



Government
Actuary's
Department

Report by the Government Actuary on the Health Insurance Fund as at 31 December 2021

May 2023

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To:

Deputy Elaine Millar, Minister for Social Security of the States of Jersey

I am pleased to present my report on the financial condition of the Health Insurance Fund of the States of Jersey and the adequacy or otherwise of the contributions payable.

Article 22(1) of the Health Insurance (Jersey) Law 1967 requires the actuary appointed by the Minister to review the operation of the Law at intervals not exceeding five years and to report to the Minister on the financial condition of the Health Insurance Fund and on the adequacy or otherwise of the contributions payable under the Law to support the prescribed benefits. I have been appointed by the Minister to carry out the review as at 31st December 2021 and I submit the following report setting out my findings.



Martin Clarke

Government Actuary (United Kingdom)

May 2023

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1 Executive summary

1.1 As required by Article 22 of the Health Insurance (Jersey) Law 1967 (“the Law”), this report is the latest review of the Health Insurance Fund (the “HIF” or “the Fund”), which has been carried out as at 31st December 2021, by the Government Actuary’s Department (“GAD” or “we”) on the instruction of the Government of Jersey (“Jersey” or “the client”), and includes projections of the Fund over the period from 2021 to 2041.

1.2 This report sets out GAD’s opinion of:

- the financial position of the HIF taking into account changes in legislation and experience since the previous review
- possible future levels of expenditure from the HIF and the contribution rates required to finance this expenditure
- the adequacy or otherwise of contributions payable to the Fund to support benefits payable from the Fund
- the future balance in the HIF, which is available to meet its expenditure and help smooth any increase in the required rate of contributions.

1.3 The structure of the report is as follows:

- Principal projections of the HIF using principal assumptions
- Change in the Fund since the 31 December 2017 review
- Sensitivity of the principal projections to changes in key assumptions
- Appendices covering underlying data and assumptions, and calculation methodology

Overall conclusions

1.4 The Fund balance at 31 December 2021 is £100m. This is compared to a balance of £93m at 31 December 2017. The improvement in the balance is less than was projected in our 2017 review. This is mainly due to unanticipated payments out of the Fund for Covid-19 support, the Jersey Care Model and Digital Care Strategy programme, and increased spending on contracted healthcare services - offset by lower than expected costs on pharmaceutical services.

1.5 The Fund balance as a multiple of primary care expenditure has been stable at around 3 times annual expenditure in the last 4 years.

1.6 The Fund is projected to decline over the 20 year projection period, in current earnings terms, and be exhausted by around 2037-2041 (depending on migration experience in Jersey), a few years later than was projected in our 2017 review. This is principally due to current contribution rates being lower than projected expenditure from the Fund year to year.

1.7 Results are shown in “real earnings” terms, meaning that the effects of future average earnings growth is taken out of future figures. This is a change from the 2017 approach when results were in cash terms, and is to provide more consistency with the review of the Social Security Fund.

- 1.8 Due to the short time horizon for the Fund, any unexpected changes such as a change in Government policy regarding the use of HIF funds, or sudden unexpected calls on the Fund, are more influential than factors such as Jersey's demographic forecasts, and could materially change the exhaustion date of the Fund.
- 1.9 There has been a change to the Fund investment strategy since 2017. The expectation of further future disinvestments for Jersey strategic projects resulted in a shift of all growth assets into low-risk liquid assets. Future investment returns are expected to be lower than at the last review, which all else being equal, would cause the Fund balance to reduce faster.

Inter-valuation experience

- 1.10 2017 to 2021 was an unusual period for the Fund as it encompassed the Covid-19 pandemic and Government response to it. The Government enforced "lockdowns" of the pandemic reduced the contribution-paying workforce, and the Government introduced temporary relief on social security contributions as a support to individuals (although the rate paid to the HIF did not change). The net result is that income to the Fund over the period is lower than otherwise would have been expected.
- 1.11 Meanwhile, increased demand for healthcare and costs associated with the Covid pandemic increased calls on the HIF. A £5.3m payment to support Covid-19 costs was made in 2020.
- 1.12 In general, investment performance was better than expected, and the investment return on the Fund over the period was estimated to be 4.8% p.a.
- 1.13 Following the review date, inflation increased significantly in Jersey. Expectation that this continues in the short term flows through to assumptions for inflation and earnings in the next few years. Our assumptions factor this in, by setting assumptions up to 2026 in line with forecasts from the Jersey Fiscal Policy Panel. There were further changes to Government policy affecting the HIF over the period, including
- Introduction of the Jersey Care Model and Digital Care Strategy in the 2021-24 Government Plan, which was set up to be funded by the HIF
 - The subsequent review of the Jersey Care Model and Digital Care Strategy at the end of 2022, which meant that the HIF funding for this project was limited to a total of £6.3m.
 - Increased use of contracted healthcare services (provided by GP surgeries and pharmacies), funded by the HIF such as the Health Access Scheme, cervical screening services, influenza vaccination programmes and a diabetic supplies scheme
- 1.14 These policies are detailed further in Appendix C.

Post review events

- 1.15 In preparing this review, we have allowed for events and relevant information which would be materially relevant to the results of our projections, and which could be included in a timely way.

- 1.16 We note the following developments in the last few months have not been captured within our calculations.
- The Minister for Social Security announced a £12 million investment in community pharmacies to be made over the next three to four years (from 2023), funded from the HIF. This may bring forward the Fund's exhaustion date by a number of years.
 - The States Assembly agreed to earmark £0.8m in 2023 for GP services for children under the age of 18.
 - The Jersey Fiscal Policy Panel released its March 2023 report, with updated economic assumptions. If we were to use the updated assumptions, we do not expect our key conclusions of the review would be materially different.

Sensitivity of results to key assumptions

- 1.17 Section 4 illustrates the sensitivity of the projection to key assumptions, to show alternative plausible outcomes if the principal assumptions made are not borne out in practice. The most sensitive assumptions are benefit costs which have a material impact on Fund outgo.
- 1.18 The number of prescriptions per GP visit¹ has increased at a rate of over 4% p.a. since our 2012 review (and has been increasing at 4.6% p.a. since 2017). We expect that this rate is unsustainable in the long term and so we have assumed 2.5% p.a. future increases in our principal results, and a lower variant assumption of 1% p.a. in section 4. As pharmaceutical costs are the largest expenditure of the Fund, this gives a variance in Fund exhaustion date of between 2038 (for 2.5% increases) and later than 2041 (for 1% increases). We also look at ingredient prices rising by 2% p.a. above earning increases, which would give an exhaustion rate around 2035.
- 1.19 We expect the low-risk investment strategy to feature lower volatility compared to the strategy in place at 2017 review and any variations in investment returns to have limited impact on the future Fund level.
- 1.20 Given the nature of the benefits paid out of the Fund, and the projection period considered, changes in the mortality assumption are not expected to have a material impact on the future experience of the Fund.

