HFMA briefing
December 2023

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Considering health inequalities in business cases

Introduction

The Healthcare Financial Management Association (HFMA) is working on a range of outputs to help finance staff to support their organisations and systems to reduce health inequalities.

This briefing builds on previous outputs focusing on the finance role in reducing health inequalities,[1] establishing the case for change,[2] the funding available,[3] and examples of good practice within finance teams.[4] This briefing goes further by considering how the impact on health inequalities should be included in business cases to help organisations to make informed decisions.

Business cases set out the rationale for change, the available options and the financial implications. This is an important part of making the case for change.

All investment decisions within the NHS will have an impact on health inequalities. This may be intentional through a service change designed to address known access or outcome differences in a given population. Or the impact on health inequalities can be an unintended consequence. If not considered explicitly in the business case, the impact may not become apparent until the investment has been made and the change enacted, potentially having an adverse effect on local inequality.

This briefing looks at practical ways in which business cases can consider health inequalities. It draws on a number of sources to demonstrate how the impact of health inequalities can be quantified and discusses how to bring health inequalities into the narrative of the business case. It also suggests questions that people can ask themselves to ensure they have considered health inequalities in all the relevant sections of their business case.

Including consideration of health inequalities in a business case

Post-pandemic, there is a clear expectation that the NHS should improve services to help address the inequalities people face in terms of access to healthcare, experience of healthcare and health outcomes. To reflect this, integrated care boards (ICBs) have a legal duty to work to reduce health inequalities, as set out in *Health and Care Act 2022*.[5]

As part of their legal duty on health inequalities, many ICBs are taking a population health management approach which aims to understand the drivers of ill-health and inequalities and shift the focus from reactive care to proactive, preventative care. ICBs have built teams who can use local intelligence and evidence bases and tools such as impactability modelling to assess the impact of different interventions. System partners can draw on this expertise when developing their business cases, and should work closely with colleagues in population health management, public health and data analytics.

NHS England recognises the importance of strong business cases, requiring major projects such as those that are part of the new hospital programme to follow HM Treasury *Better business case* guidance.[6] It offers *Better business case* training in-house and provides further guidance on the specifics of the NHS England business case process.[7] Smaller projects which are approved at a local level have more flexibility in terms of process, but nonetheless will benefit from applying some of the key principles of the business case guidance.

This briefing draws on several sources looking at how business cases should be constructed, what they should include, and how they should be evaluated. However, it must be noted that many of these guidance documents and tools were developed prior to the pandemic and do not explicitly

[1] HFMA, *The role of the NHS finance function in addressing health inequalities*, July 2021
[2] HFMA, *Health inequalities: establishing the case for change*, May 2023
[3] HFMA, *Resources and funding to reduce health inequalities*, July 2023
[4] HFMA, *How finance teams are helping to reduce health inequalities*, September 2023
[5] Legislation.gov.uk, *Health and Care Act 2022*, April 2022
[6] HM Treasury, *Guide to developing the project business case*, 2018
[7] NHS England, *Business case approval process*

describe how they link to the health inequalities agenda, or how health inequalities can be considered within them. This briefing seeks to rectify that.

Systems will need to decide locally what information and weighting will be given to health inequalities to ensure consistency of approach. This will help them to compare interventions and make decisions on what to prioritise.

Changing the concept of value

Key to changing the way that business cases are assessed is widening the concept of value. It is essential that all investments demonstrate value for money so that taxpayers' resources are used well; this becomes even more important in a time of limited resources. In response to operational pressures, the assessment of value for money in the NHS often focuses on short-term savings ('will savings be made in year that equal or exceed the investment?'). However, it's important that we also consider the longer-term value that that investment could create across the whole of the public sector, especially given changes in population and population need.

The green book, published by HM Treasury, sets out that wider social value should be included in the evaluation of publicly funded projects.[8] It recognises, for example, that an objective of a project could be 'ethical distribution', such as fair access to health. It also gives the example of a hospital expansion, saying that an assessment of value should go beyond the individual organisation to consider the wider impact on the local health economy. Of particular interest when considering health inequalities, is a section on 'distributional appraisal' which gives advice on how the impact on different sections of the population should be considered. For health inequalities, it can be important to consider value over a long period of time. *The green book* suggests 60 years as a standard appraisal period for major health projects, but gives the example of a vaccination programme for which benefits should be assessed beyond the standard 60 year timeframe.

