HFMA briefing
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# Resources and funding to reduce health inequalities

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# Introduction

The HFMA is working on a range of briefings, tools and online learning modules on health inequalities. The outputs are designed to equip NHS finance staff with relevant knowledge and tools to support their organisations in reducing health inequalities. This work builds on existing HFMA resources including *The role of the NHS finance function in addressing health inequalities*[1], the *Health inequalities data sources map*[2] designed to signpost individuals to different resources available about health inequalities, and a briefing supporting NHS finance staff to develop their local case for change[3].

This briefing is aimed at NHS finance and non-finance professionals within integrated care boards (ICBs) and their partners. It sets out the resources and funds available that could support the reduction of health inequalities.

Reducing health inequalities is one of the main priorities of the *NHS long-term plan*[4] and is highlighted in each year's planning guidance. The *Health and Care Act 2022*[5] (the Act) includes specific ICB obligations regarding inequalities and new provisions on inequalities information for ICBs, trusts and foundation trusts. However, explaining what funding is currently available for health inequalities is not an easy task, given the way funding is allocated to systems, programmes, arm's length bodies and so on. It is particularly difficult given the financial regime changes brought about by the Covid-19 pandemic and the Act. In addition, releasing this resource can also be complex. This paper attempts to identify, simplify and summarise some of the potential sources of current funding and the flexibilities available as well as some of the challenges to be addressed by ICBs.

In very general terms, each ICB's programme funding is based on its prior year funding, adjusted for factors such as boundary or policy changes. A baseline growth is then applied which is then adjusted for convergence. Over time, the convergence factor moves each ICB towards its target allocation. The target share is set using a national formula. Some resources are ringfenced for certain uses, for example the better care fund and the mental health investment standard (MHIS). In addition, there are in year service development funds (SDF) from national budgets for specific health programmes. From these funds, a proportion is expected to be used for certain purposes. For the majority of the allocation ICBs have flexibility to distribute the funds in line with locally identified plans or population health management priorities for specific programme areas. These areas of funding will be looked at in turn through the lens of health inequalities.

It is important to note that addressing health inequalities in outcomes, experience and access is one of the four core aims of an ICB. Therefore, the entirety of ICB and system funding (and cost) should be focused on reducing health inequalities. Reducing inequalities is an essential part of reducing unwarranted variation in outcomes and costs. This principle was set out in the HFMA's briefing on establishing the case for change. Furthermore, the Hewitt review[6] suggests the direction of travel for ICBs around the increased focus on health prevention and the changes needed.

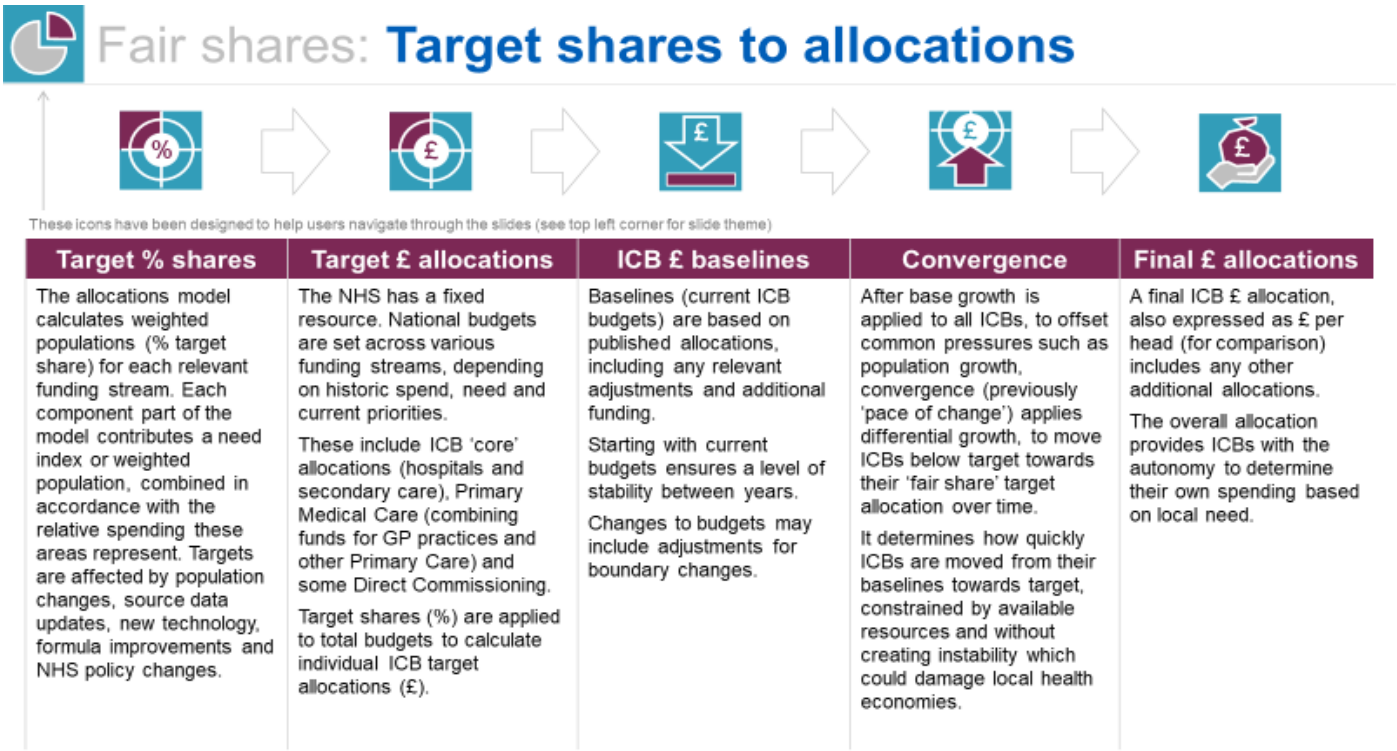
This briefing is not intended to be a detailed explanation of the allocation of funds in the NHS, but rather a summary of the health inequalities funding and resources available and the potential challenges.

