HFMA briefing
January 2024

Using financial incentives to tackle health inequalities

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 explores how the NHS can use financial incentives to reduce health inequalities. It summarises the financial incentives that currently exist at a national level, and looks at opportunities for individual systems to use financial incentives at a local level. The briefing builds on previous publications focusing on the role of finance in reducing health inequalities,[1] establishing the case for change,[2] the funding available,[3] business cases[4] and examples of good practice within finance teams.[5]

We focus mainly on organisational incentives, by which we mean incentives that encourage organisations to tackle health inequalities. Many parts of the NHS also use personal incentives, which encourage individuals to act in ways which will benefit their own health, for instance by quitting smoking or losing weight. We touch on these personal incentives only briefly.

Where relevant, we consider how incentives support NHS England's Core20PLUS5 approach on health inequalities. This is a national approach which provides structure and directs ICBs on which areas they might prioritise in order to have the greatest impact. In the approach:

- 'Core20' refers to the most deprived 20% of the population.
- 'PLUS' refers to population groups identified at a local level as facing health inequalities.
- '5' refers to key clinical areas requiring accelerated improvement.

Core20PLUS5 identifies the key clinical areas of health inequalities among adults as: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension case finding.[6] And among children and young people, it identifies the key areas as: asthma, diabetes, epilepsy, oral health, and mental health.[7]

Using financial incentives

The NHS has long used financial incentives to drive organisational behaviour, and more recently has started using them to tackle health inequalities. The NHS is transitioning towards a population health management approach, as set out in the *NHS five year forward view* [8] and the *NHS long term plan*,[9] and we have learned more about health equity and the social determinants of health. The Covid-19 pandemic brought health inequalities firmly into the public eye and the *Health and Care Act 2022* includes a legal duty for integrated care boards (ICBs) to work to reduce them.[10] It is in this context that NHS finance professionals are reviewing financial incentives to see if they can better help reduce health inequalities.

While some financial incentives already exist at a national level, we would encourage ICBs to consider how they can further incentivise organisations in their system to tackle health inequalities. Part of this will be in encouraging people to work across organisational boundaries. With some providers this could mean building further incentives into the NHS standard contract, and with others it could mean arranging to share the risks and rewards of targeted interventions. In all cases, the ICB

[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, *Considering health inequalities in business cases*, December 2023
[5] HFMA, *How finance teams are helping to reduce health inequalities*, September 2023
[6] NHS England, *Core20PLUS5 (adults) – an approach to reducing healthcare inequalities*, 2021
[7] NHS England, *Core20PLUS5 – an approach to reducing health inequalities for children and young people*, 2021
[8] NHS England, *NHS five year forward view*, October 2014
[9] NHS England, *NHS long term plan*, January 2019
[10] Legislation.gov.uk, *Health and Care Act 2022*, April 2022

is well-placed to use local data and insights to focus incentives on the people within their population who experience the greatest health inequalities.

Key principles

Financial incentives have disadvantages as well as advantages, as shown in **Table 1**. ICBs can manage the disadvantages in part by careful design, and in part by balancing the financial incentives with other measures. Financial incentives should be considered as one tool of many, not to be used in isolation but as part of a wider change programme.

Table 1: Advantages and disadvantages of financial incentives

Advantages	Disadvantages
Financial incentives can: • generate extra value and a good return on investment • engender loyalty and commitment to an objective or programme • provide feedback and reinforcement on achieving shared goals • be relatively simple to design and implement • be financially small but still have an impact • be readily supplemented with non-financial rewards as a package • be changed over time as people, organisations or relationships mature • be successful if they are part of an overall change programme that empowers people and rewards co-operation and collective achievement of joint goals.	Financial incentives can: • result in short-term compliance only • be administered unfairly or inconsistently • result in people gaming the system to gain reward without achieving the underlying aims of the incentive • cause conflict and competition for resource • remove people's autonomy in decision-making and leave them feeling controlled • result in unintended consequences, for instance skewing or diminishing performance, or reducing honesty • waste time and money if designed and implemented badly • overcomplicate tasks, leading to poor outcomes • crowd out other goals and motivations if people focus only on paid activities.

Incentives work best if they are simple, predictable, and use a clear evidence base and outcomes. They must recognise people's complex motivations and be designed to avoid the pitfalls set out in **Table 1**. Ideally, incentives should be based on achievement of collective outcomes and objectives.

