Primary Care Board – Response to the Health and Social Security Scrutiny Panel

Proposed Budget 2027–2030 [P.73/2026]

To: Deputy Beatriz Porée, Chair, Health and Social Security Scrutiny Panel

From: Primary Care Board

Date: November 2026 (deadline Tuesday 10 November 2026)

Dear Deputy Porée,

Thank you for your letter of 27 October 2026. The Primary Care Board welcomes the Panel's review. We have kept our response short so that our overarching message is clear.

General practice has significantly more patient contacts a year than the hospital (more than twice as many in England, according to the King's Fund), with between 75 and 85% of the population accessing primary care at some point during that time period. The care delivered is also significantly discounted when compared with hospital delivery of the same services.

In the widely recognised context of an aging population, suffering a greater burden of disease per head with increasingly complex treatments and rightfully rising expectations our principal points are:

1. **The money is running out.** The Health Insurance Fund (HIF) is forecast to fall from £98.2m at the start of 2027 to £52.1m by the end of 2030, which is "well under one year's worth of expenditure". Benefit payments grow faster than contributions every year (Budget, pp. 85–86).
2. **Primary care wants to work collaboratively.** GPs, pharmacists, nurses and other primary care colleagues want to help keep Islanders well and out of hospital and we are engaging with the Government's funding reform work.
3. **No more shared care until the HIF is topped up.** More and more work is moving from the hospital to general practice without the funding moving with it, including shared-care prescribing and monitoring (ADHD among them), post-discharge care and long-term condition follow-up. The Board cannot agree to take on any further shared care until the HIF is topped up and the transferred work is funded.
4. **What we ask the Panel to support.** We would like States Members to vote to top up the HIF so that it is sustainable for the Budget period and support a clear ring-fence around the HIF or any future successors. The detail of longer-term reform can then be worked through with Government officers and primary care is ready to play its full part.

(a) Adequacy of funding allocations for current and projected demand

- **Current services:** current HIF benefits are maintained, including the GP consultation subsidy, free prescriptions, free consultations for children and students, and the Health Access Scheme (Budget, p. 86). That is enough to stand still in 2027 but does not account for medical inflation which outstrips RPI.
- **Projected demand:** the funding is not adequate. HIF benefit payments rise from £66.1m to £74.3m between 2027 and 2030, while contributions rise only from £57m to £64m. The Fund therefore runs a structural deficit of about £10m a year (Budget, p. 86).

(b) Workforce recruitment, retention and succession

General practice is made up of independent businesses. Its recruitment problems are those of the wider Island, especially housing costs and the pay differential with the UK. Succession is a real risk for small practices. The UK is experiencing increasing problems with recruitment (across the full range of healthcare professionals, including nurses, allied health professionals and practice administrative staff) and there is a 'brain drain' to other westernised jurisdictions such as Australia. The Board would welcome:

- key worker housing that covers primary care as well as Health and Care Jersey staff, where needed
- a "grow our own" pipeline for primary care, including hub and spoke training links with the UK.
- pay and terms that recognise Jersey competes internationally for clinicians, including hospital specialists – neurology is a current example.

(c) Sustainability of existing funding and pressures over the Budget period

Under the present model, patients pay fees at the point of use. Practices set their own fees, and the HIF subsidises them (gov.je). This model rewards increasingly hard work but not necessarily outcomes. The Fund has also been drawn on in the past for non-primary-care purposes, including about £7.4m in 2022 (Jersey Audit Office).

Pressures over the Budget period include:

- rising prescribing costs, with the HIF drugs budget at about £20.5m in 2025;
- vaccine programmes;
- more people with long-term conditions;
- work moving out of the hospital, such as monitoring, shared care and post-discharge care, without the funding moving with it.
- patient expectations.

(d) Healthcare funding reform and long-term HIF sustainability

The Budget says the HIF will be exhausted in the early 2030s without action. It also says reform "may include" moving the Fund to the Health Minister (Budget, pp. 86, 94). The Board supports appropriate reform and wants to help shape it.

- **Top up the HIF now:** a top-up for the Budget period would keep the Fund sustainable while reform options are properly worked up. The Comptroller and Auditor General found that the Government's model so far projects costs but does not yet test the options for raising money (Jersey Audit Office). Topping up the Fund avoids decisions being made in a crisis.
- **Keep primary care funding protected:** the Budget suggests that ring-fencing "can create barriers". The Board does not agree. Removing the ring-fence without a statutory replacement would expose primary care and prevention to hospital pressures, as happened when the Jersey Care Model was introduced unilaterally by HCS.
- **Open modelling:** the Government's model is a forward forecast from a snapshot of current spending. It relies on proxies for GP use and out-of-pocket spending and it does not yet include future pressures such as new high-cost drugs. The Board asks for the ability to examine the model, including its confidence intervals and the effect of different tax, Social Security and HIF contribution options, alongside concrete policy proposals.
- **Safeguards for any insurance-based option:** if private medical insurance plays a part, protection is needed for people who cannot afford cover, for retirees and older people facing rising premiums, and for small employers, including GP practices. Private insurance costs considerably more to administer than social schemes, and Jersey, like the UK, previously removed tax relief on private health insurance, so any long-term unintended consequences of concrete proposals should be weighed alongside current budget pressures. An expansion of the established ESSH Social Insurance model underpinned by an Estonian X-Road like data exchange layer across government departments could prove more efficient and cheaper in the long run.
- **Stewardship:** the Health and Care Partnership Board is a welcome step, but it is non-statutory and has limited resources. It needs enhanced resourcing and a more defined relationship with Health and Care Jersey so that there is a true whole system approach.
- **Public engagement:** Islanders need clear, evidence-based information on the pressures, the trade-offs and what an island of around 100,000 people can afford to provide. Any workshops should be well facilitated and focused on concrete options.