[1] HFMA, *The role of the finance function in addressing health inequalities*, June 2021
[2] HFMA, *Health inequalities data sources map*, November 2022
[3] HFMA, *Health inequalities: establishing the case for change*, May 2023
[4] NHS England, *The NHS long term plan*, January 2019
[5] UK Government, *Health and Care Act 2022,* April 2022
[6] Rt Hon Patricia Hewitt, *The Hewitt review: an independent review of integrated care systems,* April 2023

# Resource allocations within the funding formula for ICBs

The allocation of funding to ICBs, with which they commission services for their local population, is one of the key duties of NHS England. According to NHS England planning guidance[7] the principles at the heart of the approach to setting allocations are ensuring equal opportunity of access for equal need and contributing to the reduction in health inequalities that are amenable to healthcare. The approach to allocations is informed by NHS England's duty to have regard to the need to reduce inequalities between patients with respect to their ability to access services and the outcomes they achieve. These two aims are reflected in the allocations weighted capitation target formula, which produces a target share percentage, or fair share, for each area, based on a complex assessment of factors which according to NHS England[8] includes sex, age, morbidity, rates of disability, excess deaths and deprivation, plus wide factors associated with health needs including housing status and unemployment. Consequently, more resources are directed to areas estimated to have higher health needs, or where health inequalities can be reduced by providing health services – larger populations, more older people and higher levels of deprivation. Additional funds also support services delivered in high-cost areas, due to the cost of staff and buildings, or unavoidable costs, for example, due to remoteness. Target shares are then applied to national budgets to calculate ICB target allocations. Target shares are also available at practice level, which ICBs may wish to use to create shares for places, but target allocations (the monetary value) are only calculated for ICBs. Actual allocations are based on applying growth each year to each of the components in the baseline to move towards the target. The level of growth is set according to a convergence policy which determines how quickly ICBs move from their baselines towards target over time without creating instability, ensuring that each ICB is no more than 5% below target. Convergence ensures that those ICBs over target, perhaps because their GP registrations (population) have fallen or have less health need, still receive a minimum level of growth each year for each stream within the formulae to support stability and medium-term planning. A summary is shown in Figure 1.

**Figure 1: Target shares to allocations**




Source: NHS England

[7] NHS England, *2023/24 planning guidance*, December 2023
[8] NHS England, *Fair Shares: a guide to NHS allocations*, May 2023

Further infographics explaining NHS allocations[9] have been recently updated by NHS England.

The body responsible for overseeing and recommending updates to the fair shares formula is called the Advisory Committee for Resource Allocation (ACRA). ACRA is an independent, expert, technical committee made up of academics, GPs, NHS managers and public health experts. ACRA's role is to develop and make evidence-based recommendations on the approach taken to estimating the relative need for healthcare resources for different populations, based on the characteristics of those people and the evidence for how their characteristics are associated with future need for healthcare. These relative needs are designed to support the allocation of resources in a way that supports equal opportunity of access for equal need and contribute to the reduction of health inequalities that are amenable to healthcare[10].