Professional standards and limitations

- 1.21 This work has been carried out in accordance with the relevant actuarial professional standards TAS 100 issued by the Financial Reporting Council (FRC) and APS X4 issued by the Institute and Faculty of Actuaries.

¹ A consultation with a GP that attracts a medical benefit under the HIF. See section C.3 for further details

- 1.22 This report has been prepared in accordance with the Health Insurance (Jersey) Law 1967, which requires an actuary to report on the financial condition of the Health Insurance Fund and the adequacy or otherwise of the contributions payable to support the benefits payable having regard to its liabilities. It is not appropriate for any other purpose. No other person or third party is entitled to place any reliance on the contents of this report and GAD has no liability to any other person or third party for any act or omission taken, either in whole or in part, on the basis of this report.
- 1.23 More detailed limitations are set out in Appendix E.

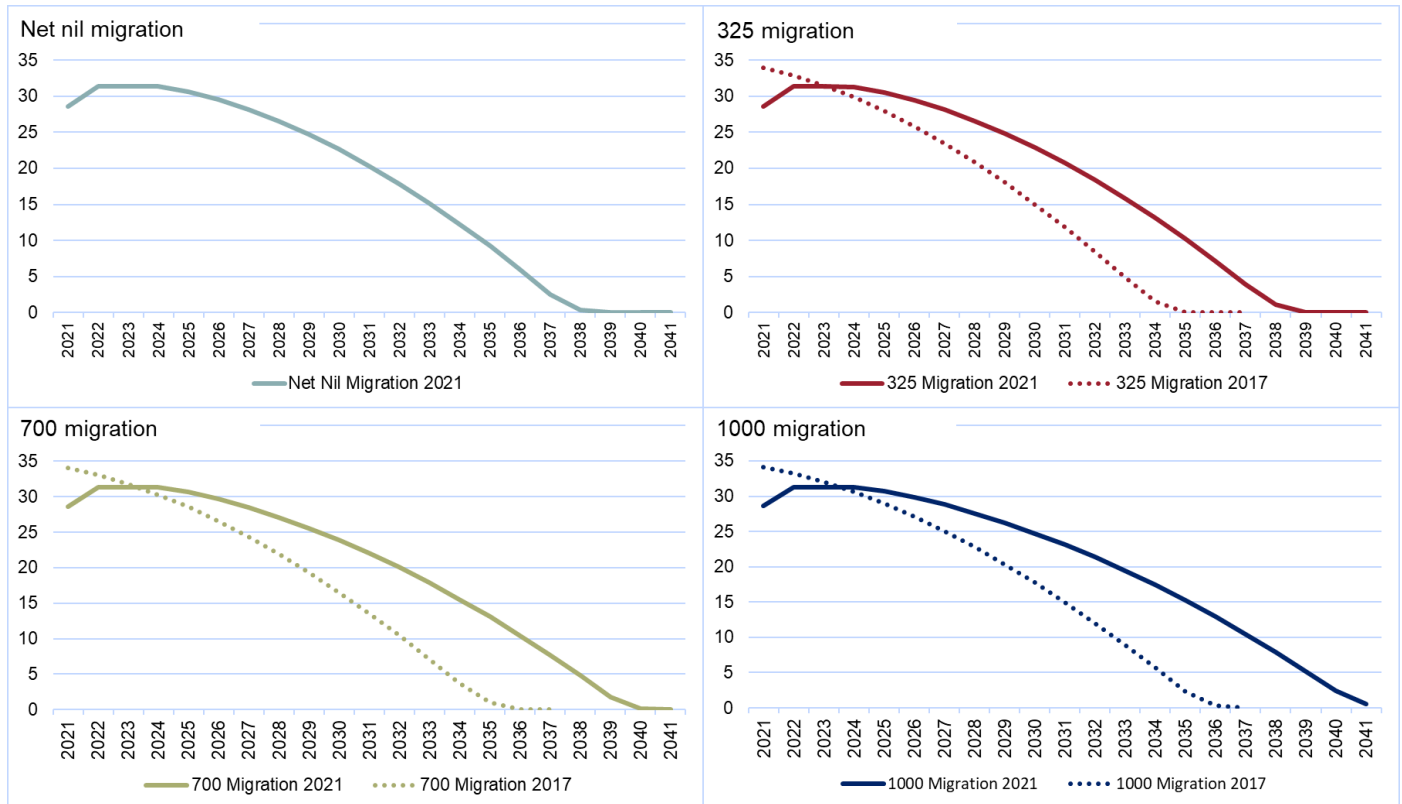
2 Principal projections

- 2.1 This section sets out the principal projection of the HIF balance and the underlying projections of income and expenditure, together with details of the key factors influencing the projection. We also provide projections of the breakeven contribution rate, which is the rate that would be required to keep the Fund at the same level (excluding the impact of investment income).
- 2.2 The charts in this section are based on the assumptions set out in Appendix A. The key assumptions are:
- Inflation and earnings growth assumptions in line with the November 2022 assumptions published by the Jersey Fiscal Policy Panel
 - Return on investments of 0.3% p.a. above earnings
 - GP consultation numbers in line with 2021 age distribution, at a cost increasing in line with RPIY
 - Pathology and other primary care services increase in line with GP consultation costs
 - The number of prescription items increasing by 2.5% per annum at a cost increasing in line with earnings growth.

Principal projection results

- 2.3 Chart 2.1 shows the projected HIF balance to 2041 based on the assumptions and methodology set out in Appendix A, under different migration scenarios. The HIF balance was £100m at 31 December 2021 and is projected to decrease in real earnings terms in every subsequent year before reaching exhaustion in 2037-2041 depending on migration scenario. The results of the 2017 review are shown in dashed lines where comparable results are available (note that in 2017, there was no projection carried out on a "net nil" migration basis).

