JERSEY AUDIT OFFICE

Health Insurance Fund

18 February 2026

R.26/2026

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Report by the Comptroller and Auditor General: 18 February 2026

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

Contents

Summary

Introduction

1. The Health Insurance Fund (HIF) provides financial benefits for medical and pharmaceutical services supplied by approved health professionals to people insured under the Health Insurance (Jersey) Law 1967. The HIF receives allocations from Social Security Class 1 and Class 2 contributions, as specified under Article 30 of the Social Security (Jersey) Law 1974. The Minister for Social Security has responsibility for the control and management of the HIF.

2. The benefits provided by the HIF include:

   - subsidised General Practitioner (GP) consultations
   - a wide range of free prescriptions at community pharmacies
   - other supplies including flu vaccinations, diabetic supplies and wound dressings
   - additional support to low-income families and pensioners for low fixed fee General Practice services through the Health Access Scheme; and
   - free GP surgery visits for children and full time students.

3. The performance of the HIF and the balance of the fund at 31 December from 2020 to 2024 are shown in Exhibit 1.

Exhibit 1: Performance of the HIF

	2024 £000	2023 £000	2022 £000	2021 £000	2020 £000
Social Security contributions	50,754	51,595	41,111	35,686	34,527
Investment income	5,362	4,847	(3,178)	5,506	5,836
Social benefit payments	(52,434)	(45,046)	(34,615)	(37,473)	(30,429)
Other operating expenses	(4,779)	(4,351)	(4,116)	(3,368)	(4,122)

	2024 £000	2023 £000	2022 £000	2021 £000	2020 £000
Impairments	(132)	59	(41)	(55)	(249)
Net Revenue (Expenditure)/ Income	**(1,229)**	**7,104**	**(839)**	**296**	**(5,563)**
Fund balance at 31 December	*110,571*	*111,800*	*104,696*	*96,072*	*107,898*

Source: States of Jersey Group Accounts 2020 to 2024

4. In recent years there have been a number of changes to the medical benefits funded from the HIF. As a result of these changes and other pressures on the HIF related to the ageing demographic, the forecast in the Budget 2026 – 2029 is that the HIF will show a deficit for each year of the budget period. By the end of 2029, the balance in the HIF is anticipated to be £61 million which is less than one year's expenditure (Exhibit 2).

Exhibit 2: Forecast HIF Income and Expenditure 2026 - 2029

Income and Expenditure	2026 £000	2027 £000	2028 £000	2029 £000
Social Security contributions	54,000	56,000	58,000	60,000
Investment income	3,409	3,088	2,764	2,406
Social Benefit payments	(59,253)	(62,002)	(64,567)	(67,345)
Other expenses	(6,639)	(6,472)	(6,663)	(6,938)
Net Income/(Expenditure)	**(8,483)**	**(9,386)**	**(10,466)**	**(11,877)**
Closing Balance	**92,776**	**83,390**	**72,924**	**61,047**

Source: Proposed Budget 2026-2029

5. The Budget 2026 – 2029 states that 'Increased expenditure against the Health Insurance Fund means that the fund will be exhausted during the early 2030's unless action is taken soon'. This contrasts to the position reported in the Government Plan 2023 – 2027 which forecast a surplus for each year of the Plan and concluded that 'the fund remains in good health over the medium term'.

Key findings

6. Overall responsibility for the HIF lies with the Minister for Social Security. However, the Minister for Treasury and Resources and the Minister for Health and Social Services also play key roles.

7. Monitoring of the HIF performance and activity takes place at different levels. There are however no routine Key Performance Indicators (KPIs) provided to the Minister for Social Security regarding HIF performance. In addition, there are no KPIs for HIF funded services reported in the suite of Service Performance Measures for the Employment, Social Security and Housing (ESSH) Department or Health and Care Jersey (HCJ) monthly Quality and Performance reports.

8. The governance arrangements for the HIF involve a number of departments and include a range of strategic, operational and working groups as well as informal groups. The relationships and interdependencies between these groups are not formally documented.

9. No clear plan of action has been developed for the HIF since the 2021 actuarial review despite the clear indication from the actuary that the fund is not sustainable. Instead a number of additional benefits and contracts have been funded through the HIF since 2021 causing additional pressure on the sustainability of the HIF. The current funding and expenditure model for the HIF is not sustainable without intervention. There is commitment to an overall review of the healthcare delivery model including primary care which will include consideration of the HIF.

10. There has been a substantial increase in funding initiatives from the HIF to support improvements in GP practices and community pharmacies in the last few years. In the period from 2022 to 2026, the additional investment available in support for general practice is estimated at £12.3 million. From 2023 to 2026, the additional investment available for pharmacies is estimated at £12.4 million.

11. In the same period, significant additional funding has been provided from the HIF to improve access to general practice by increasing benefits and subsidies

available to all eligible patients. The annual cost of this is estimated at over £16 million.

12. Investment in new schemes and initiatives has resulted in ongoing improvements to the breadth of primary care services, as well as reducing the cost barrier to accessing primary care services.

13. I have considered the key changes made in HIF expenditure since 2023 and whether they have been supported by robust business cases. Some of these changes related to States Assembly decisions, including approved Government Plan amendments. I did not observe consistency in the rigour with which business cases have been documented and did not observe good practice being adopted in some business cases supporting decisions involving significant investment.

14. Overall, my analysis suggests that new initiatives have been introduced without a full and consistent assessment of the long-term impact on the HIF and with insufficient consideration of resource and system implications. In addition, some initiatives lack the metrics to enable assessment of value for money following implementation.

15. As part of the Ministerial Decision to introduce a new contracted medical benefit of £20 in 2023, the Government agreed with all practices that price transparency would be improved. The schedule of fees charged by individual practices is now published on the website to enable patient comparisons and choice.

16. However the fees published by each practice and summarised on the Government website show a number of inconsistencies related to the HIF benefit. In addition to these inconsistencies, there are also some inconsistencies in services offered which attract the HIF benefit.

17. While contributing a significant part of the price of routine GP appointments, the Government has no locus in influencing primary care fees. There is no control to prevent general practices from increasing fees to neutralise the impact of increased benefits approved by the Minister for Social Security. I have identified instances of fees being increased in excess of inflation in the period from February 2024 to July 2025.

18. Changes to the benefits paid from the HIF have added complexities to the supporting systems, which have limitations. There is an inherent risk of errors and irregularities for practices and the Government in the current systems and processes.

Conclusion

19. There have been significant changes to expenditure funded from the HIF in recent years. These changes have removed some cost barriers to accessing aspects of primary care and funded improvements to the breadth of services offered by general practices and community pharmacies. This includes an emphasis on prevention and quality to benefit Islanders and ease pressure in other parts of the health sector.

20. However, the HIF is not sustainable in its present form and there is no tangible plan for primary care in the context of a sustainable, integrated health care model for the future. The Government does not routinely assess value for money from new initiatives funded from the HIF and the changes since 2022 have increased the risk of overpayment from error or fraud.

Objectives and scope of the audit

21. The audit has evaluated the operation of the HIF in terms of:

    - oversight and governance
    - funding and investment strategy, including managing charges
    - social security contributions from individuals and employers
    - internal controls, including, in the context of the HIF benefits and funding:
        - managing potential conflicts of interest
        - avoiding fraudulent activity
        - ensuring checks on compliance with HIF rules; and
        - appropriate coverage of all relevant providers of primary care; and
    - monitoring and reporting performance, including adherence to any funding conditions.

22. The audit extended to:

    - those departments within Government involved with managing the HIF, namely:
        - Employment, Social Security and Housing (ESSH)
        - Health and Care Jersey (HCJ); and
        - Treasury and Exchequer (T&E); and
    - The Primary Care Body (PCB).

23. The audit has not evaluated the quality of health care services being funded by the HIF.

24. I am undertaking a separate audit of the Government's programme of work looking at long-term sustainable healthcare funding.