The different funding formula models for core services (consisting of general and acute services, community, maternity, prescribing and mental health), primary care and specialised healthcare include different measures and population characteristics to assess relative needs. Each component of the allocation formula is based on statistical modelling that examines the association between the utilisation of health services on the one hand, and the characteristics of individual patients and the areas where they live on the other hand. These models are used to decide which factors to include in the formula to predict future need per head and the relative weight on each of the factors. The formulae also include supply characteristics that might influence the utilisation of services. The impact of these is removed before the model is implemented.

Currently 10.2% of the ICB core allocations and 15% of the primary medical core allocations are also targeted using a health inequalities and unmet need adjustment based on age-standardised avoidable mortality. This adjustment recognises and targets additional funding at the most challenged areas with high rates of avoidable mortality and adjusts where perhaps there is unmet need due to lower access to services by certain population groups. For example, if they aware of a health problem but have not or cannot access a GP. Overall, this ensures that the allocations are as accurate as possible in predicting future relative need.

**Age-standardised avoidable mortality**
Avoidable mortality (deaths) are defined as deaths which were either preventable or treatable.
The age-standardised ratio is a weighted-average of the age-specific mortality rates using the proportions of people in the corresponding age groups.
The rate provides a comparable measure of mortality between populations and so inequality, as preventable deaths tend to be linked to inequality of health outcomes or access to care.

Annex G of the planning guidance for 2023/24 details the specific health inequalities adjustment to target shares for ICBs for 2023/24 and 2024/25.[11] The £200m funding in 2022/23 through the health inequalities adjustment has been made recurrent and is in ICB 2023/24 baselines. The funding is intended to help systems to ensure that health inequalities are not exacerbated when they are seeking cost savings post pandemic or delivering required efficiencies. It is also intended to support the implementation of the Core20PLUS5 approach outlined in the *2023/24 priorities and operational planning guidance*[12] and inclusive elective waiting list recovery. NHS England expects the funding to be directed towards the services and populations facing the largest inequalities in access, experience and outcomes with local flexibility to target the funding where it is most needed to narrow the healthcare inequalities gap.

One of the challenges is that baseline allocations are used to fund legally binding contracts. Therefore, it may be hard to shift resources from one service area or organisation to another, without pump priming for prevention, especially given the current financial challenges. Systems with a larger convergence adjustment, or that have more financial risk, may find it more difficult to switch

[9] NHS England, *Fair Shares: a guide to NHS allocations*, May 2023
[10] NHS England, *Update of the formula for general and acute hospital services for 2022/23 allocations,* April 2022
[11] NHS England, *2023/24 planning guidance – annex G*, December 2023
[12] NHS England, *2023/24 priorities and operational planning guidance*, December 2023

significant resources recurrently into prevention at the moment. In addition, there can be a time lag between investment and return, especially where the investment is addressing unmet need. So, it is important for partners to understand the overall growth in system funding through allocations received and the reasons why and how this relates to the overall costs of the services provided for their local population and how to minimise and manage the financial risks associated with such a move so as not to destabilise providers.

An ACRA review[13] suggested further developments of the health inequalities adjustment including:

- improving data, methods, and measures
- a review into how mental health (including learning disability and autism) information is captured
- the impact of a project on unmet need, funded by the National Institute for Health and Care Research (NIHR), which may result in improvements in how adjustments for unmet need are made
- relative size of adjustment and ability to address health inequalities
- increased transparency of the health inequalities adjustment to ICBs.

The guidance does not tell ICBs how to transfer resources or how effective those transfers have been in meeting need. This gives ICBs autonomy, which is in line with the Hewitt review[14] recommendations. There would need to be some tracking mechanism by ICBs of where resource has been moved from and to, as well as tracking the impact over time using alternative techniques. The difficulty will be in identifying and allocating resource differently to better reflect opportunities to reduce health inequalities for targeted populations utilising updated techniques. This will be explored in further stages of the HFMA's health inequalities work, with examples of best practice.