Chart 2.1: Projected HIF balance (as a multiple of monthly expenditure) to 2041 in real earnings terms



- 2.4 In terms of months of benefit expenditure covered by the projected Fund balance, this falls from a current level of 29 months to zero by the same dates as shown above.
- 2.5 It is expected that if Government policy remains similar (i.e. the HIF continues to cover the same level of benefits as it currently does), then expenditure from the Fund would continue to exceed income, and the Fund will reach zero under all the migration scenarios.
- 2.6 Given the exhaustion date's proximity to the review date (i.e. only 17-20 years away), the timing of the exhaustion of the Fund is particularly vulnerable to variations in experience or one-off occurrences such as a change in policy.
- 2.7 The 2017 review projected a Fund exhaustion date around 4 years earlier than is shown above. The improvement in the future position is largely a result of the following factors
- Earnings growth is expected to exceed price inflation after 2025, and so from that date the rate of increase in Fund income will exceed the rate of growth in expenditure, all else being equal
 - Expenditure on certain benefits did not increase by as much as had been forecast as part of the 2017 review, and so cost projections are slightly lower.

Real earnings terms



The cashflow projection figures in this report are presented in ‘real earnings’ terms, meaning that the effect of earnings inflation has been removed from the projection of nominal amounts.

For example £100 in 15 year’s time is the equivalent of £62 in 2021 once the effect of earnings inflation over the period after 2021 has been removed.

This approach has been adopted to facilitate more meaningful comparisons between different projections, which can become difficult in nominal terms over a long projection period.

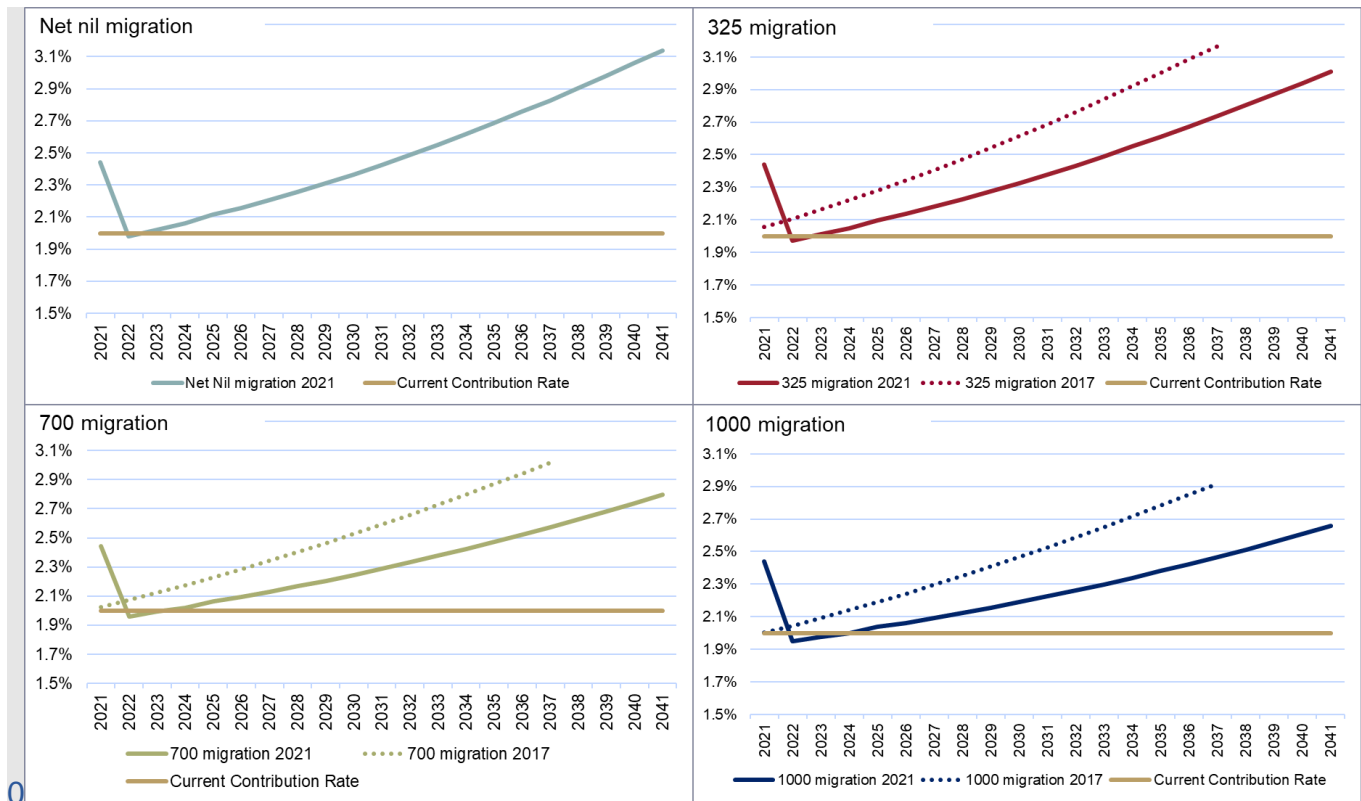
In 2017, results of the HIF review were shown in nominal terms (not adjusted for changing prices or earnings). Using “real earnings” rather than “real prices” is in line with the approach taken for the Social Security Fund review, and is justified given that future contribution income to the fund is largely driven by earnings. This change in approach does not change the results, but visually the charts may look different.

In the 2017 review, earnings and inflation were assumed to be the same for the review period, whereas in the 2021 review, we expect earnings to increase at a higher rate, so fund income would increase more quickly than rises in inflation-linked costs.

Additional financing

- 2.8 Chart 2.2 shows the projected breakeven contribution rate, that is, the contribution rate required to cover benefit expenditure (and expenses) in that year, ignoring investment returns on the Fund balance. This is shown against the current contribution rate of 2%. This gives an indication of whether or not, and by how much, current contribution rates are sufficient to meet benefit expenditure. We have considered different migration scenarios, and shown the results of the 2017 review alongside the 2021 results, where comparable figures are available.

Chart 2.2: Projected breakeven contribution rate required for income to equal expenditure



2.9 Throughout the projection period, the current contribution rate is expected to be insufficient for the Fund to meet projected benefit expenditure under all the migration scenarios. The breakeven rate is forecast to be above the current rate of contributions to the Fund, increasing over time from around 2% to over 3% in 20 years' time in all cases.

2.10 The initial high rate in 2021 is due to costs related to the Jersey Care Model and Digital Care Strategy funding which appear in that year only.