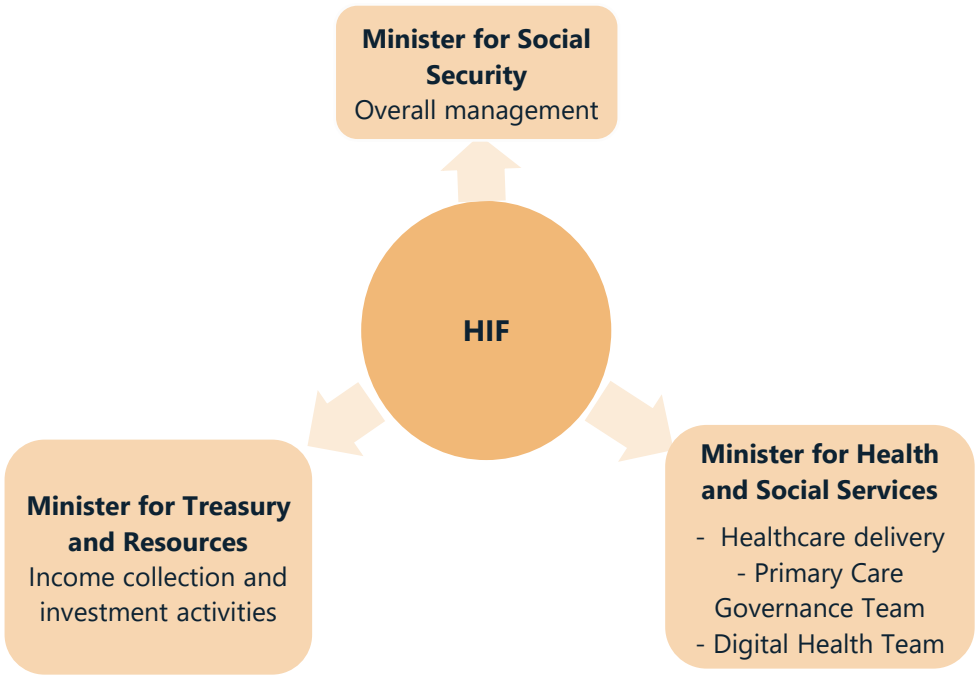
Detailed findings

Governance and oversight

Ministerial responsibilities

25. Overall responsibility for the HIF lies with the Minister for Social Security. However, the Minister for Treasury and Resources and the Minister for Health and Social Services also play key roles. Exhibit 3 demonstrates the key Ministerial responsibilities.

Exhibit 3: Ministerial responsibilities for the HIF



Source: Jersey Audit Office

26. The Minister for Social Security holds the overall responsibility for the HIF in Law. However, the Minister for Social Security must rely on the Minister for Treasury and Resources to ensure proper collection and recovery of the contributions to the HIF. The Minister for Social Security is also reliant on the Minister for Health and Social Services in driving changes to the provision of healthcare in Jersey that support the sustainability of the HIF.

27. Monitoring of the HIF performance and activity takes place at different levels. There are however no routine Key Performance Indicators (KPIs) provided to the Minister for Social Security regarding HIF performance. In addition, there are no KPIs for HIF funded services reported in the suite of Service Performance Measures for ESSH or HCJ, or the HCJ Quality and Performance monthly reports.

28. ESSH analysts produce annual data on:

- primary care appointments
- pathology costs
- pharmacy – drug volumes
- pharmacy costs
- pharmacy dispensing fees; and
- gluten free vouchers.

29. The 2025 HCJ Annual Plan included an objective to amend the Law to transfer responsibility of the HIF to the Minister for Health and Social Services. No such amendment has been brought forward at this time however.

30. In September 2025 the States approved a proposition to establish an advisory Health Partnership Board. This Board is planned to be established in 2026 and will include primary care representatives.

Officer responsibilities and governance groups

31. The governance arrangements for the HIF involve a number of departments and include a range of strategic, operational and working groups as well as informal groups. These groups include:

- HIF Oversight Group
- HIF Operational Group
- General Practice Community Service (GPCS) Management Board; and

- statutory Pharmaceutical Benefit Advisory Committee (PBAC).

32. The relationships and interdependencies between these groups is not formally documented.

HIF Oversight Group

33. The Accountable Officer for the HIF is the Chief Officer for ESSH. Prior to 2024, the Accountable Officer received routine updates on the operation of the HIF from officers within the ESSH (then Customer and Local Services Department) as well as the Primary Care Governance Team (PCGT). However, this lacked structure.

34. More structure was added to this process since 2024 through creation of the HIF Oversight Group. This Group is scheduled to meet quarterly and has a Terms of Reference describing its role and responsibilities. These responsibilities include advising on priorities, providing governance to HIF projects and financial scrutiny. The Terms of Reference do not include a specific focus on long-term sustainability of the HIF.

35. While I acknowledge that the funding of the HIF is considered by the Senior Leadership Team within ESSH on a monthly basis using data from the Finance Business Partner, there is merit in cross departmental consideration of this risk as part of the HIF Oversight Group. Without the HIF Oversight Group having such a role there is a risk that a decision to invest in primary care services proposed by ESSH may not be pursued because the benefits accrue in HCJ and are not quantified. For example, while recent initiatives such as those within Jersey Quality Improvement Framework and wounds and dressings funding were approved, the business case did not make reference to the efficiency savings which may accrue in HCJ services.

36. The initial agendas for the HIF Oversight Group were limited in depth. While the agenda for July 2025 showed more substance it continued to lack the detail required to demonstrate full coverage of the matters specified in the Terms of Reference.

37. The HIF Oversight Group meetings are not minuted. However, actions, issues and decisions arising from the meetings are captured in an action log alongside the HIF Oversight Group risk register.

38. The Clinical Lead for the PCGT within HCJ is part of the HIF Oversight Group and reports to the Accountable Officer for ESSH on HIF matters. A Memorandum of Understanding (MoU) is in place between the Accountable Officer in ESSH and the PCGT outlining the PCGT objectives related to management of the list of GPs and support for the HIF contracted work.

39. There is accountability to the Minister for Health and Social Services and the Accountable Officer within HCJ on the clinical component of the role but there is no reporting line or accountability on HIF matters within HCJ.

HIF Operational Group

40. At the operational level, a HIF Operational Group meets monthly to discuss all operational matters related to the HIF using a standard slide format covering projects, contracts and system issues. The HIF Operational Group does not include a review of overall financial performance against budget. There is no Terms of Reference for this group and the relationship and reporting line to the HIF Oversight Group is not documented. No minutes or action logs are produced from the HIF Operational Group but a summary of points arising is emailed to the Group Director (ESSH) and other managers.

GPCS Management Board

41. A representative from the PCGT as well as a General Practice Representative sit on the General Practice Community Service (GPCS) Management Board. The Board supports delivery of primary care and community healthcare in Jersey through the EMIS system [primary and community care IT] and directly associated operating platforms. This Board's objectives are:

    - improved primary healthcare and patient safety in Jersey through transformation of change and digital technology
    - clinical data sharing
    - efficient delivery of primary health care systems through the use of IT

- discuss and agree changes to the GPCS, including funding arrangements and terms for new and additional User Organisations, and launch the relevant implementation projects
- facilitating the recharge to services for the EMIS network
- enable efficient auditing of EMIS usage
- review performance of the GPCS and supporting agreements, including supplier performance and contracts; and
- receive updates on projects relating to primary and community services.

42. The disconnect related to the activities of the GPCS Management Board and the HIF Oversight Group is noted as a risk in the HIF Oversight Group risk register, and this is being addressed.

Statutory PBAC

43. The statutory Pharmaceutical Benefit Advisory Committee (PBAC) is convened quarterly or as required to consider pharmaceutical issues on behalf of the Minister for Social Security who is responsible for the Approved List of Pharmaceutical Preparations (the 'Prescribed List'). Applications for new medicines or removals from the Prescribed List are considered by PBAC following referral from approved prescribers.

44. The Chair is a layperson appointed by the Minister for a period of five years. The Chair's report presented to PBAC in September 2025 shows:

- new medicines to be added with estimated costs
- different strengths of existing medicines to be added
- items to be removed with cost impact; and
- discussion on other medicines and representations.

45. The minutes of PBAC are thorough and demonstrate the detail required for decision making processes of this nature.

46. The Health Insurance (Pharmaceutical Benefit Advisory Committee) (Jersey) Order 2017 specifies the representatives to sit on the PBAC. This includes an officer from ESSH appointed by the Minister. The officer in this role is now engaged on HIF activities from within the Strategic Policy, Planning and Performance team in the Cabinet Office. The officer acts as Vice Chair for PBAC and may be required to preside over PBAC in the temporary absence of the Chair. However, the 2017 Order makes clear that a States employee may not be appointed as Chair.