## Place-based allocation tool

NHS England has produced a place-based allocations tool that can be used to break down the target allocation to a more local level.[15]

This tool is designed to help ICBs looking to allocate budgets at place or service level, including targeting resources to reducing inequalities. It allows the user to aggregate GP practices into defined areas or places and calculates the weighted populations and relative need for these defined areas. The tool provides insight into the lower-level data that informs the overall allocations to ICBs by providing information on the variation in need between different areas within ICBs.

Distribution methodologies within ICBs are still under debate and can be subject to local sensitivities around historic funding levels and investment and informed by local datasets and insight. Providing the tool for 2024/25 as well as 2023/24 allows time for sufficient consultation and agreement of partners on the approach to take. The HFMA is working on case studies to show how some ICBs have redistributed resources to reduce health inequalities.

# Other sources of funds

## Service development funding

Service development funding (SDF) from separate national Department of Health and Social Care (DHSC) programmes is allocated annually. It is split into discretionary and non-discretionary funds and can be recurrent or non-recurrent, additional or included in baselines depending on the programme. In addition to the health inequalities allocation included in baselines described above, ICBs can look to target their fair share of discretionary SDF funds to address health inequalities priorities locally.

[13] ACRA, *Review of the health inequalities adjustment to the CCG funding formulae*, April 2022
[14] Rt Hon Patricia Hewitt, *The Hewitt review: an independent review of integrated care systems*, April 2023
[15] NHS England, *ICB place based allocation tool 2023/24 and 2024/25*, January 2023

The challenges here include the perceived fairness of ICB distribution methods to places where some might receive less than their fair share due to different start points and outcomes achieved. Factors for consideration in distributing to places could include:

- investment history
- perceived relative efficiency and progress
- availability and complexity of information to support distribution calculations
- late notifications of SDF allocations as well as finance staff understanding of the programmes
- distribution methods
- relative health inequalities
- finance staff capacity to do the work in time for setting ICB and place budgets.

Each ICB will have an agreement on the approach to the distribution of system resources, including SDF. It may be helpful if the approach to using SDF to better support health inequalities is debated and included in ICBs' financial strategies.

NHS England's national healthcare inequalities improvement programme is working with national programme leads to ensure that these monies are used effectively to support reducing health inequalities in their programme areas. Each national programme will clarify requirements with ICBs where they expect reductions in health inequalities to be achieved. In addition, co-ordination between national programmes and earlier notification of funding to ICBs will aid more aligned and focused plans, better value and greater likelihood of delivering outcomes to reduce health inequalities.

For example, community diagnostic centres[16] are intended to increase access closer to people's homes allowing issues to be picked up and treated earlier. In cancer diagnosis and treatment, for example, there is lower uptake of screening in some protected groups, and this means cancer diagnoses can happen at a later stage and result in a worse prognosis. Therefore, improving access should also improve outcomes for these groups. The Glassworks Diagnostic Centre in Barnsley is a good example of providing more convenient access and additional capacity for the local population. Other examples include the Falmer Community Stadium, home of Brighton and Hove Albion Football Club. Several health initiatives at sports grounds have encouraged take up by men less likely to access health services in traditional settings for blood pressure checks and so on.

## Mental health investment standard

The mental health investment standard (MHIS) is a requirement to grow resources from ICB allocations to support improvements in mental health care, rather than additional resource. However, it could be argued that the MHIS is an attempt to protect resources, which if focused on specific cohorts using appropriate population health management techniques upstream could improve health inequalities.

In addition, given the integration of physical and mental health and potential impact on primary and secondary care of poor mental health, the challenge is coordinating numerous investment plans and pathways across sectors and alliances for maximum benefit and value.

## NHS England digital funding

NHS England sees investment in technology as key to delivering the *NHS long-term plan*. Funding from NHS England (previously NHS Digital) is available to ICBs. These resources are allocated separately to the ICB allocation, based on national priorities for agreed investment plans and business cases. System partners need to be aware of the governance, plans and processes for these to take full advantage. The challenge is ensuring sufficient investment in this area at system and place level to make a real difference to health inequalities as an enabler of change. This may be especially difficult in an integrated care system that is in deficit, over target allocation and a legacy of multiple organisations with different IT systems, processes and planned priorities. Digital investment, alignment of data sets and improved digital access should release system efficiencies over time and business cases could better reflect these, as well as improvements in health inequalities to ensure

[16] Department of Health and Social Care, *40 community diagnostic centres launching across England,* October 2021

prioritisation against limited resources. Any savings could be re-invested in reducing health inequalities in the longer term.