2.11 Costs are projected to rise (as a percentage of earnings) over the twenty year period because benefits paid from the Fund are expected to rise at a faster rate than income to the Fund. The reasons for this are:

- We assume a continuation of a trend of increasing number of prescriptions over time, which leads to higher pharmaceutical costs (which is the single largest cost of the Fund)
- The cost of the main benefits of the HIF (Pharmaceutical benefits and medical benefits) are assumed to increase with RPIY, and Fund contributions will increase with the increase in Jersey average earnings. In the first four years of the review period, inflation is expected to be higher than earnings growth, and so costs of services are growing by more than increases in funding initially
- The pensioner population is expected to grow at a faster rate than the working population, so demands for healthcare are assumed to increase by more than contributions received.
- Investment returns are assumed to be marginally above the rate of earnings growth. The investment strategy is lower risk than it was for the 2017 review.

- 2.12 The policy is currently that the HIF should hold a balance equal to at least 12 months' expenditure, and in the year to 31st December 2021 the assets exceeded this level, at 34 months' expenditure.
- 2.13 If additional financing is deemed necessary, this could be through increases in Social Security contributions or some other source, such as a States Grant.
- 2.14 The actuarial projections are based on the current approach to funding healthcare in Jersey and the Health Insurance Fund's role in that. We are advised that the Government of Jersey has started a review of healthcare funding which could lead to a change in the way that healthcare is funded in Jersey in future. The Health Insurance Fund and the role that it plays is included in the review of healthcare funding. We expect that the next actuarial review of the Fund will be carried out as at 31 December 2025, with the results finalised early in 2027 to support the next government's long-term planning. Our next review will take in to account the outcomes of the review of healthcare funding and any changes in policy that the States Assembly might agree.

3 Evolution since 2017 review

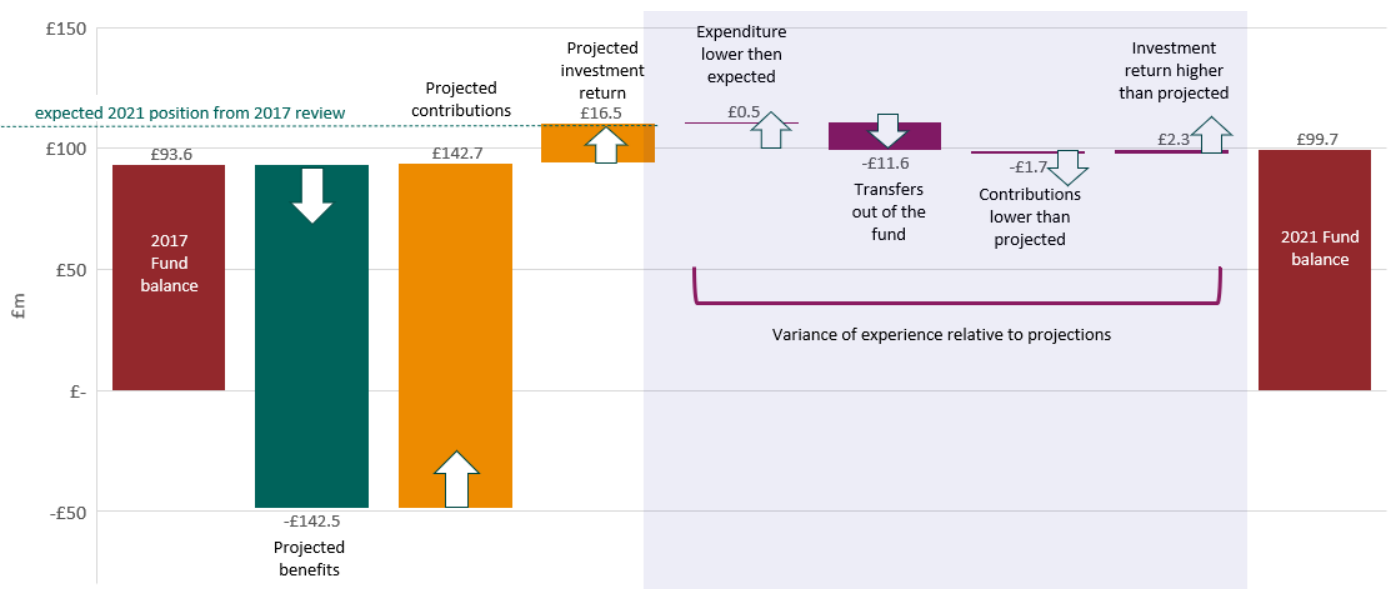
Comparison of results between 2017 and 2021

3.1 We have reviewed the experience of the Fund in the inter-review period to understand the reasons for change in the Fund position at the valuation date, and how the experience varied relative to our assumptions at the last review.

3.2 Chart 3.1 shows that the Fund balance in 2021 is slightly lower than projected in the 2017 review. This is because:

- Regular expenditure was £0.5m lower than projected.
- There were additional transfers out of the Fund of approximately £11.6m.
- Contribution income was £1.7m lower than projected.
- Investment returns were £2.3m higher than expected.

Chart 3.1: Comparison of projected Fund balance with actual Fund balance (end of year)



4 Sensitivity of results to variations in the assumptions

- 4.1 This actuarial report is based on a projection of the Fund's revenues and expenditures over a long period of time, using "best estimate" assumptions. Given the length of the projection period and the number of assumptions required, it is unlikely that actual future experience will develop precisely in accordance with the best-estimate projections.
- 4.2 The Fund's finances over the 20-year projection period will in reality depend on changes in Jersey's population in different economic groups (i.e. demographic changes), investment performance of the Fund's assets, and other economic and policy changes, amongst other factors.
- 4.3 In Section 2 we provided results under a range of future migration scenarios. This section looks at how sensitive the results are to other key assumptions, if future experience is different to the core assumptions.
- 4.4 We do not consider every possible outcome, but look at a range of plausible alternative assumptions which illustrate a range of reasonably conceivable outcomes.

Variant scenarios

- 4.5 In this section, we have shown the effect of varying assumptions relative to the Principal Projections. For ease of reading some of the charts, we have included fewer migration scenarios.
- 4.6 The factors most likely to result in the experience of the Fund deviating from the projection provided are changes in:
- Benefit inflation, number of claims and cost of services provided
 - Demographic experience, particularly changes to the working population in the short term
 - Government policy around future of the HIF
 - Investment performance of Fund assets
- 4.7 The effect of multiple variant assumptions can broadly be estimated by combining the effects of the relevant scenarios.