National incentives

There are incentives built into national payment mechanisms which help to address health inequalities. Some of the national incentives target the key clinical areas set out in NHS England's Core20PLUS5 approach, while others focus on other areas of health inequality. Several of these incentives are under review, and may be paused, replaced or changed significantly in the next 12 months. NHS England is consulting on the investment and impact fund (IIF), the quality and outcomes framework (QOF), and commissioning for quality and innovation (CQUIN) in early 2024.

Investment and impact fund (IIF)

The IIF supports primary care networks to deliver high quality care and meet the objectives of the *NHS long term plan*.[6] Prevention and tackling health inequalities has been a key focus of the IIF from its launch in 2020/21, incentivising primary care networks to take a proactive approach to prevention for groups at risk of poor health outcomes.

Rules and guidance are set each year by NHS England and the scheme is overseen at a local level by integrated care systems.[11] The IIF has five clinical indicators in 2023/24, which are worth £59m and intended to fund workforce expansion and services in primary care.[12] The theory behind the IIF is that primary care networks should benefit from 'shared savings' across the system, for instance when their work helps to reduce avoidable A&E attendances and emergency admissions. In 2023/24, in line with Core20PLUS5, there is an indicator on early cancer diagnosis (specifically on faecal immunochemical testing to guide referrals for lower-gastrointestinal cancers). And beyond Core20PLUS5, there is a health inequalities indicator on learning disability health checks.

NHS England is currently consulting on the IIF, and the incentive may change depending on the results of the consultation. The outcome is not clear at this stage, but questions look at whether incentives could be flexed at a local level, whether there should be more focus on managing long-term conditions (including multiple, complex long-term conditions), and whether to incentivise continuity of care and patient choice.[13]

Quality and outcomes framework (QOF)

The QOF is a general practice incentive scheme which rewards practices for their performance against a set of national indicators that are designed to improve patient outcomes and quality of care.

The QOF is a voluntary part of the general medical services contract, but most practices choose to take part, receiving around 8% of their annual income from the QOF.[14] In 2023/24 there are 76 indicators relating to clinical care, public health and quality improvement.[15] Supporting Core20PLUS5, this includes indicators on:

- physical checks for people with severe mental illness
- reviews and referrals for people with chronic respiratory disease
- blood pressure and lipid management to help people with hypertension
- asthma reviews, testing, and records of young patients' smoking status or exposure to second-hand smoke
- people newly-diagnosed with diabetes being referred to a structured education programme.

Beyond Core20PLUS5, the QOF includes indicators on smoking, obesity, vaccination and immunisations, which can help to address health inequalities through prevention.

NHS England is consulting on the QOF alongside the IIF, so again there is scope for this incentive to change. The consultation asks the same questions on the QOF as on the IIF, but of significance for the QOF, it asks if NHS England should shift the incentives so they apply to bigger populations. They could be applied for instance at a primary care network or place level rather than at a practice level.[15]

Commissioning for quality and innovation (CQUIN)

Commissioning for quality and innovation (CQUIN) is an incentive scheme which rewards NHS trusts for improving the quality of their services. It is intended to drive transformational change which can help reduce health inequalities.

Currently, CQUIN is a mandatory part of the standard NHS contract.[16] It is worth 1.25% of the fixed value of each contract and the expected value of any variable element relating to elective activity. To be eligible for the full CQUIN payment, providers must perform well against their CQUIN indicators.

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[11] NHS England, *A five-year framework for GP contract reform to implement The NHS long term plan*, January 2019

[12] NHS England, *Investment and impact fund 2023/24: guidance*, April 2023. The IIF also funds a capacity and access payment, which is worth £246m and requires primary care networks to improve the experience of patients contacting their GP and receiving an appropriate response or assessment.

[13] NHS England, *Role of incentive schemes in general practice*, December 2023

[14] NHS England, *Report of the review of the quality and outcomes framework in England*, July 2018

[15] NHS England, *Quality and outcomes framework guidance for 2023/24*, March 2023. Since 2020/21, and to support the ongoing response to Covid-19, NHS England has applied payment protection to parts of the QOF. Practices are guaranteed payment on these indicators, whether they reach target or not. In 2023/24, payment protection applies to 19 indicators which require practices to maintain registers of patients with specific diseases.

[16] NHS England, *Commissioning for Quality and Innovation (CQUIN): 2023/24 guidance*, updated May 2023

For each contract, commissioners choose five indicators, weighting each one equally (i.e. at 0.25%). Nationally, there are 17 indicators which commissioners can choose from. Linked to Core20PLUS5, there is an indicator on reducing the use of restrictive practices in mental health settings, and another on complying with timed diagnostic pathways for cancer services. There is also an indicator on treatment for hepatitis C, which while outside of Core20PLUS5, could help to address health inequalities.