47. The Minister for Social Security also appoints an independent Pharmaceutical Adviser to support PBAC and pharmacists and to promote cost-effective use of medicines funded by the HIF. The current adviser has been in post since 2001. An exemption to the Public Finances Manual was obtained to renew the contract through to 2027. The Pharmaceutical Adviser has no role in relation to the hospital.

48. Prescriptions funded by the HIF are restricted to those medicines on the Prescribed List. Applications for new medicines or different strengths are encouraged from GPs. There is flexibility for GPs to prescribe other medicines which are paid for privately and outside of the HIF. The Prescribed List is largely focussed on medicines and does not allow products such as food supplements or stoma care products to be funded from the HIF. There are current initiatives in place regarding development of digital health support (aimed at enhancing wellbeing through the recommendation of non-medical support such as apps) but much of this has no additional cost implications for the HIF.

Recommendations

R1 Review and document a clear governance map for the Health Insurance Fund including all existing and planned boards, groups and committees. In doing so, seek to eliminate duplication and inefficiency and ensure interdependencies between the various groups are documented, understood and can operate effectively.

R2 Review Government representation on the Pharmaceutical Benefit Advisory Committee to ensure it aligns with the statutory requirements.

Overall HIF sustainability

49. The States of Jersey Annual Report and Accounts 2024 show that the balance on the HIF at 31 December 2024 was £110 million (2023 £112 million). Benefits and other payments from the HIF in 2024 exceeded income by £1.2 million and this pattern is expected to continue during the next budget period to the end of 2029.

50. Section 22 of the Health Insurance (Jersey) Law 1967 requires the Minister for Social Security to appoint an actuary to review the operation of the fund at least every five years. The last actuarial review was based on the HIF position at the end of 2021 and was reported to the States Assembly in May 2023 (R.97/2023).

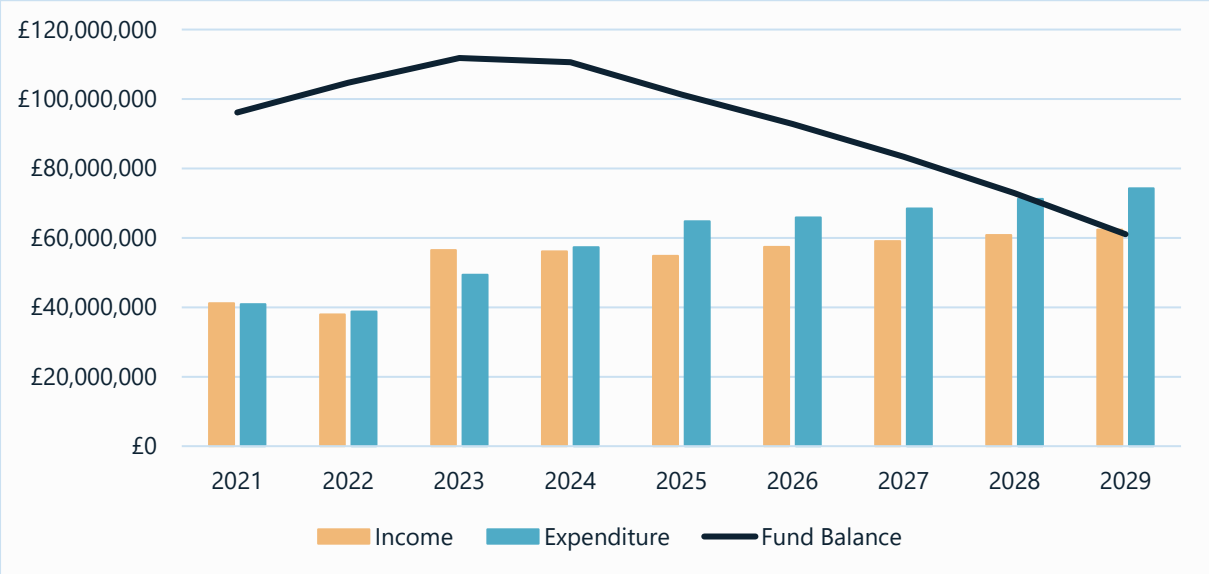
51. The actuarial review was carried out by the UK Government Actuary and concluded that 'The Fund is projected to decline over the 20 year projection period, in current earnings terms, and be exhausted by around 2037-2041 (depending on migration experience in Jersey), a few years later than was projected in our 2017 review.' This position was based on the costs met from the HIF in 2021, which are significantly increased now.

52. No clear plan of action has been developed for the HIF since the 2021 actuarial review despite the clear indication from the actuary that the fund is not sustainable. Instead a number of additional benefits and contracts have been funded through the HIF since 2021 causing additional pressure on the sustainability of the HIF.

53. The most recent actuarial reviews have been after four years rather than the maximum of five and the ESSH Business Plan 2025-26 states that an updated actuarial review is a key objective for this period. However, I am advised that the Minister for Social Security has decided not to commission a review as at 31 December 2025. The next review will therefore be at the conclusion of five years at 31 December 2026. On the basis of the previous timetable, this means that the work will be carried out in 2027 and will report in 2028.

54. Exhibit 4 shows the levels of HIF expenditure and income compared to the balance for 2021 to 2024 and the forecast position from 2026 to 2029.

Exhibit 4: HIF Income and Expenditure 2021 - 2029



Source: States of Jersey Annual Report and Accounts 2021 to 2024 and States of Jersey Budget 2025-2028 and Budget 2026 - 2029

55. The Government is forecasting that by 2029 the balance on the HIF will be less than one year's expenditure.

56. At ESSH departmental level, the Senior Leadership Team (SLT) receives a monthly finance report showing actual figures to date against budget across the main cost centres with explanations in respect of variances from expectations.

57. However despite the clear reference contained within the Budget 2026 – 2029 that '*the fund will be exhausted during the early 2030s unless action is taken soon*', there is no tangible plan in place to address the declining fund. The Risk Register within the ESSH Department includes sustainability of the HIF as a risk as it may not be able to support Primary Care leading to poorer health outcomes. The ESSH Business Plan for 2025-26 does not include any actions in relation to the risk. The only reference is '*Continue to develop and maintain primary care services delivered through general practice and community pharmacy providing access in the community to a range of health services*'. While there is commitment to an overall review of the healthcare delivery model including primary care which will include consideration of the HIF, a greater focus on delivering a solution is required including aligning the risk to specific actions.

58. Sustainability of the HIF has been raised in meetings of the Health and Social Security Scrutiny Panel in September and October 2025 in the context of the forthcoming Budget for 2026. Similar concerns were raised during a meeting of the same Scrutiny Panel in November 2022. Whilst the Minister for Social Security has acknowledged concerns, and the commitment to an overall review of healthcare delivery is noted, there are no current actions in place to arrest the decline.

59. The current funding and expenditure model for the HIF is not sustainable without intervention. Any intervention should be taken in the context of the overall objectives of funding and delivering sustainable and efficient healthcare to Islanders.

Recommendations

R3 Prepare and implement a formal policy statement specifying the minimum balance to be held in the Health Insurance Fund.

R4 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.

HIF income

60. There are two sources of income in the HIF:

- social security contributions; and
- investment income.

61. The States could also decide to pay a grant contribution into the HIF. They have not however chosen to do so.

Social security contributions

62. The annual contributions from the Social Security Fund are specified under Article 30 of the Social Security (Jersey) Law 1974. The current allocation has been fixed since changes were made to the Law in the Social Security (No 2) (Jersey) Regulations 1993. The split is shown in Exhibit 5.

Exhibit 5: Social Security contributions to HIF

Contributions	Total	Employer		Employee	
	%	Total %	HIF %	Total %	HIF %
Class 1 (Employed)	12.5	6.5	1.2	6	0.8
Class 2 (Self-Employed)	12.5	of which 2% relates to HIF			

Source: Jersey Audit Office analysis

63. Despite the declining position of the HIF, there have been no recent changes to the social security contribution levels. There have however been a number of changes to expenditure funded by the HIF alongside other pressures impacting on the HIF including:

- life expectancy
- population growth (the dependency ratio is similar to the level 20 years ago but the actual number of older people is greater)
- public expectations of the Primary Care sector evidenced by the number of GP appointments and drug costs; and

- growth in preventable conditions such as Type 2 diabetes.