## Academic health science networks including MedTech funding mandate

The 15 academic health science networks (AHSNs) bring together the NHS, industry, academic, third sector and local organisations and work closely with ICBs on developing improvement approaches.

The AHSN Network and NHS England's NHS innovation accelerator[17] may be able to provide free advice or funding to support high impact innovative pilot schemes within NHS and social care or help spread innovation and improvement at pace and scale, to create better outcomes for patients and the public. They are also a critical delivery partner for the accelerated access pathway helping to identify local NHS needs and enabling evaluations.

The MedTech funding mandate is delivered by AHSNs in partnership with the NHS. It is designed to accelerate the uptake of innovative medical devices, diagnostics and digital products. The approved technologies within it have been shown to deliver a return on investment within three years, with implementation funding within ICB baselines. Some of these technologies directly impact health inequalities for example, pre-eclampsia is more prevalent in certain ethnic minority groups so placental growth factor testing can directly address inequalities in maternity care.

AHSNs are also currently supporting partners on improving birth outcomes across ethnic minority populations.[18]

## Other primary care

The allocations formula is explained in the first section. There are also contracts for national and local enhanced services and incentive schemes which can support the local reduction of health inequalities. In addition, national pump priming partial funding has been provided to invest in a range of additional roles through the reimbursement scheme (ARRS). For example, social prescribing link workers in practices who can help signpost people to relevant services locally, including the third sector, as well as health and wellbeing coaches and care co-ordinators. Many of these additional roles to support personalised care could impact on outcomes for underserved groups through access to appropriate services and there are many good examples of this nationally.

## Funding to NHS trusts

NHS England and ICBs have duties to reduce inequalities between people with respect to their ability to access health services and the outcomes achieved by the provision of health services.

NHS trusts have a duty under the Act to reduce health inequalities in partnership with NHS England and ICBs. In support of those legal duties, additional information is required to be produced and operational planning guidance has required that trust board performance packs are expected to be disaggregated by deprivation and ethnicity to help focus on actionable insights for improvement activity.

Trusts can use a number of approaches and funding streams to tackle health inequalities in the populations that they support. Health inequalities create inefficiencies, therefore costing and value programmes to reduce variation can be also support this work. Wider programmes that involve other partners and look across the system, can support the ICS's financial envelope through improved pathway costs.

Elective recovery funding is expected to be used in a way that allows more inclusive access and waiting list reduction, this has the potential to help galvanise a focus on health inequalities in trusts'

[17] https://nhsaccelerator.com
[18] The AHSN Network, *Six ways AHSNs are supporting safer maternity care for black and Asian families*, November 2022

operating models. Some trusts have used accelerator funding to help reduce did not attend or was not brought patients focusing on, for example, deprived groups.

Charitable funds held by trusts for the benefit of patients, depending on the purpose they have been given for, could be used to improve health inequalities, for example, transport or legal advice to improve access to services.

It is essential that trusts are part of the wider system plan to reduce health inequalities, as set out in the NHS standard contract, potentially with an additional incentive to do so through CQUIN payments or the variable element of the aligned payment and incentive approach. ICBs need to ensure that organisational plans are part of a blended system plan and strategy and held to account to maximise outcomes and value for prioritised groups.

## Better care funds and section 75 agreements

According to the Marmot review[19], 80% of the wider determinants of health are outside of the direct remit of the NHS. ICBs' integration agendas could involve joint investment plans utilising or adding to section 75 agreements. This might be particularly relevant to public health prevention ideas including healthy lifestyles and access to wider local services.

**Section 75 agreement**
Section 75 of the *NHS Act 2006* allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services.

Additional funding for social care increases following the green paper[20] and research into unmet need, should in theory, release more of this resource to support work to reduce health inequalities. The future of the better care fund is still under review. The challenge is that this resource may be supporting existing social and community care spend and contracts, so will need to be maintained in some form. At the very least, ICBs will want to review and improve outcomes, access and value added to reduce health inequalities from this ringfenced resource. Utilising the latest population health management approaches, insights and targeting scarce resource could support delivery of this.

The Hewitt review [21] which considered how integrated care works, highlighted the need to focus on promoting health rather than the treatment of illness and called for the share of total NHS budgets at ICS level going towards prevention to be increased by at least 1% over the next five years. The review also considered the future direction of travel for section 75 agreements, recommending the acceleration of their expansion into previously excluded functions (such as the full range of primary care services) and simplification of the supporting regulations. However, the government has rejected some of the recommendations of the review.