NHS England is however consulting on whether it should pause CQUIN while it reviews its incentive schemes. Providers would continue to receive the 1.25% CQUIN payment, but this would be given regardless of performance. In addition, NHS England would continue to publish CQUIN indicators as a non-mandatory list that commissioners and providers may choose to use for local prices and reporting. More information on local prices is included under 'adapting the NHS standard contract' on page 6 of this briefing. Depending on the results of the consultation, CQUIN could be paused from April 2024.[17]

Pharmacy quality scheme (PQS)

The pharmacy quality scheme (PQS) rewards community pharmacies for improving clinical effectiveness, patient safety and patient experience. It is intended to support the *NHS long term plan* and includes elements that link to health inequalities.

PQS is part of the community pharmacy contractual framework and is worth £45m in 2023/24.[18] Pharmacies report their performance against quality domains set by NHS England in order to claim a share of the fund. Quality domains on respiratory health, for instance to check people's inhaler technique, align well to the Core20PLUS5 focus on chronic respiratory disease and asthma.

Maternity incentive scheme (MIS)

NHS Resolution offers a maternity incentive scheme to support the delivery of safer maternity care. The focus on maternity is primarily because of the catastrophic and life-changing impact that obstetric incidents can have, and because they make up NHS Resolution's biggest area of spend. It is, however, also important to health inequalities, with maternity being a key element of NHS England's Core20PLUS5 approach.

The maternity incentive scheme is priced into NHS Resolution's clinical negligence scheme for trusts (CNST). Trusts are charged an additional 10% on their maternity contribution into the CNST. They can then claim this back if they can demonstrate that they've met 10 safety actions which are specified in the incentive scheme. An interim evaluation of the scheme suggested that the scheme was successful in increasing the number of trusts achieving all 10 safety actions since the scheme started.[19]

Future developments

The incentive schemes summarised above generally undergo annual reviews, where indicators are added or taken away, and these provide an opportunity to further encourage work on health inequalities. The IIF, QOF and CQUIN are currently subject to more rigorous review, with consultations underway in early 2024. This is in line with a recommendation in the Hewitt Review that NHS England reviews its payment models and incentives to enable better outcomes.

> *'NHS England should work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSs, drawing upon international examples as well as local best practice, to identify most effective payment models to incentivise and enable better outcomes and significantly improve productivity.'*
>
> The Hewitt Review[20]

[17] NHS England, *Consultation: Proposed amendments to the 2023/25 NHS Payment Scheme*, December 2023
[18] NHS England, *Pharmacy quality scheme guidance 2023/24*, June 2023
[19] NHS Resolution, *Maternity incentive scheme: an interim evaluation,* April 2020
[20] Department of Health and Social Care, *The Hewitt Review: an independent review of integrated care systems*, April 2023

Table 2: Coverage of national incentives against the key clinical areas in the Core20PLUS5 approach

	Key clinical area	IIF	QOF	CQUIN	PQS	MIS
Adults	Maternity					✓
	Severe mental illness		✓	✓		
	Chronic respiratory disease		✓		✓	
	Early cancer diagnosis	✓		✓		
	Hypertension case finding		✓			
Children and young people	Asthma		✓		✓	
	Diabetes		✓			
	Epilepsy					
	Oral health					
	Mental health					

Local incentives

Being aware of national incentives and how they help to tackle health inequalities will help ICBs to spot gaps where they might want to add their own local incentives. As shown in **Table 2,** the national incentives touch on all five clinical areas of focus within the Core20PLUS5 approach for adults, and two of the five areas of focus for children and young people (with nothing on epilepsy, oral health or mental health). There are also no national incentives on health disparities, meaning that organisations are not financially incentivised to target seldom-heard groups who experience some of the worst health inequalities.

ICBs may also choose to use incentives to tackle issues which are specific to their local population. This is the 'PLUS' element of the Core20PLUS approach, where ICBs target groups within their population who have poorer-than average health access, experience or outcomes but are not included in the national priorities.

Adapting the NHS standard contract

Commissioners must use the NHS standard contract for all healthcare contracts except for primary care. There is flexibility within the contract for ICBs to work in incentives on health inequalities.