64. Social security contributions paid into the HIF are collected by Revenue Jersey. In my report *Tackling Fraud and Error* (November 2024), I reviewed some of the controls within Revenues Jersey to prevent fraud and error. I reported on positive developments in respect of the compliance strategy which had yielded significant benefits in tax recovery since 2024.

Investment income

65. The Minister for Treasury and Resources is responsible for the States' investment strategies and consults with the Minister for Social Security in respect of HIF investments.

66. The Treasury Advisory Panel (TAP) is established by the Minister for Treasury and Resources to provide advice on discharging responsibilities in relation to investments. TAP comprises the States Treasurer plus three independent people with appropriate experience. Alongside this, an independent investment advisor is appointed to advise TAP and the Minister and Treasurer. Investments are reviewed each month and the investment advisor reports quarterly to TAP on performance.

67. The HIF investment strategy is set out annually as part of the Government's overall investment strategy. The current investment strategy for the HIF is low risk with emphasis on capital preservation and liquidity. The strategy was amended in 2022 in recognition of the depleting fund and the need to de-risk in order to preserve the capital balance. Prior to this, 40% of the fund was invested in equities. My conclusion is that the current investment strategy is appropriate.

68. The investment strategy is shown in Exhibit 6.

Exhibit 6: HIF Investment strategy December 2024

	Strategic aim (%)	Range (%)
Fixed Income	50	40 - 60
Cash	50	40 - 60

Source: States of Jersey Investment Strategies 2024 (R185/2024)

69. At the time of my fieldwork in November 2025, the performance of the HIF was 0.4% above the Sterling Overnight Index Average rate (SONIA). However, over the period of the Budget, the low risk strategy and reducing balance are expected to reduce the annual yield by £1 million to £2.4 million by 2029. This compares to a yield of £5.4 million in 2024.

HIF expenditure

70. I have considered the following aspects of expenditure from the HIF:

- changes in the range of payments made to support healthcare delivery
- GP fees
- quality and modernisation initiatives; and
- management costs.

Changes in the range of payments made to support healthcare delivery

71. In recent years there have been changes to the way the HIF benefit operates and consequently, the expenditure funded by HIF. Exhibit 7 provides a chronology of the main changes in the last ten years.

Exhibit 7: Chronology of main HIF changes since 2015

Date	Additional Service	Estimated impact 2026 (£)
2015	Jersey Quality Improvement Framework introduced. Payments made to GP practices under a standard contract with the aim of encouraging high quality outcomes for patients.	2,963,000
2017	Flu vaccination service. Payments made to GP practices and pharmacies to provide flu vaccinations to indicated groups. Programme extended to include cost of vaccines and Covid 19 vaccinations from 2020. Shingles and respiratory syncytial virus (RSV) vaccines added also.	2,266,000
2018	Cervical screening service introduced for eligible individuals to receive screening check-ups free of charge.	310,000

Date	Additional Service	Estimated impact 2026 (£)
2018	Diabetic supplies scheme introduced. Patients with a diagnosis receive supplies for testing blood glucose levels free of charge.	964,000
2020	Remote service contract introduced. GPs are provided with a fixed fee when undertaking a remote consultation.	712,000
2020	Health Access Scheme. Introduced to support lower income households. Adult GP surgery consultation fee is capped at £10 and consultation for children is free.	2,393,000
2022	GP workforce support package. Phased funding to support broadening of workforce in general practices from 2022 to 2025. (Estimated cost £2 million in 2023, £1.3 million in 2024, £666,000 in 2025)	N/A (scheme ended)
2022	Allied Health Professional fee. Introduced to provide subsidy for non-GP consultations in order to offset costs payable by patients. At time of introduction, activity cost estimated at £250,000 increasing to £2 million by 2026.	2,000,000
2023	Reduced GP fees. Agreement to reduce the cost of GP consultations by £20 plus a payment of £5 to GP practices to assist with business costs. Cost to HIF initially estimated at £6 million each year.	5,202,000
2023	Budget amendment to provide for free GP appointment for all patients under age 17.	1,600,000
2023	Budget amendment to extend free GP appointments to all students.	128,000

Date	Additional Service	Estimated impact 2026 (£)
2023	Budget amendment agreed to meet the cost of hosiery and wound dressings for patients with a clinically assessed need.	300,000
2023	Introduction of Pharmacy Quality and Performance initiatives.	558,000
2023	Introduction of Pharmacy Package of modernisation initiatives. Increased dispensing fees (Phased increase from May 2023) Wage support scheme/training Independent Prescribers (£1.53m May 23/24 and 24/25, £0.8m in 25/26) Commissioned patient services	 2,430,000 416,000 520,000
2024	Reduced primary care fees. Agreement to reduce the cost of GP and other consultations by a further £10. Cost to HIF estimated at £3.6 million each year.	3,600,000
2025	Reduced primary care fees. Agreement to reduce cost of Health Care professionals by £10 including remote services plus a payment to GP practices to assist with business costs.	986,000

Source: Employment, Social Security and Housing Department

72. The States of Jersey Accounts show that actual expenditure on social benefit payments increased from £30 million in 2020 to a level of £52 million in 2024 and this is forecast to exceed £67 million by 2029. Within these figures, the total drugs budget in 2025 is £20.5 million.

73. On the basis of these figures, the additional annual cost to the HIF since 2020 for routine appointments (including remote consultations) for adults, children, students and those who qualify for the Health Access Scheme is estimated at over £16 million in 2026.

74. In addition to these costs, the HIF has also been used as a source of funding for the following two items:

- 2020 – a transfer of £5.3 million was made to meet some of the costs of primary care services organised by the (then) Health and Community Services Department during the COVID-19 pandemic.
- In 2020 and 2021, the States Assembly approved that the HIF could be used to meet costs of the Jersey Care Model and the associated Digital Care Strategy. In a response to the Health and Social Security Scrutiny Panel hearing on 7 November 2022, the former Director General for Health and Community Services advised that the total sum transferred during 2022 was £7.4 million to meet costs incurred in the hospital and in the community.

75. I have considered the key changes made in HIF expenditure since 2023 and whether they have been supported by robust business cases. Good practice for such business cases would be to include consideration of the following key elements:

- a summary of the issue including the case for change
- objectives for the initiative
- consideration of options including doing nothing as well as an assessment of the benefits and risks of each option
- financial analysis including affordability considerations; and
- interdependencies.

76. Some of the changes made to HIF expenditure related to States Assembly decisions, including approved Government Plan amendments. I did not observe consistency in the rigour with which business cases have been documented and did not observe good practice being adopted in some business cases supporting decisions involving significant investment. Exhibit 8 summarises my observations.

Exhibit 8: Observations on business cases supporting changes to HIF expenditure since 2023

Change and summary rationale	Observations
£20 reduction in GP Fees plus £5 payment to GPs for each consultation **Ministerial Decision MD SOSEC-2023-347** **June 2023** • Request from Minister for Social Security for urgent, targeted action in response to cost of living pressures • Cost estimated as £6 million • Would result in annual deficit on HIF • Affordability based on opening balance of £105 million • £20 to be passed on to patient through a fee reduction • Risks considered • Initiative to be in place for two years	• High risk noted that GPs may simply increase fees rather than pass price reduction on. No guarantee or robust control however was put in place to prevent this happening • Benefit was universal rather than targeted. Did not take into account that groups of Islanders may feel cost of living impact differently, or may have private health insurance • No justification or analysis to support additional £5 contribution to business costs • No assessment of potential for volume of GP appointments to increase • Longer-term impact on the HIF balance not rigorously considered • No detailed assessment of longer-term impact or implications of cost of living pressures on residents • System implications not evaluated for Government or GP practices