Table 4.1 – Summary of variants runs considered

Assumption	Variants shown	Migration scenarios
Number of prescription items and ingredient cost	<ul style="list-style-type: none"> • 1.5% lower p.a. than the principal projections • Ingredient prices 2% p.a. higher 	<ul style="list-style-type: none"> • migration of +325 p.a.
Other primary care services	<ul style="list-style-type: none"> • Medical benefits increase 2% p.a. higher 	<ul style="list-style-type: none"> • migration of +325 p.a. • migration of +700 p.a.
Demographic	<ul style="list-style-type: none"> • -1 year life expectancy • +1 year life expectancy 	<ul style="list-style-type: none"> • migration of +325 p.a.
Investment return	<ul style="list-style-type: none"> • 0.3% p.a. higher • 0.3% p.a. lower 	<ul style="list-style-type: none"> • migration of +325 p.a.

Benefit inflation and number of claims

4.8 We have considered the effect of varying:

- the rate of increase of the number of prescription items per consultation
- the ingredient cost of drugs

4.9 These variants show that the expenditure on benefits from the HIF, and the future financial status of the HIF are very dependent on the growth in the number of items dispensed and on the growth in average cost of items dispensed. Charts 4.1 and 4.2 on the following pages illustrate -

- If growth in prescribed drugs is lower than it has been in recent years, as illustrated in the scenario where the annual rate of growth of the average number of prescription items per GP consultation would be 1% a year, and the average cost of prescribed items increases in line with earnings, the break-even contribution rate increase at the end of the projection period (2041) would be 2.5% rather than 3.0%, and the projected Fund balance would be exhausted after 2041 rather than 2038 as in the principal scenario in section 2.
- Conversely, if there is a continuing increasing reliance on prescribed items, and the average cost of prescribed items increases in line with earnings growth plus 2% a year, with a 2.5% a year increase in the average number of prescription items per GP consultation, the break-even contribution rate at the end of the projection period (2041) would be 3.7% rather than 3.0%, and the projected Fund balance would have fallen to zero by 2035, earlier than the 2038 projected date of Fund exhaustion for the principal scenario in section 2.

Chart 4.1: Projected break-even contribution rates showing results on variant assumptions for growth in pharmaceutical benefit costs (+325 p.a. in-migration assumption)

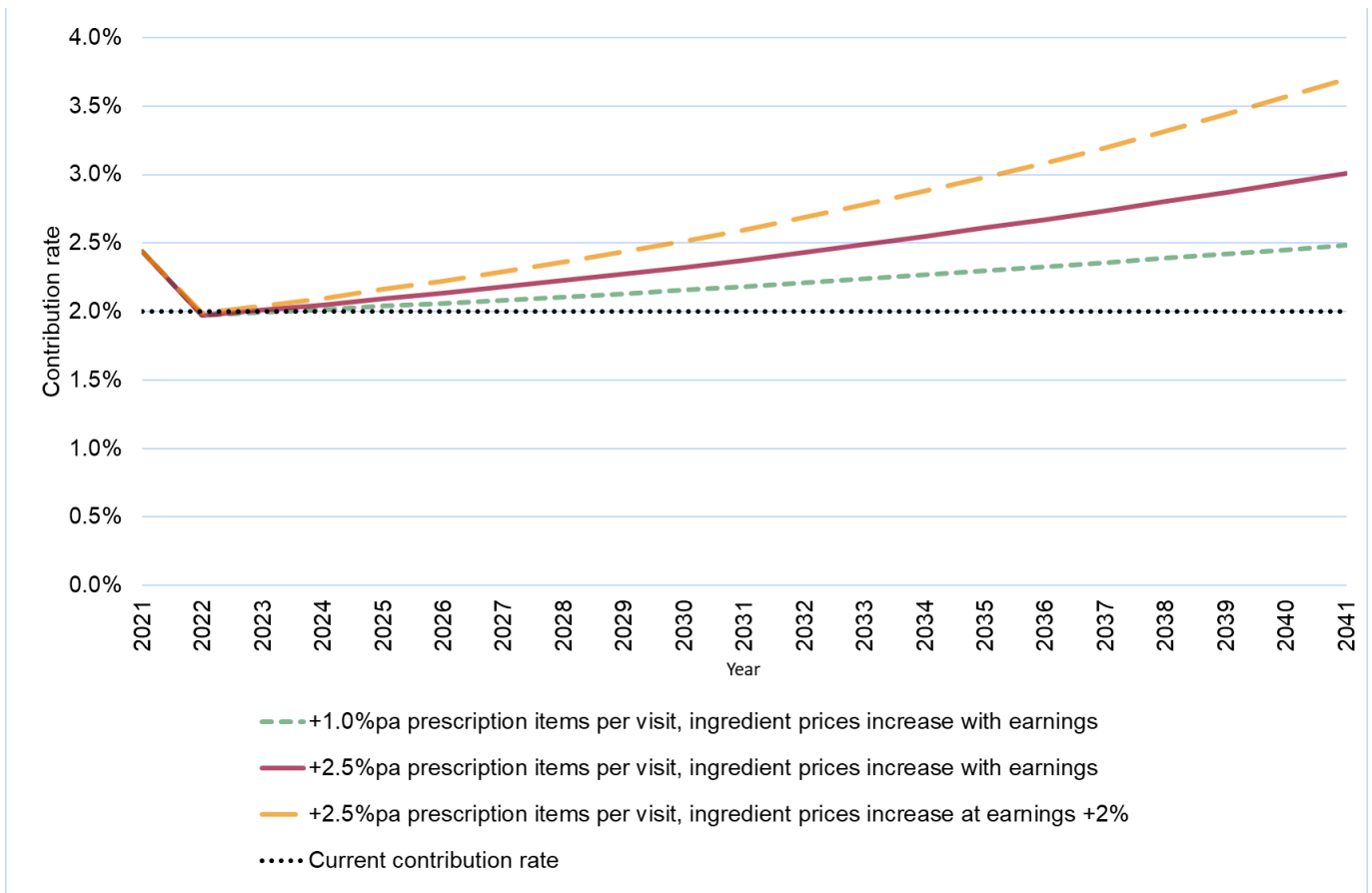
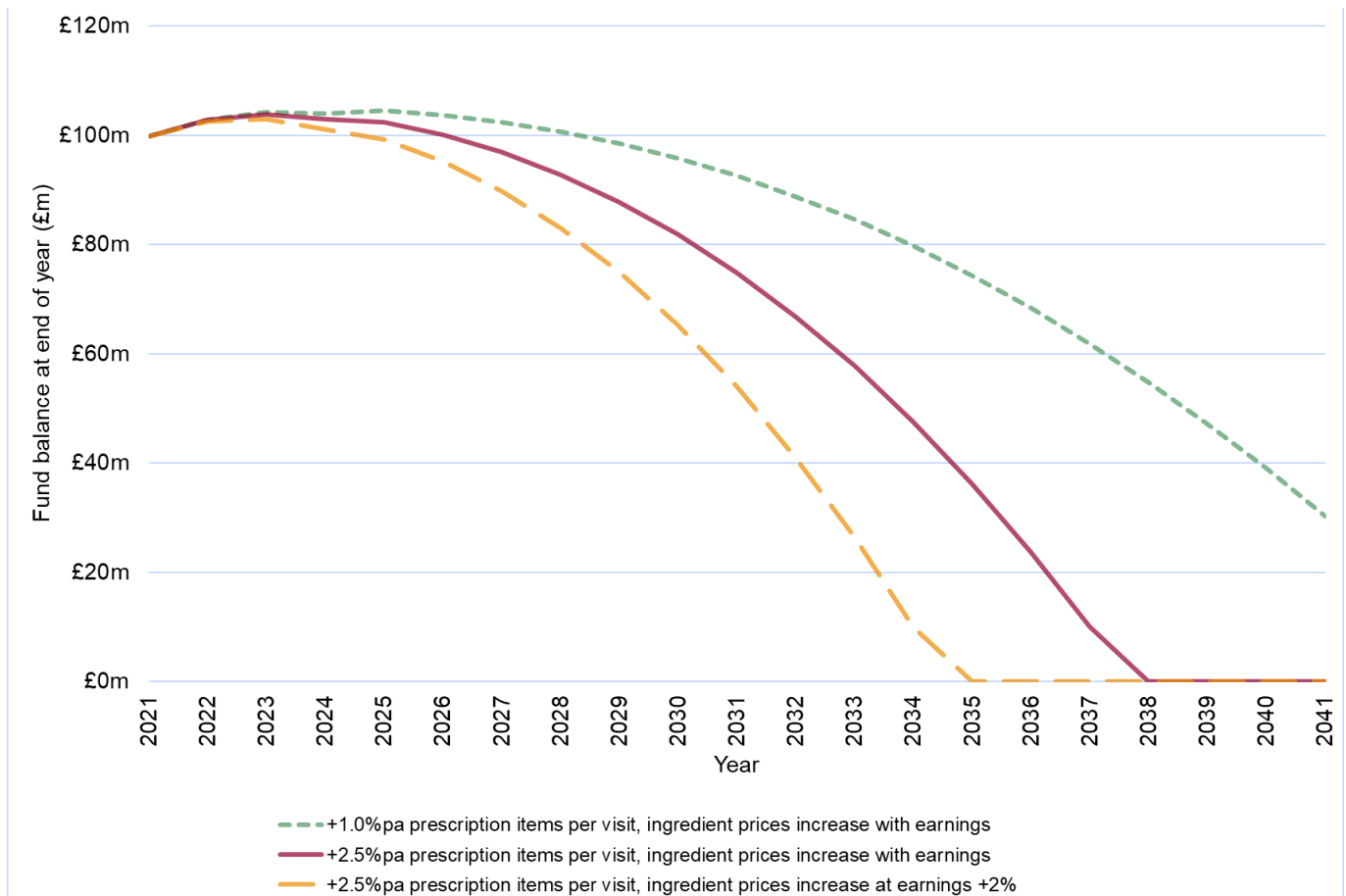