The contract includes an optional section on health inequalities, which can be used to drive incentives if they are added as locally-agreed adjustments on price. The relevant sections of the NHS standard contract are schedule 2N (health inequalities action plan) and schedule 3C (local prices).[21]

Schedule 2N (health inequalities action plan) gives guidance on how providers and commissioners can work together to make better use of data on health inequalities, as well as how they can engage with communities. ICBs can use it to agree actions and timescales, how to monitor progress and how to measure outcomes. This should provide some key milestones and data points which can be used for incentives.

Schedule 3C (local prices) allows providers and commissioners to agree local adjustments on price, with approval from NHS England. It is not possible for ICBs to apply sanctions (reducing the prices) but it is possible for them to add incentives (increasing the prices) based on how providers perform against agreed goals. This enables them to build a local 'pay for performance' regime, which could focus on health inequalities.

[21] NHS England, *2023/24 NHS Standard Contract*

An HFMA case study on the Bolton quality contract gives an example where the NHS standard contract has been adapted to incentivise improvements to health inequalities.[22]

Making health inequalities part of the decision-making process

ICBs can help guide the work of organisations across their system by making health inequalities an explicit part of their decision-making process. The easiest place to apply this is in the business case process, and the HFMA has published a briefing to help people produce and review business cases that better explore the impact projects have on health inequalities.[4]

In the current financial climate, additional funding is limited. But when ICBs are able to invite providers to apply for discretionary revenue or capital funding, they can stress the importance of projects addressing health inequalities. Given ICBs' statutory duty on health inequalities, this can apply to all available funds, and not just those which were set up specifically to improve health inequalities. ICBs can use the business case process to build an incentive – asking for more information on what impact a project will have on health inequalities and giving health inequalities a greater weight in the decision.

ICBs can also be explicit about prioritising health inequalities as part of their existing funding streams. This might be, for instance, by setting targets or key performance indicators which focus attention on health inequalities. Where providers receive national incentive payments, they can use them to target particular groups, and ICBs can encourage them to do so. For instance, Devon Partnership NHS Trust used CQUIN funding to improve the psychological and practical support available to people with learning disabilities and mental health problems, reducing A&E attendances and saving more than £300,000 over two years, mainly for their neighbouring acute trust.[23]

Sharing risks and rewards

Another approach ICBs can consider is setting up arrangements where organisations share the risks and rewards of success. This is particularly appropriate when one organisation would bear most of the costs of improving a patient pathway, but another would take most of the benefits. For instance, if primary care providers increase the uptake of cancer screening and more cancers are diagnosed early, it's likely to benefit the local NHS trust because it no longer needs to treat as many complex late-stage cancers.

There are several different mechanisms by which organisations can share risks and rewards. Some of the national incentives seek to do this, such as the IIF, which rewards primary care networks in anticipation of 'shared savings' across the system (from the impact of their work in reducing A&E attendances and emergency admissions). At a local level, ICBs might also consider using section 75 arrangements (pooled budgets) or alliance contracting.

Section 75 of the NHS Act 2006 sets out the arrangements for pooled budgets between NHS bodies and local authorities, and is the route through which the better care fund is delivered.[24] When organisations pool budgets across a service or a pathway, they have a clear structure through which to share the risks and rewards of success. Section 75 arrangements can be administratively complex and are currently only available to NHS bodies and local authorities. However, the Department for Health and Social Care is currently considering ways to simplify the arrangements, and whether section 75 should be extended to a wider range of organisations.[25]

Alternatively, ICBs could use alliance contracting to set up a shared contractual arrangement with an alliance of providers who work across a service or pathway. This includes a risk share across all parties, with risks and rewards based on overall performance rather than the performance of individual organisations. An example where this has been used is the Lambeth Living Well Collaborative, through which commissioners, mental health and social care providers work to improve the mental health and wellbeing of the people of Lambeth. A shared goal can drive improvement, innovation and change.[26]

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[22] HFMA, *Health inequalities case study: Bolton quality contract*, January 2024
[23] NHS Providers, *Providers deliver: Dorset Partnership NHS Trust*, July 2020
[24] Legislation.gov.uk, National Health Service Act 2006
[25] DHSC, *Review of section 75 arrangements: supporting document* (September 2023)
[26] Lambeth Together, *About the Living Well Network Alliance*

Setting up local prescribing incentive schemes

Some ICBs have set up their own local incentive schemes, often at a place level and often focusing on prescribing. One example is Cheshire and Merseyside ICB, which has recognised a specific challenge in Halton (one of its places) regarding the use of opioid and other high-dependency drugs among populations in its more deprived wards. In response, the ICB has further developed its quality incentive scheme to target reductions in the number of patients from these wards either entering or continuing on that particular medication track, by influencing changes in prescribing practices and incentivising providers to proactively support people who are overly-dependent on opioid pain medications. Other opportunities where local incentives could help address health inequalities include improved prescribing for people experiencing homelessness,[27] and prescribing for those at high risk of pre-eclampsia from black and ethnic minority groups.[28]