The appraisal of public sector investment already has a structure which allows for the inclusion of health inequalities as a factor, but this is not widely recognised in NHS business cases. This is partly due to the pressing need to make financial savings, and partly due to the technical challenges of measuring the value of improvements to health inequalities. It is essential that NHS organisations widen their definition of value to better serve their populations, and this may mean using new tools and techniques to measure value, details of which are included later in this briefing.

This changed view of value is the golden thread throughout the following sections, which set out what needs to be included in a robust and comprehensive business case.

Key components of a good business case

HM Treasury's *Better business case* guidance describes how business cases should be developed in the public sector. According to this guidance, public sector organisations should structure their business cases around a five case model, which breaks each business case down into five dimensions: the strategic case, the economic case, the commercial case, the financial case and the management case. NHS England requires business cases for national funding, such as the new hospital programme, to adhere to this structure. While local investment decisions may not need such a lengthy business case, using the five case model can ensure that all aspects of the investment have been considered.

This section considers each of the five dimensions of a business case, what should be included on health inequalities and what questions should be asked when reviewing the business case.

The strategic case

The purpose of the strategic dimension of the business case is to make the case for change and to demonstrate how it provides strategic fit. For NHS organisations this means demonstrating how the project fits with the organisation's objectives and, where relevant, the aims of the wider integrated

[8] HM Treasury, *The green book: central government guidance on appraisal and evaluation,* 2022

care system (ICS) and NHS. The strategic case should also demonstrate how the project fits with other activities being undertaken within the organisation and ICS.

When considering the strategic case, it is important to be aware that NHS organisations have statutory duties on health inequalities. According to the *Health and Care Act* 2022, integrated care boards (ICBs) must work to reduce inequalities of access and outcomes, while NHS trusts and foundation trusts must consider the effect that their decisions have on health inequalities.[5] As such, all business cases within a system should look at how they contribute to this aim.

A key document for organisations to refer to is the their ICB's joint forward plan, which sets out how the NHS organisations in the local system will support the local integrated care strategy.[9] This is a five-year plan that ICBs were first required to publish by the end of June 2023, and which they should review and update every year. It ties back to the statutory duty to reduce health inequalities and gives clear objectives that can be used in the development of business cases, to support the strategic case.

To support the joint forward plan, many NHS organisations have developed their own strategy and objectives to tackle inequalities. These may be referenced in the system's health inequalities action plan which outlines each partner's specific deliverables and can be added as part of the NHS standard contract. A business case developed within an individual trust should first link to its own strategy and objectives on health inequalities, with an onward discussion around how that links to wider system objectives.

Questions to consider for the strategic case

- Has an explicit link been made between the planned investment and the organisation's objectives?
- Has an explicit link been made between the planned investment and the ICS's health inequalities strategy or joint forward plan or health inequalities action plan?
- Are there other projects within the organisation or ICS which have similar aims or are focused on the same population segment, where work should be aligned?

The economic case

The purpose of the economic dimension of the business case is to identify the proposal that delivers best public value to society, including wider social and environmental effects. HM Treasury guidance states that all options should be set out and analysed, including the option of doing nothing.

As with all business case guidance reviewed for this briefing, value is defined in terms of value for money, with an expectation that a cost benefit analysis or cost effectiveness analysis is carried out for each option. Larger business cases for national funding, such as the new hospital programme, will need to use the comprehensive investment appraisal (CIA) model,[10] but for local investment decisions organisations can choose their own approach. HM Treasury identifies that one of the challenges for the economic case is measuring and monetising the benefits and risks.

Improvements to health inequalities have a broad impact, can bring significant benefits to society and as such form a significant part of the economic case. This section considers how reducing health inequalities can feed into project benefits. It uses The King's Fund definitions of what return on investment means for public health to give some structure to a vast area for consideration.[11] The King's Fund splits return on investment into three categories: cashable savings, utilisation reduction, and value of other outputs. Each category should be considered for each option, including the option of doing nothing.

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[9] NHS England, *Guidance on the preparation of integrated care strategies*, July 2022
[10] Department of Health and Social Care, *Comprehensive investment appraisal model and guidance*, updated December 2019
[11] The King's Fund, *Talking about the 'return on investment of public health'*, April 2018

Cashable savings

Cashable savings provide organisations with direct financial savings that help reduce cost. This might be because fewer staff are needed to provide the same service, because fewer drugs and equipment are needed, or because an organisation is able to secure additional income. HM Treasury refers to these savings as 'cash-releasing benefits' and most NHS trusts would choose to recognise them as cost improvement programme (CIP) savings.