Chart 4.2: Projected Fund balance in real terms showing results on variant assumptions for growth in pharmaceutical benefit costs assuming the current contribution rates are maintained (+325 p.a. in-migration assumption)



Costs of other primary care services

- 4.10 Other primary care services include the Health Access Scheme, pathology tests, vaccination programs, Jersey Quality Improvement Framework (JQIF) awards and other contracted services. We have considered a variant assumption about the growth of these costs of RPIY + 2% a year instead of in line with RPIY.
- 4.11 We illustrate the variant assumptions alongside the principal projection under both a +325 and +700 annual in-migration scenario. The impact would be similar under other migration scenarios.
- 4.12 Other primary care services are only a small part of the expenditure of the HIF as at 2021, and even when they increase faster than prices, they still do not grow to be particularly significant part of total expenditure. Therefore these variants do not show considerable changes in the projected results in terms of higher break-even contribution rates or earlier dates of exhaustion of the assets of the HIF.

Chart 4.3: Projected break-even contribution rates showing results on variant assumptions for increases in costs of other primary care services

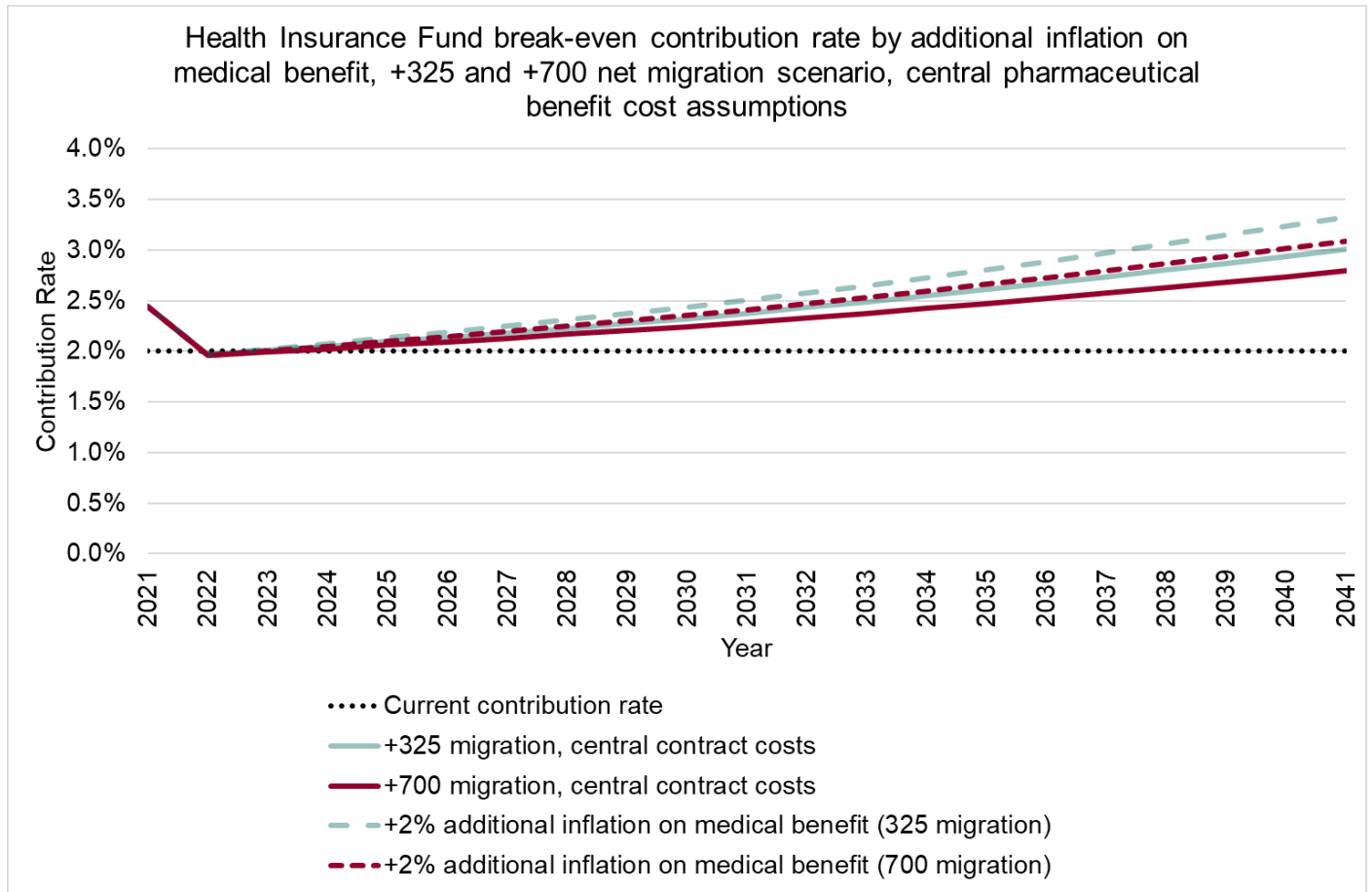
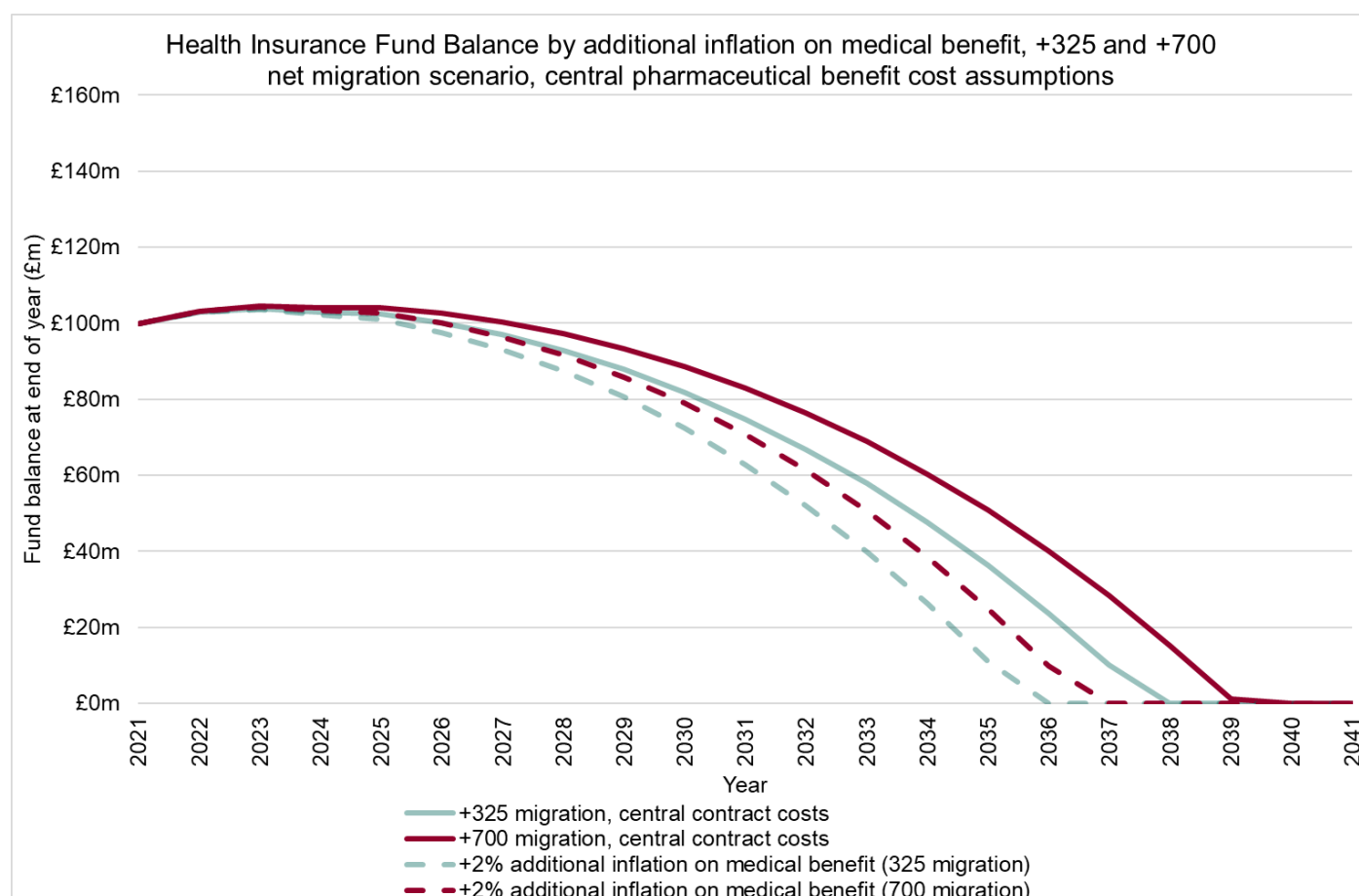


Chart 4.4: Projected Fund balance in real earnings terms showing results on variant assumptions for increases in primary care activity expenditure



Variant demographic assumptions

- 4.13 The Fund balance is sensitive to demographic changes over the projection period, although to a lesser extent than the Social Security Fund due to the different nature of payments from the Fund. The most significant demographic factor is future migration, which we covered earlier in this report, in section 2.3. Future mortality trends will also have an effect but to a lesser extent. Fertility experience is not expected to be significant to the Fund.
- 4.14 We have modelled the future breakeven rate and balance of the Fund, if life expectancy were to be around one year longer or shorter than the central assumptions. We do this by looking at what would happen if each individual had the life expectancy of someone currently one year older, or one year younger, than their current age.
- 4.15 If life expectancy were to increase (or decrease) by 1 year on average, the Fund exhaustion date would be around 1 year sooner (or later).