Change and summary rationale	Observations
Free GP appointments for all Children plus no charge for common tests and procedures **MD-SOSEC-2023-489** **July 2023** Ministerial Decision followed Government Plan amendment raised by a States Member. • Estimated cost to exceed £1 million in accompanying report • Cost based on census data and assumptions of number of GP consultations (1.8 each year) and nurse consultations (10% of GP total) • Cost based on estimate of £22 as average practice fee • Initiative to be in place for two years with no review process specified	• Basis for calculation is simple with limited evidence to validate assumptions • Report does not consider risk of increased volume of GP consultations • Difficult to measure impact • Affordability and impact on fund not considered • System implications not evaluated for Government or GP practices
Free GP appointments for Students – **MD-SOSEC-2024-986** **December 2024** Ministerial Decision followed Government Plan amendment raised by a States Member • Cost based on number of students and average number of consultations • Cost based on average cost of GP consultation of £33 • Total cost of £70,000 plus £5,400 unspecified additional costs	• Basis for calculation is simple with limited evidence to validate assumptions • Method inconsistent with assumptions and method used for children • Report does not consider risk of increased GP consultations • Difficult to measure impact • Affordability and impact on fund not considered • System implications not evaluated for Government or GP practices

Change and summary rationale	Observations
Free wound dressings and hosiery for patients with clinical need Sixth Amendment to Government Plan 2024-27 • Business case based on increased take up of scheme for free hosiery provided through Family Nursing and Home Care (FNHC). Budget of £40,000 annually not considered to be sufficient • Case made that there would be a number of tangible benefits for patients and care sector • Cost estimated as £1 million including wound dressings (£855,000) and hosiery (£169,000)	• No reference made to overall affordability and longer-term impact on HIF • Efficiency savings in secondary and acute sector not included • No measures included to enable outcomes to be assessed • No cost of implementation included • No detail provided on controls to be added to system • System implications not evaluated for Government or community pharmacies
Additional £10 deduction from GP and other practitioner fees, including remote consultations. Extension of financial support to include home visits. **MD-SOSEC-2024-397** **May 2024** Further response considered necessary to cost of living pressures • Implementing a universal scheme which was not means tested or targetted • Initiative was for £10 to come directly off GP fees • Implementation costs included at £40,000	• Considered before the £20 reduction had operated for a year and without evaluation of this • Other observations as noted with £20 reduction above • No evaluation of impact of subsidised home visits • System implications not evaluated for Government or GP practices • Was the highest cost of the three options considered

Source: Jersey Audit Office analysis

77. Overall, my analysis suggests that new initiatives have been introduced without a full and consistent assessment of the long-term impact on the HIF and with insufficient consideration of resource and system implications. In addition, some initiatives lack the metrics to enable assessment of value for money following implementation. The inability to demonstrate value for money is acknowledged as a risk in the HIF Oversight Group risk register.

General practice fees

78. General practices are independent businesses and set their own fees. Despite the clear relationship between the HIF benefit and general practice fees, the Government exercises no direct control over these fees.

79. As part of the Ministerial Decision to introduce a new contracted medical benefit of £20 in 2023, the Government agreed with all practices that price transparency would be improved. The schedule of fees charged by individual practices is now published on the website to enable patient comparisons and choice.

80. The schedule at July 2025 is shown in Exhibit 9.

Exhibit 9: Schedule of GP practice fees July 2025

Practice name	GP in surgery	GP home visit	Nurse in surgery	Para-medic in surgery	Health Care Assistant in surgery	Repeat prescript-tion (90 days)
Government subsidy	**£50.28**	**£50.28**	**£30.28**	**£30.28**	**£30.28**	**N/A**
Castle Quay Medical Practice	£38	£135.55	£21.52	N/A	£13	£15
Cleveland Clinic Ltd	£45	£125	£17.30	N/A	N/A	£10
Clifden House Surgery	£30	£105	N/A	N/A	N/A	£12
Como Villa Surgery	£15	£100	N/A	N/A	N/A	£10
First Medical Limited	£40	£120	£5	N/A	£0	£18
Health Plus	£42	£151	£0	N/A	£0	£9
Indigo Medical	£40	£105	£27	N/A	£8	£10

Practice name	GP in surgery	GP home visit	Nurse in surgery	Para-medic in surgery	Health Care Assistant in surgery	Repeat prescript-tion (90 days)
Government subsidy	**£50.28**	**£50.28**	**£30.28**	**£30.28**	**£30.28**	**N/A**
Island Medical Centre	£43	£117	£27.50	N/A	N/A	£5
Lido Medical Practice	£40	£150	N/A	N/A	N/A	£12
Lister House Associates Ltd	£39	£120	£12	£39	£12	£13
Route Du Fort Surgery	£38	£115	N/A	N/A	N/A	£8
Seven David Place Surgery	£29	£96	£13	N/A	N/A	£8
St Martin Surgery	£35	£85	£20	N/A	N/A	£8
Windsor Medical	£0	£150	£0	N/A	N/A	£5

Source: Government of Jersey website

81. At the time that the additional £20 benefit was agreed in 2023, it was described as a 'contracted medical benefit' to be deducted from the fee charged for a face to face GP consultation. When the additional £10 benefit was added in 2024, this was on a similar basis but was extended such that the whole additional subsidy of £30 applied to face to face consultations and home visits.

82. The risk that the additional benefit would not be passed on to the patient was recognised in the business case at the time and the mitigation provided was the potential for the Minister to intervene if prices were considered to be unacceptable. It is not clear what form this intervention would take and whether it would be effective given that the Government does not exercise any price control.

83. While the risk was recognised, there is nothing to stop practices increasing fees in a way that removes the direct benefit to the patient. Officers maintain a dashboard of fee changes over time, and the increased transparency alongside routine engagement with practices provides the basis for officers to understand the rationale for fee variances. However, there is no formal process in place for review of practice fees.

84. As part of my audit, I have reviewed the GP face to face consultation fees since February 2024. Assuming that £10 was deducted from the fees reported at the time of the Ministerial Decision in May 2024, records show that eight practices have since increased fees to a level greater or equal to those in February 2024 and greater than would be explained by inflation in that period. The details are shown in Exhibit 10.

Exhibit 10: GP fees which have increased since February 2024

Practice Reference	% increase between May 2024 and July 2025
1	32%
2	33%
3	40%
4	38%
5	33%
6	52%
7	53%
8	59%

Source: Jersey Audit Office analysis from published data and data in Scoping Paper supporting MD-SOSEC-2024-397 (17 May 2024)

85. The fees published by each practice and summarised on the Government website show a number of inconsistencies related to the HIF benefit. While it is the responsibility of each practice to publish accurate fees, it is important that these are reviewed by the Government to ensure accuracy and consistency in the disclosure of the relevant medical benefit applicable to each fee. The statutory and contracted benefit from the Government is £50.28 for a routine face to face GP appointment. In some cases the wrong subsidy is included on the price list and others show just the net (customer pays) price. This is confusing for patients, it may indicate some confusion in the general practice community and it heightens the risk of errors in billing and payment.

86. In addition to these inconsistencies, there are also some inconsistencies in services offered which attract the HIF benefit. For example, some practices quote a fee for well man or well woman medical examinations. In some cases the fees attract benefit, in other practices there is no discount quoted. The same applies to the cost of a minor operation (which may be at the request of a patient). Where discretionary services are undertaken at the request of a patient, it may be more appropriate for the patient to meet the cost and/or claim this on private insurance if relevant.

Quality and modernisation initiatives

87. I have considered the following quality and modernisation initiatives that have been implemented as part of changes to the expenditure of the HIF:

- Jesey Quality Improvement Framework
- General Practice initiatives
- monitoring and review of GP practices
- Pharmacy Quality Improvement Framework; and
- pharmacy initiatives.

Jersey Quality Improvement Framework

88. The Jersey Quality Improvement Framework (JQIF) was introduced in 2015 to improve health outcomes for Islanders by incentivising general practice to undertake specified activities and evidence information with an emphasis on:

- the management of common chronic conditions (for example, diabetes)
- activity to address key public health concerns (for example, alcohol use, obesity); and
- increasing focus on priority areas to support developments in Jersey's health care system (for example, mental health, palliative care).

89. JQIF requires GPs to report on a range of clinical indicators specified by the Primary Care Governance Team (PCGT). These have been developed using

information from the UK Quality and Outcomes Framework (QOF) adjusted following consultation with representatives from Jersey's primary care sector. The arrangements for JQIF are formalised in a contractual arrangement included as a Schedule to the Services Agreement with each practice.

90. Prior to having a quality framework in place, Island GPs lacked a consistent process for formal validation of performance quality. JQIF comprises a range of indicators which are split between clinical register and intervention (75%) and organisational indicators (25%). Exhibit 11 summarises the JQIF indicators for 2025.