Traditionally, NHS organisations have focused on cashable savings when considering whether a business case should be approved. While cashable savings are not usually the primary purpose of a health inequalities project, there are examples where these projects can have a positive financial impact.

In a recent article in the HFMA's *Healthcare Finance* magazine,[12]Professor Bola Owolabi, director of healthcare inequalities at NHS England, described how inequalities can impact prescribing costs. NHS Business Services Authority carried out an analysis to compare prescribing patterns between the most deprived and the most affluent groups across three clinical areas – mental health, respiratory, and cardiovascular. In respiratory it was found that fewer preventer inhalers but more rescue inhalers were being prescribed to people in the more deprived quintile.[13] With fewer preventer inhaler prescriptions correlating with higher mortality, there is a clear human cost to this inequality. But there is also a financial cost to the extra rescue inhalers.

Finding the cashable savings will require delving into the detail of current behaviour to identify what will change through a new approach to the service or condition. However, this will also support the understanding of the costs of doing nothing. In the example above, ongoing increased prescribing costs would have a direct impact on the financial position of the system.

Population health management methods such as impactability modelling can help to identify cashable savings. Impactability modelling uses actuarial techniques to look at the degree to which different sub-populations will benefit from a range of interventions and recommend options which will maximise value. These techniques are not widely used in the NHS in-house, but are sometimes used by consultancy firms offering advice to the NHS and are regularly used in insurance-based systems abroad. A detailed briefing is available from the Institute and Faculty of Actuaries,[14] and an introductory webinar from the HFMA.[15]

Utilisation reduction

Utilisation reduction reduces the demand pressure on public services but is not directly cashable as financial savings. This could be for example if fewer people needed to be admitted to hospital, but it was not possible to close a ward or a bay. It could be that fewer appointments were needed, but it was not possible to cancel a clinic. Or it could be that changes saved staff time on administrative tasks, but it was not possible to reduce the number of staff. HM Treasury would classify utilisation reduction as a 'monetisable but non-cash releasing benefit'.

Sometimes projects enable significant utilisation reduction, but this does not result in cashable savings because gaps are quickly filled by other demands. This is particularly the case in the context of increased demand from a growing and aging population, where more people are living with multiple and complex needs. It is important that the 'do nothing' option of a business case includes expected growth in demand and that other options are measured against this. A project might usefully temper growing demand rather than reducing it from the current day.

The example of rescue inhalers given above also links to the assessment of utilisation reduction. While the cost of inhalers provides a cashable saving, reduced admissions if people's underlying condition were managed effectively would result in utilisation reduction. If fewer people were admitted with COPD this would reduce demand at A&E departments and inpatient wards (bearing in mind that COPD accounts for around one in eight emergency admissions[14]). It is unlikely that capacity could be

[12] Healthcare Finance, *The finance case for tackling inequality*, June 2023
[13] NHS Business Services Authority, *Healthcare Inequalities: Access to NHS prescribing and exemption schemes in England*, January 2023
[14] Institute and Faculty of Actuaries, *Impactability modelling for population health management*, June 2020
[15] HFMA, *Population health management: An introduction to impactability modelling*, July 2021

taken out, either by reducing the number of A&E staff or reducing the number of inpatient beds. Nonetheless, the utilisation reduction should be measured and monetised as it's valuable to the NHS in freeing up time and space to meet other demands.

Reducing the number of people who do not attend appointments is another way in which work to tackle health inequalities might result in utilisation reduction. Many NHS trusts have analysed their data on missed appointments and found a link to health inequalities, with people not attending due to a range of barriers to access including language barriers, shift patterns that prevent attendance or not being able to afford childcare. Initiatives have addressed these issues by changing clinic times, providing transport and providing communication in additional languages, and have reduced the number of people who do not attend their appointments.[16] Business cases for such initiatives can point to the expected drop in missed appointments and quantify the resource that would have been wasted, recognising improvements as utilisation reduction.

The economic case should consider the longer-term impacts of utilisation reduction and not just the short-term. This is an area where the NHS often struggles, due to the short-term nature of targets and funding. For instance, decisions to expand community diagnostic capacity were driven largely by political motivation to address waiting lists, through expanding the numbers of tests that could be carried out outside of an acute setting. However, there will also be a long-term benefit to identifying conditions early, reducing the need for emergency admissions and the more intensive treatments that are required when conditions are identified at a late stage.

