence:

- Director of Strategic Planning and Projects, HCJ
- Director of Improvement and Innovation, HCJ
- Associate Director of Improvement and Innovation, HCJ
- Chief Officer, HCJ
- Strategic Director of Finance and Commercial, HCJ
- Lead Finance Analyst, HCJ
- Deputy Head of Finance Business Partnering, HCJ
- Head of Public Health Analytics, HCJ
- Public Health Analyst, HCJ
- Medical Director, HCJ
- Medical Officer for Health, HCJ
- Director of Mental Health, Adult Social Care and Community Care, HCJ
- Chief Operating Officer for Acute Services, HCJ
- Chief Officer, Treasury and Exchequer

- Chief Economic Advisor, Economy Department
- Assistant Director of Public Policy, Cabinet Office
- New Healthcare Facilities Programme Business Lead, HCJ
- Director of Digital Health and Informatics
- Group Director of Strategic Finance, Treasury and Exchequer
- Director of Strategic Health Policy, HCJ
- Chair of Primary Care Body and retired GP

The fieldwork was carried out by affiliates working for the Comptroller and Auditor General, between December 2025 and May 2026.

Appendix Two

Summary of Recommendations and Areas for consideration

Recommendations

R1 Update the Jersey Health Accounts on a periodic basis such as every four years to improve strategic and operational healthcare decision making.

R2 Publish the results of the actuarial review of the Long-Term Care Fund and ensure that the results and impact of the review are considered as part of the wider healthcare funding options.

R3 Undertake an exercise to model social care costs (including the impact on the Long-Term Care Fund) to ensure the full estimation of health and care costs is available for future policy decisions.

R4 Implement a formal communications campaign to explain the reasons for and support implementation of all fees and charges policies.

R5 Undertake a system-wide review of discharge planning policies and procedures to identify and implement systems improvements.

R6 Identify some high profile early adopters of the Patient Knows Best app to support a successful launch of the app, share experiences and encourage its widespread adoption.

R7 Consolidate all the learning from the various funding options papers (going back to 2008) into a concise view on healthcare funding options.

R8 Establish a Ministerial Health Funding Reform Group to ensure collective consideration of and accountability for policy reform proposals. Ensure this Group includes the Ministers for Health and Social Services, Employment, Social Security and Housing and Treasury and Resources.

R9 Review and enhance strategic and operational practices for managing difficult complex change programmes. The enhanced practices should include more

formal structured engagement conversations with a broad range of stakeholders on key reform proposals.

R10 Ensure that robust programme management disciplines are in place to implement the Clinical Services Strategy when it is finalised.

R11 Alongside the Clinical Services Strategy, develop and implement an integrated health and social care strategy that provides a road map to the future of integrated care and prevention on the Island.

R12 Ensure robust succession planning is in place for known and expected changes in leadership.

Areas for consideration

A1 Consider whether legislation should be brought forward to facilitate the eviction of medically fit people, whose capacity to make decisions is safeguarded, from a hospital or community bed, where there is a refusal to transfer to a suitable facility.

A2 Consider whether one Minister should be made accountable for Health and Care Jersey, the Health Insurance Fund and the Long-Term Care Fund.

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