Exhibit 11: JQIF Clinical indicators 2025

Type	No.	JQIF points	
		Intervention	Register
Asthma	2	6	
Atrial fibrillation	1	2	
Blood pressure	1	2	
Cancer	1		1
Chronic kidney diseases	4	5	0
Coronary heart disease	3	4	
COPD	3	5	0
Dementia	1	2	
Diabetes	8	17	
Epilepsy	1		1
Heart failure	1		1
Hypertension	2	3	
Learning disabilities	1	2	
Mental health	3	6	2
Non-diabetic hyperglycaemia	1	4	
Obesity	1		2

Type	No.	JQIF points	
		Intervention	Register
Palliative care	1		2
Rheumatoid arthritis	1	2	
Smoking	1	4	
Stroke and transient ischaemic attack	2	2	
Total		**66**	**9**

Source: JQIF specification 2025

JQIF Organisational indicators 2025

Measure	JQIF points
Cancer diagnosis – newly diagnosed patients	6
Complaints	2
Safeguarding	5
Polypharmacy – review of patients on eight or more medicines	6
Patient feedback survey	6
Total	**25**

Source: JQIF specification 2025

91. The JQIF indicators described above have been added as a Schedule to the Services Agreement for GP services as part of the overall contracted activity. Where initiatives have been introduced for a limited time, these have continued due to contract extensions to the Services Agreement. The latest variation extends this agreement to the end of March 2026.

General Practice initiatives

92. Alongside the JQIF, a series of general practice initiatives has also been agreed in recent years with a funding package met from the HIF. These initiatives,

implemented between 2022 and 2025, were agreed to contribute to the following goals:

- preserve the delivery of high quality, patient centred care
- improve patient outcomes
- enable General Practice to deliver care in response to the (then) emerging requirements of the Jersey Care Model; and
- enable patients to see the right practitioner.

93. The package of initiatives and the planned funding are shown in Exhibit 12.

Exhibit 12: GP initiatives funding package 2022 - 2026

Initiative	2022 £000	2023 £000	2024 £000	2025 £000	2026 £000	Total £000
Funding Health Care professionals	1,000	2,000	1,300	770	Nil	5,070
Non GP consultations	250	250	500	1,000	2,000	4,000
Expansion of JQIF	115	400	700	1,000	1,000	3,215
Total	**1,365**	**2,650**	**2,500**	**2,770**	**3,000**	**12,285**

Source: GP Initiatives Memorandum of Understanding 2022 - 2025

94. The General Practice package has provided additional capacity in primary care and contributes to improved value for money by enabling subsidised consultations with nurses and health care assistants. It has also embedded remote consultations into the system following changes introduced during the COVID-19 pandemic.

95. The package of modernisation initiatives is separate from the contracted activity. The detail related to the package is contained within a Memorandum of Understanding (MoU) with the Board of the Primary Care Body.

96. The MoU indicates that the new initiatives were introduced to help encourage the development of a holistic approach to primary care in the context of the Jersey Care Model (JCM) which had been approved in November 2020. By introducing the initiatives from 2022, the intention was that individual practices would develop improved processes as part of the JCM by 2025. Since the JCM was ceased in 2022, and in the absence of a coherent future model of integrated healthcare, there is a danger that these initiatives lose impact and that value for money is diluted. As funding for health care professionals falls away from 2026, there is a risk that some practices will not be able to meet the costs of recruiting and retaining nurses in competition with other parts of the health sector.

97. There are no incentives within the HIF for efficiency savings in respect of activity delivered by general practice.

Monitoring and review of GP practices

98. Detailed performance monitoring and review in General Practices is undertaken by the PCGT for the sector overall and for individual practices. At sector level, the PCGT produces an annual report and mid-year report for the HIF Oversight Group. This includes progress by each practice against the JQIF clinical and organisational indicators and the implications for the budget available for individual practices. JQIF revenue is allocated to practices on the basis of patient list size with distributions based on an aspirational achievement of 80% of the JQIF targets during the year.

99. The final clinical report for 2024 shows that five out of 14 practices under achieved the aspirational level, which required clawback from the routine payments in 2025. One of these was paid a total of £112,000 during 2024 but only achieved JQIF clinical indicator outcomes attracting £71,000, resulting in an overpayment of £41,000. Only two practices were paid the maximum allocated sum for meeting JQIF clinical targets.

100. The analysis of organisational indicators shows that three practices under achieved on the aspirational target of 80% but only by a small amount. Eight practices received the maximum budgeted sum which suggests that greater challenge should be added to JQIF organisational indicators to ensure continuous improvement in 2026.

101. At individual practice level, the PCGT has developed the Jersey QIF report. This report demonstrates current performance for all JQIF indicators by practice as well as trends. This data can also be analysed in different ways which allows the PCGT to monitor performance for all practices in respect of a particular indicator, or trends or comparison between different practices. On the basis of this analysis, the PCGT is able to conclude that the quality of primary care has improved as a result of JQIF.

102. In addition, the PCGT produces Jersey Activity Monitoring (JAM) cards which provide data on prescribing and referrals. The JAM cards enable the PCGT to identify outliers in prescribing patterns and referrals and use these in the regular meetings with individual GPs and practices. There is also the opportunity for the PCGT to liaise with the Pharmacy Advisory Service on specific prescribing issues.

Pharmacy Quality Improvement Framework

103. A package of pharmacy initiatives was also introduced from 2023. The Pharmacy QIF indicators encompass the following elements:

- entry
- safeguarding
- digital
- public health; and
- sustainability.

104. Sums totalling £540,000 (April 2025 to March 2026) and £558,000 (April 2026 to March 2027) are available for pharmacies subject to satisfying a range of criteria set out in the Pharmacy QIF specification in respect of these five elements. An entry payment in year one is payable to participants in the scheme subject to completion of one of the thematic areas. My assessment of the Pharmacy QIF is that the incentives are quite small but require pharmacies to demonstrate compliance with a wide range of requirements. There is also limited stretch in the process. For example, the criteria for safeguarding in year two are the same as in year one.

105. At the time of my audit, all but two pharmacies from a total of 30 branches across 14 providers were engaged with QIF.

Pharmacy initiatives

106. The package of pharmacy measures is having less impact than the General Practice initiatives suggesting a need for review. The measures being supported by the HIF were described in the Pharmacy MoU in 2023 together with the allocated budgets at that time. These are shown in Exhibit 13.

Exhibit 13: Pharmacy initiatives package 2023 - 2026

Initiative	Year 1 from May 2023 £000	Year 2 £000	Year 3 £000	Total £000
Increased dispensing fee	1,060	1,730	2,430	5,220
Wage support scheme	1,532	1,532	832	3,896
Commissioned services	377	650	720	1,747
Quality and Performance Framework	500	500	500	1,500
Total	**3,469**	**4,412**	**4,482**	**12,363**

Source: Pharmacy Investment Package Initiatives Memorandum of Understanding 2023 - 2026

107. Dispensing fees were fixed between 2014 and 2023. The 2023 increases took the Tier one fee (first 50,000 items) from £3.51 to £4.01 from 1 May 2023 with further annual increases to a level of £4.67 in 2025. The current dispensing fee in Guernsey is £3.83 for the first 1,500 items each month. In England, the Single Activity dispensing fee is £1.46 but this is part of a wider package of support to pharmacies. The fees were increased without an assessment of the true cost of dispensing.

108. Dispensing fees are paid for each item on a prescription. As part of the package of initiatives, prescribers are able to prescribe repeat medicines for

up to 90 days rather than 30 days where this is in the best interests of the patient. As this may have led to reduced pharmacy volumes, the pharmacy package from 2023 included provision for compensation if income levels dropped.

109. There are initiatives in place to start to address the risk of over-prescribing and waste in the system. This includes a 'dump campaign' where residents are encouraged to return unused medicines. General practice is also encouraged to undertake polypharmacy reviews as part of the JQIF. The last actuarial report in 2021 concluded that the average number of prescription items per consultation had increased to 6.7, compared to 5.8 reported in the actuarial report from 2017.

110. The wage support scheme introduced for pharmacies was designed to increase capacity in community pharmacies by meeting the cost of developing support staff to become pharmacy technicians. This has not been consistently embraced by pharmacies as some contend that there is insufficient work to justify the additional capacity which they will have to fund when the support ends. At the time this scheme was introduced from May 2023, the support extended to retrospective funding to cover the wage costs from January to May 2023 where pharmacies had already taken the initiative to employ pharmacy technicians.