(e) Demographics, population growth, complexity and chronic illness

The population aged 65 and over will be about 28,000 or more by 2040, up 36% from 20,600 at the end of 2024, whatever the level of migration (Statistics Jersey). Older people with several conditions

consult more often and take more medicines. Most of the extra demand will therefore land in general practice and community pharmacy first.

Funding choices also raise questions of fairness between generations: a growing share of resources for older Islanders falls on younger working people, whom the Island needs to retain.

(f) Balance of investment between primary, community and secondary care

The balance is still tilted towards the hospital. The Health and Care Jersey revenue budget is about £406m in 2027 (Budget, p. 46), compared with HIF benefits of about £66m. The extra Health and Care Jersey funding (about £10m in 2027) goes to the hospital-led system (Budget, p. 49). Where work moves out of the hospital, the funding needs to move with it.

To make that happen, the Board would support a time-limited Transformation Fund, to pay for running old and new services side by side while work moves, and pooled budgets for specific pathways, such as frailty, diabetes and COPD, with each party's share agreed in advance. This fits the Government's emerging funding reform framework, which proposes enabling funding to flow across the system.

(g) Preventative care and care closer to home

Public health was about 5.8% of government health spending in 2023, and the Budget includes no new prevention growth beyond existing commitments. The Board strongly supports prevention, modernised screening and care closer to home, supported by shared records and enhanced community diagnostics. Primary care cannot deliver more of this without the capacity and funding to do so.

(h) New Healthcare Facilities Programme and transformation

The programme has about £569m of capital in 2027–2030 (Budget, p. 58). The hospital's size assumes that demand will move to the community.

If primary care capacity is not funded alongside it, the assumption will not hold. The Board asks that the clinical model and estates plan state explicitly what activity primary care is expected to absorb, and how it will be paid for.

Increased resources being diverted to diagnostics are paramount. Current long waiting times are leading to late diagnoses with devastating effects on people's lives and increased care costs.

With a population of around 100,000, Jersey cannot provide every hospital service locally. Clear public messaging is needed about what is provided on-Island and what is provided through partnerships with UK centres.

(i) Women's health, mental health, prevention and other priorities

The Budget identifies no specific revenue growth for primary care, mental health, women's health or ADHD. Cervical screening continues to be funded through the HIF (Budget, pp. 86, 107) while mammography is hospital based.

- **Women's health:** the Board supports HPV self-sampling, menopause care in primary care, and access to contraception and long-acting reversible contraception (LARC) without cost barriers. It also endorses the recent changes to Termination of Pregnancy legislation.
- **Mental health:** the Board supports mental health practitioners, potentially working across practice clusters, and measures based on outcomes.
- **Shared care, including ADHD:** see point 3 of our main message. The Board would welcome the chance to set out a fair and funded basis for shared care at a later date.
- **Priorities:** priorities should be set on evidence and population impact, for example obesity, rather than on the most vocal demands.

(j) Risks, opportunities and emerging pressures

Risks:

- the HIF falling below one year's expenditure by 2030;
- the ring-fence being removed without a statutory replacement;

- workload moving to primary care without funding – UK experience;
- GP succession;
- patients facing higher costs if reform favours continued co-payments without concomitant health index-linked rises in rebate
- data-sharing and digital projects stalling where implementation runs ahead of the groundwork and public communication;

Opportunities:

- a properly funded partnership between primary care and the hospital;
- linked, whole-system clinical and financial data comparable to Estonia's X-Road, connecting outcomes with location and socioeconomic status so that decisions can be provider-neutral;
- a fair, funded basis for shared care.

Timely access, evidence and steps to sustainability

The Budget maintains access in 2027 but does not secure it to 2030. The Board recommends the following steps:

1. Vote to top up the HIF so that it is sustainable for the Budget period.
2. Keep primary care funding protected in law as part of any HIF reform.
3. Make sure funding moves with any work transferred from the hospital, including shared care, before the work moves.
4. Set up a time-limited Transformation Fund and pooled pathway budgets so that funding can follow the work.
5. Resource the Health and Care Partnership Board and clarify its relationship with Health and Care Jersey.
6. Implement workforce housing (where needed) and measures to sustain appropriate pay and conditions.
7. Publish primary care data, including demand, capacity, waits and outcomes, through shared records.
8. Give stakeholders access to the funding model, its uncertainty ranges and scenarios, alongside concrete policy options.
9. Work through the detail of longer-term reform with primary care, through the Government's funding reform work.

We would be happy to meet the Panel, or to present further detail, if that would help.

Yours sincerely

Doctors Besson, Klaber, Kumar-Beurg, Minihane, O'Tuathail, Perchard & Yamamoto

For and behalf of the Primary Care Board