Other incentives

While we have focused on organisational incentives, there is also a growing body of evidence on personal incentives and the impact they can have on health inequalities. Most personal incentives will relate to preventative and public health, for instance rewarding people for eating better and exercising more, encouraging mothers to breastfeed, or giving money for people to keep their houses warm. NHS finance staff are often asked to help support these initiatives.

NHS organisations will also want to consider their role as 'anchor institutions' – large institutions which are unlikely to move and have a significant impact on their local area. Through procurement, NHS organisations can incentivise suppliers to act in ways that address social determinants of health. Suppliers might, for instance, be expected to add social value by offering apprenticeships or employing local people who are long-term unemployed. To help with this, NHS England has produced a step-by-step guide on how to apply the government's social value model to NHS procurement.[29]

Advice on implementing incentives

Based on a review of the literature and case study examples, we would suggest that ICBs take the following steps before implementing incentives:

- **Do your research**. Review any research, rationale, evidence base, ethics and efficacy, pilots, best practice, guidance, evaluations or recommendations, support and resources/tools available prior to design or implementation.
- **Identify the intended outcomes and the incentive to be used**. Specify the desired outcomes required to be achieved by whom as specifically as possible, the standards/KPIs to be applied and the period they will be achieved over and the groups to be targeted. Identify what type of incentive to be used and why.
- **Specify how the incentive scheme will work**. This includes the principles and rules underpinning the scheme, what it is applied to and when, and the expected benefits.
- **Consider the contractual basis**. What type of contract will be used? Will it be the NHS standard contract for providers? What is expected to be delivered and in what context? Will there be any potential penalties, risks or consequences of non-compliance? Will there be an appeals process?
- **Consult and engage with key stakeholders.** Communicate the overall change programme's aims, the reasons for doing it, the evidence base and goals. Stakeholders need to understand how the scheme is intended to improve behaviours or access, and who it will apply to. Depending on the scheme, ICBs may want to work with people and communities from the outset to coproduce and design incentives.

[27] BMC Public Health, *Protocol for a pilot randomised controlled trial to evaluate integrated support from pharmacist independent prescriber and third sector worker for people experiencing homelessness,* February 2023
[28] PubMed (American Journal Perinatol), *Understanding health disparities in preeclampsia*, February 2023
[29] NHS England, *Applying net zero and social value in the procurement of NHS goods and services*, March 2022

- **Understand the finances.** Estimate the cost of the scheme and budget for it. Calculate the expected return on investment and identify how it will be used. Understand the nature of potential payments, fixed or variable elements, any weightings to be used, as well as any financial limits or sliding scales to be used for partial achievement. How will any financial risk or gain sharing arrangements work?
- **Consider your partners**. How will any partnership arrangements work for research, investment, delivery, scaling or evaluation? Will there be any necessary additional processes, rules or requirements, for example, procurement, contractual, legal and taxation.
- **Understand if the incentive is working.** How is performance to be measured? What data or evidence will be used? What monitoring systems and processes will be in place? Will there be any data rules? How will unintended consequences be monitored, reported and dealt with?
- **Learn the lessons**. How will continuous improvement methodologies and processes be taken into account? Is there a post implementation review timeline? Will there be an independent evaluation?
- **Be flexible**. Flexibility is important to develop the incentive scheme over time as data, systems and relationships mature and priorities change.
- **Ensure appropriate governance arrangements are in place**. What financial governance, audit and risk assurance processes are in place? What governance policies will apply?

Conclusions

Finance staff have a key role in ensuring financial incentives are designed effectively and form part of a wider financial strategy to reduce health inequalities. Financial incentives should be considered as one tool of many, not to be used in isolation but as part of a wider change programme. They work best when they are simple, predictable, use a clear evidence base and are designed to avoid the pitfalls.

Some financial incentives are already built in at a national level, including CQUIN, QOF, the IIF and the PQS, though several of these are under review. At a local level, ICBs can look to adapt the NHS standard contract to include local incentives, or they can look for other ways that organisations can share the risks and rewards of success across a care pathway. With local data and insights, ICBs are well-placed to focus incentives on the people within their population who experience the greatest health inequalities.

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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