Some ICBs may already have invested over and above the minimum required for the better care fund in a section 75 agreement to improve outcomes and influence the wider determinants of health and social care. Some areas have gone further in terms of devolved government funding, for example Greater Manchester, which in theory should create more opportunities for cross working on reducing health inequalities by removing financial barriers and maximising value across the public sector.

## Non-NHS funding

Several areas within local authority budgets may support reducing health inequalities including public health grants. Funds have also been allocated to local councils for more research around health inequalities.[22] It would be useful for links to be made between this and future ICB health inequality financial plans. In addition, there are several supporting programmes and resources within

[19] Sir Michael Marmot, *Fair society, healthy lives (The Marmot review)*, February 2010
[20] HM Government, *People at the heart of care: adult social care reform*, December 2021
[21] Rt Hon Patricia Hewitt, *The Hewitt review: an independent review of integrated care systems*, April 2023
[22] HM Government, *£50m to tackle health inequalities through research*, October 2022

government that could be used innovatively, such as back to work programmes, housing support funds and levelling up funds (as demonstrated in the *Changing futures* programme[23]).

There are also a number of cross government funded grants for research pilots and evaluation that support reducing health inequalities. For example, the drug strategy innovation fund including £5m to reduce recreational drug use[24] led by the National Institute for Health and Care Research (NIHR).

Universities also have access to research funding which may help in supporting implementing and evaluation of research evidence. For example, the University of Plymouth provided matched funding for researchers in residence [25] to review integrated personalised care in partnership with Devon ICS. These sorts of initiatives may further support the funding case for specific projects especially around multifactorial interventions.

The NHS may be able to supplement funding for integration and reducing health inequalities with social impact bonds.[26] Social investors are interested in schemes that have a wider impact on society for a rate of return. Social Finance is a non-profit organisation and provides help with finance (including social impact bonds and other social investment), strategy, design, data and building partnerships to tackle complex and enduring social issues. It works with the NHS and other provider and third sector organisations to support the development of outcomes-based services. Funding available includes the Macmillan Fund for End of Life Care. It is working in partnership with IPS Grow[27] to help people find work to aid recovery and support the expansion of individual placement and support (IPS) services. IPS Grow has developed national standards and guidelines and provided technical support and resources to IPS service providers. They work with a range of employment specialists, mental health experts and academics to support people with severe mental illness to find or stay in employment. This supports the NHS long-term plan goals and produced promising results.[28]

At place level, third sector bodies including community and faith groups, may be able to bid for grants or provide support from various sources including the private sector, to support prevention programmes and reducing health inequalities. This is particularly the case where it has a social impact and stimulates local economies. For example, healthy living centres, dementia friendly support groups and cafes, befriending and bereavement support, carer support, outdoors activities to improve mental health, social cohesion and so on.

Responsible employers in the private sector have in the past part funded health programmes for their employees in partnership with health and charitable organisations, where health access may have been an issue. ICBs and places may want to work with local partners to review some of these programmes, re-establish links with the private sector and attempt to expand the range of private sector funded workplace health programmes focusing on issues such as weight management, smoking cessation and mental health.

# Conclusion

This briefing has identified some of the potential sources of funding for reducing health inequalities. Simplifying these funding sources and aligning them with the reducing health inequalities agenda will help organisations to pursue this work.

Overall, there is a clear national expectation that better health value will be obtained from these different resources, as well as cost and variation reduced in order to impact on health inequalities locally. Finance staff have a key role in:

- providing financial leadership and vision
- championing this agenda
- understanding health inequalities and explaining the funding available

[23] Department for Levelling Up, Housing and Communities, Changing futures website, last updated July 2021
[24] NIHR, *£5 million innovation fund to reduce recreational drug use*, March 2023
[25] Health Anchors Learning Network, *University and care systems partnership: Researcher-in-residence*
[26] HFMA webinar, *Using social investment to support system priorities and drive outcomes*, May 2021
[27] *Story of IPS Grow - IPS Grow*
[28] Social Finance, *Our impact and learning: IPS service transformation across England*, 2021

- addressing some of the challenges of identifying and releasing resources
- combining data sets to identify variation across populations
- working with clinicians and managers across the system to improve outcomes and reduce the cost of avoidable mortality
- helping navigate complex, uncoordinated funding systems and rules in order to shift resource to where it is most needed.

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# About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For nearly 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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