111. The commissioned services refer to additional services which contracted pharmacies and the Government agreed would be beneficial to be funded from HIF. The cost of these services was forecast as £720,000.

112. Where initiatives were proposed for community pharmacies which may reduce the burden on other parts of the health sector, the efficiencies were not identified or included as part of a business case. The initiatives have been slow to develop. The total expenditure on commissioned services and wage support in 2024 was £554,000 and this was lower than the anticipated expenditure.

Management costs

113. Management costs charged to the HIF are determined by Ministerial Decision as part of the annual Budget process. The principal charge for the period

since 2022 is shown in Exhibit 14. This represents the charge from the ESSH Department. Separate charges are also included for the Primary Care Governance Team (£787,000) as well as smaller charges to reflect costs of the actuarial review, system development and investment activity.

Exhibit 14: Management charges to HIF 2022 to 2026

Management Charges	2022 Actual (£000)	2023 Actual (£000)	2024 Actual (£000)	2025 Actual (£000)	2026 Budget (£000)
HIF management charge	1,450	1,540	1,847	2,126	1,161

Source: Jersey Audit Office analysis from States of Jersey Annual Reports and Accounts 2022 – 24, Detailed Budget provided by Department

114. The management charge was introduced in 2016 on the basis of estimated staff time allocated to the HIF as well as other Social Security Funds. By 2022, the level approved was £1.45 million and this increased to £1.54 million to take account of inflation in 2023. A further increase was added to the charge for 2024 including a £185,000 specific allocation to the base figure in respect of the costs of the Pharmacy and GP packages funded from HIF.

115. In my report *Long-Term Care Fund* (February 2022), I recommended a full review of the management charge of the Long-Term Care Fund which would have implications for management charges to other Social Security Funds. A full review of staff allocations and management charges was undertaken by the Accountable Officer in 2024 which resulted in a further increase to the HIF management charge to a total of £2.13 million for 2025. This represented a 15% increase compared to increases between 6% and 7% for the other two funds. This increase was in recognition of the significant growth in HIF benefits and complexity of the scheme since the management charge was introduced.

116. A further, high-level review of staff allocations was undertaken in 2025 which resulted in a number of costs being removed from the management charge. This represents an improvement in management accounting as costs are now separately recorded and monitored to improve transparency rather than being included in the recharge. These removed costs amounted to around £1 million

which left a balance of management costs attributable to ESSH of £1.16 million.

117. The calculation of the management charge in respect of the Social Security Funds is a complex process and subject to change during the course of each year. In my view, the methodology to arrive at an estimate of overall staff time and costs to allocate to each fund is reasonable for the purpose.

118. Recent and future increases to the establishment in ESSH will impact on the balance of staff time allocated to the HIF. I have been advised that the opportunity will be taken to adjust staff time allocations across each fund at the time of the next full management charge review, which may be in 2027.

Recommendations

R5 Update procedures for States propositions and Ministerial Decisions to ensure that any future expenditure changes proposed are supported by business cases which demonstrate good practice characteristics in documenting the resource and system implications. This should include consideration of the long-term impact on States' finances and specific funds.

R6 Review all fees published by GP practices to ensure accuracy and consistency in all cases where the Health Insurance Fund benefit is quoted.

R7 Review all fees published by all GP practices to ensure that the Health Insurance Fund benefit is appropriately applied to relevant services.

R8 Carry out a post-implementation review of the GP initiatives package to identify outcomes and assess value for money.

R9 Review the Pharmacy Quality Improvement Framework programme to ensure that it provides appropriate incentives based on continuous improvements.

R10 Undertake an exercise to assess the true cost of dispensing prescribed items.

R11 Use data from current initiatives to develop additional measures to address the risk of waste and over prescribing.

R12 Carry out a post-implementation review of the pharmacy package of initiatives in liaison with pharmacists in order to refine the current package and deliver change.

Work planned that should be prioritised

P1 Review the management charge to the Health Insurance Fund at the time of next full review to ensure that all utilised resources are included in the charge.

HIF risk and control framework

119. Following the introduction of the first contract under Article 20B in 2015, by 2024 there were 18 schemes and services receiving HIF funding. This has added layers of complexity to systems and processes within Government as well as in general practice and community pharmacies. In the case of providers, these changes have put pressure and additional learning requirements on administrative capacity which in some settings is very limited. This has created an inherent risk which is recognised in the departmental and HIF Oversight Group risk registers. In particular, the risk register for the HIF Oversight Group describes significant irregularities identified during audits in 2024.

120. The HIF utilises a number of systems to ensure activity is recorded and payments made to general practices and pharmacies. Exhibit 15 summarises the systems currently used.

Exhibit 15: Systems supporting the operation of the HIF

System	Description and comment
EMIS	Patient record system used by GPs to store clinical records. Standard system used in UK NHS. System manged by HCJ.
MediBooks	General practice system for billing patients and Government.
Pharm Outcomes	Web based system used by community pharmacies to keep patient details and record services delivered such as vaccines. Also used for raising invoices which are then processed by the ESSH Department.
NHS Prescription Pricing System	Outsourced system for calculating amounts due to pharmacies for medicines dispensed.
Nessie	Benefit system maintained by ESSH.
Navision	ESSH ledger system for making payments from HIF to GPs and pharmacies following interface with Nessie.

System	Description and comment
Alteryx	Separate processing system for HAS patients only. Implemented quickly to avoid confusion with Nessie/Navision.

Source: Jersey Audit Office analysis from data provided by ESSH

121. The key processing systems require significant manual input to ensure compliance with parameters associated with different elements of the HIF schemes. There is therefore inherent risk of error and fraud in general practice and pharmacies, as well as within ESSH.

122. The Nessie benefit system has been in place for nearly 20 years and the recent changes to add different categories of patient benefit have stretched the system functionality. A plan to replace this system is part of the current Transform project.

123. The EMIS system is operated under a contract managed by HCJ with limited ESSH oversight to ensure that interdependencies related to the HIF are managed. This is recognised as a risk in the HIF Oversight Group risk register.

124. Other risks include:

- resource capacity both to manage the systems and deliver the work plan
- system resilience related to the HAS system
- poor value for money
- inaccurate or fraudulent activity in General Practice or pharmacies; and
- business continuity.

125. The different databases mean that while the EMIS system records patient eligibility data in General Practice, this is not the case in pharmacies. In order to demonstrate eligibility for HIF pharmaceutical benefit, the Health Card, issued to residents who have lived in Jersey for six months and have paid Social Security contributions, needs to be checked. However, I am advised by officers that this is not routine practice. There is therefore a risk that subsidies are provided where the patient is not eligible.

126. The introduction of new components to the HIF has been a major change for General Practices which continue to be supported by ESSH in implementing these changes. The lack of consistency in the way practices set out their fees and available subsidies mentioned earlier suggests that there is confusion. There is also evidence of misinterpretation of certain aspects which the PCGT has identified following discussions with groups of GPs and there remains the potential risk of fraud and error.

127. To mitigate the risk of errors and irregularity in operating the routine appointments system, the PCGT has produced separate guidance for General Practice on:

- General Description
- Statutory and contracted medical benefit guidance
- Definitions of General Practice and Specialist activity; and
- Remote service guidance.

128. This is a positive step but the guidance was only produced in August 2025.

129. The potential for confusion in the primary care system will extend to patients and there is merit in developing a consolidated and accessible guide to the services funded by the HIF in GP practices and community pharmacies.

130. In addition to the recent guidance for General Practice, the PCGT also proposes to introduce audits of individual practices to cover compliance and consistency in relation to routine practice work as well as the JQIF. This is not yet in place due to capacity constraints, and therefore intervention only takes place when issues are identified from a retrospective review of data or through information from other sources.

131. ESSH is improving its processes to ensure compliance with contractual requirements. A seven stage audit process has been developed and will be implemented when new capacity is in place from early 2026. In addition to this some risk based reactive audits have been undertaken on key areas. These include remote claims, double claim risk, IT security and non-medical approved prescribers.