The longer-term impacts of utilisation reduction will often link into the strategic case. A business case which was looking to reduce childhood obesity in Dorset could, for instance, refer to NHS Dorset's joint forward plan, which explains that one of NHS Dorset's areas of focus is to prevent 55,000 children from becoming overweight by 2040 (see **example 1**). The detail of the joint forward plan flags utilisation reduction as a benefit, explaining that achieving this aim will reduce obesity-related disease, tempering future demand for healthcare services.

Properly quantifying the 'do nothing' option is an essential part of seeing the longer-term view. This means factoring in demographic change and expected growth in demand rather than baselining to the current year. In turn, this exposes the risk of doing nothing and can justify investment as a means of managing and mitigating against future avoidable increases in demand.

[16] A case study is included on this in the HFMA's recent briefing on HFMA on *How finance teams are helping to reduce health inequalities*

Example 1: Extract from NHS Dorset's joint forward plan on why it's important to prevent 55,000 children from becoming overweight by 2040

Why it's important

On average, in Dorset three out of ten 11-year-old children are overweight. In our most deprived areas this number will be even higher.

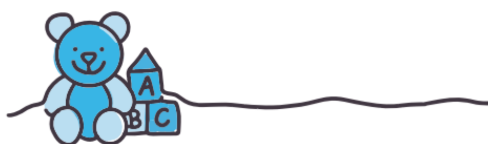
If nothing is done, nationally about 40% of 11-year-olds will be overweight by 2040. Obesity in children can have serious and long-term consequences on their physical health, mental health, and overall quality of life.

Why it is important to prevent obesity in children:

1. **Physical health:** being overweight means you are more likely to develop diseases such as type 2 diabetes, high blood pressure, heart disease, stroke, and certain types of cancer in adulthood. Being overweight or obese can have serious consequences on a child's health and wellbeing.
2. **Mental health:** children who are overweight are more likely to have depression, anxiety, and other mental health problems. They may also face bullying and unfair treatment, which can affect their mental health.
3. **Social and emotional wellbeing:** children may struggle with self-esteem and body image issues, which can affect their social and emotional wellbeing. They may also have difficulty taking part in physical activities and social events, which can lead to isolation and loneliness.
4. **Academic performance:** obesity has been linked to poor academic performance. A range of things such as stigma, physical activity and school absence can affect a child's ability to concentrate and learn.
5. **Long-term consequences:** children who are overweight or obese are more likely to become obese adults, which can lead to more health problems and a shorter lifespan. Preventing obesity in children is crucial for their overall health and wellbeing. It can help them lead healthier and happier lives, both now and in the future.

In Dorset we are determined to do everything possible to prevent children from experiencing the serious and lifelong consequences of obesity. This will need us to make a long-term commitment with all our partners including NHS, local authorities, and the voluntary and community sector, as well as businesses.

We will need to improve the health and wellbeing of parents to be and families to support children in the first 1,000 days of their life and to work across both health services and in early years, pre-schools and schools.



Source: NHS Dorset, *Joint forward plan 2023-2028*, 2023

Value of other outputs

Other outputs (aside from cashable savings and utilisation reduction) look at the wider value to society beyond the NHS. This could be for instance people living for more years in better health.[17] It could be people being able to access work or perform better in education. Or it could be environmental benefits such as reduced carbon emissions or improved air quality. HM Treasury refers to these outputs as 'wider benefits to UK society' and explains that they should be monetised wherever possible so that they can be included in the cost-benefit analysis that supports the economic case.

Building on previous examples:

- changing the prescribing approach to COPD in more deprived areas could reduce mortality and help people to live for more years in better health and improve their ability to work
- community diagnostic facilities in town centres could improve access for people facing health inequalities, enabling early diagnosis which helps the live more years in better health
- addressing childhood obesity in Dorset could improve children's emotional wellbeing and improve their academic performance, which is a known social determinant of health.

Considering health inequalities specifically, there is a clear link to the work of Sir Michael Marmot and the Institute of Health Equity, who estimated that productivity losses due to inequality in illness totalled £31-33 billion per year, with lost tax revenue and higher welfare payments of £20-32 billion per year.[18]

[17] Improving healthy life expectancy is a key part of the government's Levelling Up agenda. See Department for Levelling Up, Housing and Communities, *Levelling Up the United Kingdom*, February 2022
[18] Institute of Health Equity, *Fair society, healthy lives*, February 2010

Calculations on the value of other outputs will never be exact, whether on a large scale such as in the work of the Institute of Health Equity, or on a smaller scale such as in an individual business case. The Institute of Health Equity used proxy measures, such as tax revenue and welfare payments, to indicate the impact of health inequalities. Likewise, NHS staff writing local business cases will need to find relevant proxy measures to value other outputs.

Detailed methodological guidance is available in supplementary guidance to *The green book*, including sections on valuing health, wellbeing and environmental factors.[19] More general guidance on financial proxies is available from the Cabinet Office,[20] and some worked-through examples from Greater Manchester are available from HM Treasury.[21] The HFMA has also published a directory of useful resources which can enable finance staff to locate relevant facts and figures to support this part of the business case, linking to specific regions or health issues.[22]

Questions to consider for the economic case

- Have cashable savings been identified? If not, are they required?
- Has utilisation reduction been considered?
- Has the impact of doing nothing been considered? As part of this, has demographic change and growth in demand been modelled into the longer-term?
- Has the value of other outputs been evaluated? Has wider social value been quantified using proxy measures?
- What tools and modelling techniques have been used to assess wider and longer-term value?

The commercial case

The purpose of the commercial dimension of the business case is to demonstrate that the preferred option will result in a viable procurement and a well-structured deal between the public sector and its service providers. Much of this is not directly relevant to health inequalities. However, recent work has stressed the importance of the NHS as an 'anchor institution' (see **exhibit 1**).[23] Through this lens, the procurement choices made in the commercial case can help to make a difference to local socio-economic inequality. Suppliers might for instance be expected to add social value by offering apprenticeships or employing local people who were long-term unemployed.

Under the Public Services (Social Value) Act 2012, local authority commissioners are required to consider social value when awarding public service contracts and consider the social impact before starting the procurement process. The knowledge of how to do this will exist in each ICS and can be shared through partnership working around procurement processes. NHS England has also produced a step-by-step guide on how to apply the government's Social Value Model to NHS procurement.[24]

While the question should always be asked around whether there is a commercial aspect to the project, in many cases, the commercial dimension will not be applicable.

The upcoming HFMA briefing on commissioning approaches to support reducing health inequalities, explains further how the new provider selection regime and other proposed changes to procurement rules will support this.

Questions to consider for the commercial case

- If items or services are being purchased, is there an opportunity to address inequalities or deliver social value through procurement and contracting?

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[19] HM Treasury, *The green book and accompanying guidance and documents*, updated September 2023
[20] UK Cabinet Office, *A guide to social return on investment,* 2012 (see pages 45-52)
[21] UK Government, *Supporting public service transformation: cost benefit analysis guidance for local partnerships*, April 2014
[22] HFMA, *Health inequalities data sources map*, November 2022
[23] The Health Foundation, *The NHS as an anchor institution*, 2019
[24] NHS England, *Applying net zero and social value in the procurement of NHS goods and services*, March 2022

Exhibit 1: What makes the NHS an anchor institution?

What makes the NHS an anchor institution?

NHS organisations are rooted in their communities. Through its size and scale, the NHS can positively contribute to local areas in many ways beyond providing health care. The NHS can make a difference to local people by:

Purchasing more locally and for social benefit
In England alone, the NHS spends £27bn every year on goods and services.

Using buildings and spaces to support communities
The NHS occupies 8,253 sites across England on 6,500 hectares of land.

Working more closely with local partners
The NHS can learn from others, spread good ideas and model civic responsibility.

Widening access to quality work
The NHS is the UK's biggest employer, with 1.6 million staff.

Reducing its environmental impact
The NHS is responsible for 40% of the public sector's carbon footprint.

As an anchor institution, the NHS influences the health and wellbeing of communities simply by being there. But by choosing to invest in and work with others locally and responsibly, the NHS can have an even greater impact on the wider factors that make us healthy.

References available at www.health.org.uk/anchor-institutions

© 2019 The Health Foundation.

Source: The Health Foundation, *The NHS as an anchor institution*, 2019

The financial case

The purpose of the financial dimension of the business case is to demonstrate the affordability and funding of the preferred option, including the support of stakeholders and customers, as required. This is an essential part of the business case which gets into the nuts and bolts of the proposal, setting out the capital and revenue consequences of the project throughout its lifetime. Health inequalities will not however always be relevant to the financial case.