132. An Internal Audit review was undertaken in 2023 and reported in early 2024 which identified some control weaknesses to be addressed. These issues are also being followed up through the ESSH programme of reviews and visits to practices and pharmacies.

133. While the ESSH audit process is designed to ensure compliance with contractual terms, there is overlap with the proposals being developed by the PCGT and there may be scope for efficiencies.

134. The risk of fraud and error also exists within community pharmacies. Community pharmacies do not yet use the EMIS patient management systems. There are plans to introduce this at some point in the future which will improve patient safety by allowing pharmacists the opportunity to confirm conditions and medicines. Without EMIS, pharmacies do not have access to any clinical records so must rely on accuracy of prescriptions presented by patients. Pharmacies also do not have secure email, queries are referred to GPs by fax with a key control being reliance on the diligence of the pharmacist.

135. The Pharmaceutical Adviser and two pharmacist colleagues add a further level of control by review of system data each month to identify outliers including high volumes, expensive medicines or medicines which are not on the approved list. Issues are followed up directly with pharmacists.

136. While these controls are in place, there is still a risk of over prescribing. There are limited controls to prevent a patient signing up with two practices for the same prescription or asking the GP to prescribe different medicines following consultation which would be more appropriately purchased over the counter.

137. In terms of cost, the Pharmaceutical Adviser states that 80% to 90% of medicines dispensed are cheaper, generic versions. Each pharmacy sources its own medicines. The calculation of drug cost reimbursement is outsourced to the NHS Prescription Pricing Authority which is provided with copies of all prescriptions to calculate payments to be made to pharmacies on the basis of standard rates. The price paid to suppliers by pharmacies does not affect the reimbursement paid through the HIF.

Recommendation

R13 Develop a consolidated user guide for all Health Insurance Fund subsidised services for patients and providers.

Work planned that should be prioritised

P2 Review options to minimise weaknesses and risks within the current Employment, Social Security and Housing Department's benefits systems as part of the Transform project.

P3 Introduce a programme of audits of practices by the Primary Care Governance Team to ensure consistency and compliance in interpreting Health Insurance Fund and Jersey Quality Improvement Framework guidance.

P4 Prepare a detailed plan to introduce the EMIS IT system into community pharmacies.

Area for consideration

A1 Consider developing a joint audit programme using staff from the Employment, Social Security and Housing Department together with the Primary Care Governance Team and with the Pharmaceutical Adviser.

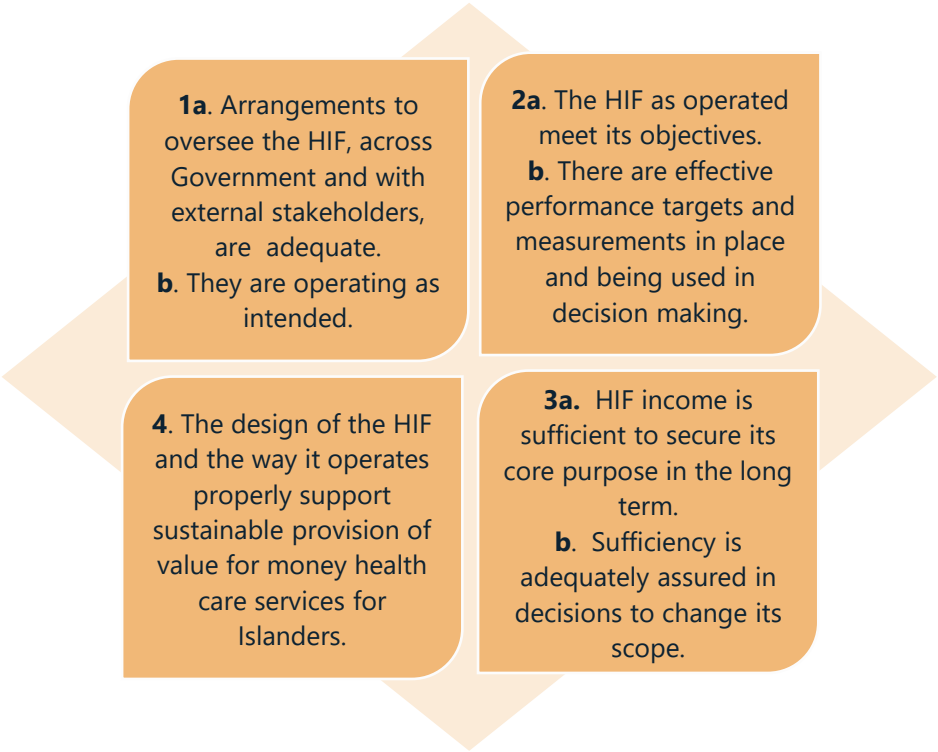
Appendix One

Audit Approach

This audit used a:

- result-oriented approach, and
- system-oriented approach.

The audit used the following criteria:



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:

- Agendas and Minutes from key stakeholder groups
- Departmental Risk Register extracts

- Detailed budget analysis documentation
- ESSH Business Plan 2025
- General Practice Services Agreement and variations
- GP package of initiatives MoU
- HCJ Business Plan 2025
- HIF Actuarial Report 2021
- HIF data reports
- Investment Strategy 2025
- Jersey QIF organisational and clinical indicators guidance
- Jersey QIF specification
- Pharmacy package of initiatives MoU
- Pharmacy QIF specification
- Proposed Budget and amendments 2026 – 2029
- Scoping paper for Ministerial Decisions and Business Cases supporting changes to HIF funding and use
- States of Jersey Annual Report and Accounts 2024

The following people contributed information through interviews or by correspondence:

- Chief Internal Auditor
- Contract and Project Manager (ESSH)
- Finance Business Partner (T&E)
- Group Director (ESSH)
- Head of Treasury and Investment (T&E)

- Pharmaceutical Adviser
- Policy Principal (SPPP)
- Primary Care Governance Lead (PCGT)
- Primary Care Medical Director (PCGT)
- Representatives from the Primary Care Body (PCB)

The fieldwork was carried out by affiliates working for the Comptroller and Auditor General, in October to December 2025.

Appendix Two

Summary of Recommendations, Work planned that should be prioritised and Area for consideration

R1 Review and document a clear governance map for the Health Insurance Fund including all existing and planned boards, groups and committees. In doing so, seek to eliminate duplication and inefficiency and ensure interdependencies between the various groups are documented, understood and can operate effectively.

R2 Review Government representation on the Pharmaceutical Benefit Advisory Committee to ensure it aligns with the statutory requirements.

R3 Prepare and implement a formal policy statement specifying the minimum balance to be held in the Health Insurance Fund.

R4 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.

R5 Update procedures for States propositions and Ministerial Decisions to ensure that any future expenditure changes proposed are supported by business cases which demonstrate good practice characteristics in documenting the resource and system implications. This should include consideration of the long-term impact on States' finances and specific funds.

R6 Review all fees published by GP practices to ensure accuracy and consistency in all cases where the Health Insurance Fund benefit is quoted.

R7 Review all fees published by all GP practices to ensure that the Health Insurance Fund benefit is appropriately applied to relevant services.

R8 Carry out a post-implementation review of the GP initiatives package to identify outcomes and assess value for money.

R9 Review the Pharmacy Quality Improvement Framework programme to ensure that it provides appropriate incentives based on continuous improvements.

R10 Undertake an exercise to assess the true cost of dispensing prescribed items.

R11 Use data from current initiatives to develop additional measures to address the risk of waste and over prescribing.

R12 Carry out a post-implementation review of the pharmacy package of initiatives in liaison with pharmacists in order to refine the current package and deliver change.

R13 Develop a consolidated user guide for all Health Insurance Fund subsidised services for patients and providers.

Work planned that should be prioritised

P1 Review the management charge to the Health Insurance Fund at the time of next full review to ensure that all utilised resources are included in the charge.

P2 Review options to minimise weaknesses and risks within the current Employment, Social Security and Housing Department's benefits systems as part of the Transform project.

P3 Introduce a programme of audits of practices by the Primary Care Governance team to ensure consistency and compliance in interpreting Health Insurance Fund and Jersey Quality Improvement Framework guidance.

P4 Prepare a detailed plan to introduce the EMIS IT system into community pharmacies.

Area for consideration

A1 Consider developing a joint audit programme using staff from the Employment, Social Security and Housing Department together with the Primary Care Governance Team and with the Pharmaceutical Adviser.

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