Where the economic case identified cashable savings (including any that relate to health inequalities), these should feed through to the financial case. They should be set out annually, with any assumptions used to calculate the savings clearly stated. A range of assumptions may be needed to enable those assessing the business case to be assured of the level of risk being accepted.

Because health inequalities have a wide impact, projects to address them will sometimes bring in multiple partners and more complex funding arrangements. Where this is the case, all partners will need to commit to funding and risk sharing arrangements as part of the financial case.

Questions to consider for the financial case

- Have cashable savings been factored into the financial case? Are they robust and justified with assumptions clearly stated?
- If funding is coming from multiple partners, can all partners guarantee funding for the length of their commitment?

The management case

The purpose of the management dimension of the business case is to demonstrate that robust arrangements are in place for the delivery, monitoring and evaluation of the scheme, including feedback into the organisation's strategic planning cycle.

The management case must consider who is affected by the project and set out how they will be engaged and how they can feed their views in. It is important that this includes any wider public sector stakeholders and system partners which were identified as part of the strategic case. All projects should consider health inequalities, not only those that specifically set out to address inequalities. As such, project teams should seek to involve stakeholders representing vulnerable or seldom heard population groups, particularly if they have identified there is a risk that their project could exacerbate health inequalities.

Patient voice is also a key part of this work, and it is important to consider how to include people from seldom-heard groups. Patients can share their insight and knowledge of the service, bringing out wider links, implications and stakeholders that may not be immediately obvious. NHS England has produced guidance on how the NHS can better engage with 'inclusion health groups' who are socially-excluded and at greater risk of poor health.[25]

The management case includes evaluation of the project, which should be set out at the beginning, so that the correct data is collected during the work. On health inequalities, project teams could consider using a Health Equity Assessment Tool which helps them to determine and track their impact.[26] The process of defining what success will look like and how it will be measured helps to inform the design of the project and ensures that success is measurable and not purely anecdotal. Part of the challenge of developing business cases that address health inequalities is that much of the evidence for interventions is anecdotal, meaning that the business cases fail when presented beside others with more traditional robust, quantifiable data. It can help to tie the evaluation back to the benefits identified in the economic case.

Evaluation should not be a one-off process that takes place shortly after the work has been implemented. For all healthcare investments, and particularly for those that impact health inequalities, outcomes can be longer term and circumstances that existed when the work was devised, may have changed. It is therefore important to revisit projects in the years after their implementation to understand if they are still having the expected impact. Disinvestment and ending a project should always be an option, if circumstances have changed such that it is no longer a good use of resources, even if it was initially effective.

The UK Government has published guidance on how to design and carry out effective evaluations of publicly funded projects in *The magenta book.*[27]

Questions to consider for the management case

- Is it clear who the stakeholders are and how they will be involved?
- Are the views of patients or service users a key part of all stages of the project?
- Is there a clear and achievable evaluation methodology which ensures that success is measurable and not purely anecdotal?
- Is there a commitment to review the outcome of the project after it has been embedded as business as usual?

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[25] NHS England, *A national framework for NHS action on inclusion health,* October 2023
[26] Public Health England, Health Equity Assessment Tool, updated May 2021
[27] UK Government, *The magenta book*, April 2020

Conclusions

Business cases are a key means by which NHS organisations make investment decisions. And ICBs, NHS trusts and NHS foundation trusts each have a statutory duty to consider the impact of their decisions on health inequalities. This briefing considers practical ways in which to bring these two things together, helping NHS organisations to factor the impact of health inequalities into their decisions.

From the five case model, the most crucial places where health inequalities should be included are in the strategic case and the economic case. The strategic case should explain how the project fits with the organisation and system's objectives, which should link back to the statutory duty of ICBs to reduce health inequalities. The economic case then quantifies public value to society, which should be taken in its broadest sense to include cashable savings, utilisation reduction and value of other outputs. Improvements to health inequalities have a broad impact, can bring significant benefits to society, and as such should form a significant part of the economic case.

It is also important that both system partners and user lived experience are included as part of the management case, bringing a richer insight on a project's impact on health inequalities.

The appraisal of public sector investment already has a structure which allows for the inclusion of health inequalities as a factor, but this is not widely recognised in NHS business cases. This is in part due to the pressing need to make financial savings, and in part due to the technical difficulties of measuring the value of improvements to health inequalities. It is essential that NHS organisations widen their definition of value to better serve their populations. This may mean using new tools and techniques to measure value, developing modelling skills in financial and analytic teams, and sharing learning across local systems and the wider NHS.

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

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