Future policy

- 4.16 Future policy direction will have considerable influence on the future direction of the Fund. For example, the Government of Jersey may make changes in areas such as:

- The investment strategy for the Fund (which currently includes no growth assets)
- The range and extent of services which will be funded by the Fund
- Changes to the contribution rates or limits, or from additional Government funding

4.17 These changes are harder to predict and so we have not modelled these within this report. We would be glad to support the Government of Jersey with modelling the impact of any new policies under consideration.

Variant economic and labour market assumptions

4.18 We considered the effect of changing the assumption for investment return. We looked at increasing the assumed rate of investment return from 0.3% a year in excess of assumed earnings growth to 0.6% a year in excess of assumed earnings growth and reducing it to 0.0% a year in excess of assumed earnings growth. Both had negligible impact on the results (less than 1 year change to exhaustion date and no change to the breakeven rate).

4.19 Given that the results are presented in constant earnings terms, the results are not very sensitive to changes in inflation or earnings increase assumptions.

Appendix A: Methodology and technical assumptions

- A.1 This appendix summarises the core assumptions to be used when projecting income and expenditure of the Fund under the principal projections. There are three main categories of assumptions:
- Membership assumptions used for projecting the members who are eligible to receive benefits from the Fund and those who pay contributions to the Fund
 - Economic assumptions, covering matters such as the rate of earnings growth and the investment return on the Fund assets
 - Benefit assumptions covering the projection of the individual benefits payable from the Fund.
- A.2 The core assumptions have been chosen so that they represent a reasonable estimate of the likely future experience of the Fund with no explicit (or implicit) margin for prudence.
- A.3 The population assumptions used in this report are taken from analysis undertaken by GAD and provided to Jersey in February 2023, and summarised in appendix D of this report.
- A.4 The economic and benefit assumptions used in this report were proposed by GAD and previously discussed with Jersey to agree they are appropriate for use
- A.5 In our view, these assumptions are reasonable for the purposes of estimating the financial position of the Fund over the period considered in this report.
- A.6 My previous report was published in March 2019. The estimates in that report were based on population projections provided by Statistics Jersey and economic assumptions prepared by GAD and agreed with the Government of Jersey.

Membership assumptions

Table A.1: Summary of the core assumptions (membership)

<i>Membership</i>	<i>2017 review</i>	<i>2021 review</i>
Membership numbers	<p>Equal to projected population, based on the projections prepared by the Statistics Jersey for the 2017 Social Security Fund review, assuming:</p> <ul style="list-style-type: none"> • +325 annual net inward migration and • +700 annual net inward migration 	<p>Based on the population projections produced by GAD, assuming:</p> <ul style="list-style-type: none"> • annual net nil migration • +325 annual net inward migration and • +700 annual net inward migration • +1000 annual net inward migration

- +1000 annual net inward migration

Contributor numbers	Based on actuarial review of the Social Security Fund as at 31 st December 2017	Based on the actuarial review of the Social Security Fund as at 31 st December 2021
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Economic assumptions

A.7 In general, our approach for the 2021 valuation is to set economic assumptions in line with core economic assumptions of the Fiscal Policy Panel (November 2022 report²) and allow for known experience since the valuation date.

Table A.2: Summary of the core assumptions (economic)

<i>Economic</i>	2017 review	2021 review
Earnings growth	3.0% a year, with actual figure (3.5%) for 2018 as published by Statistics Jersey in August 2018, and projection for 2019 from Jersey Fiscal Policy Panel's August 2018 document	2022: 6.2% 2023: 6.2% 2024: 3.1% 2025: 1.8% Thereafter: 2.8% p.a.
Price inflation	RPIY of 3.0% a year, from the Jersey Fiscal Policy Panel's August 2018 document, with actual figure, 4.2%, in 2018 (increase in year to June 2018)	2022: 6.5% ³ 2023: 6.6% 2024: 2.6% 2025: 1.7% Thereafter: 2.4% p.a.
Increase in earnings limits for contributions	In line with earnings	In line with earnings
Investment return on Fund assets	0.75% a year above earnings (3.75% nominal from 2020 until end of the projection period in 2037)	0.3% a year above long term Jersey earnings increases

² <https://www.gov.je/SiteCollectionDocuments/Government%20and%20administration/FPP%202022%20Annual%20Report.pdf>

³ Published Jersey RPIY for June 2022. Later years are as per FPP November 22 report

Contribution income

- A.8 The projected numbers of contributors in future years have been obtained by applying assumed proportions of men and women contributing at each age in the different contribution classes to the projected numbers in the population. These proportions were derived from statistics on the number of contributors in past years. The analysis was made on the basis of the average position throughout the year, and thus allows for the average number of seasonal workers who contribute.
- A.9 Consistent with the approach at the previous review, the assumed short-term proportion of the population that contributes has generally been based on the average proportions (for each age and gender group) experienced in the ten years 2012 to 2021. We have also assumed the proportion of the population contributing in 2021 is consistent with the data provided to us for 2021.
- A.10 At this review pension age is mid-transition from age 65 to 67 and is not at an integer age. As a result the proportion of the population contributing during 2021 is unlikely to be reflective of the proportion contributing for all future years. We have allowed for this transition to a higher pension age by assuming that the long-term behaviour is reflective of that for previous integer pension ages, i.e. we have assumed that the long-term behaviour for people contributing at age 67 is similar to the proportion of the population contributing at 65 based on the contribution data at the last point 65 was pension age. This is a slightly different approach to last time where we assumed that behaviour would be in line with 2017 experience.
- A.11 As part of this transition to a pension age of 67 by 2031 we have also made the following assumptions about members' contribution behaviour:
- participation rates are unchanged for ages up to 62
 - rates at the two ages immediately below the new pension age are equal to the initial rates at ages 63 and 64
 - rates at ages between 62 and two years below the new pension age are equal to the initial rate at age 62
- This is the same approach as in the 2017 review.
- A.12 It is possible that the proportions contributing will vary in response to changing economic and labour conditions. For example, there could be a further increase in the proportions contributing at older ages. However, given the very significant uncertainties inherent in how the labour market might develop, we have generally assumed that the age and gender specific proportions will not vary in future years.
- A.13 As part of the 2017 review we made allowance for two transitional effects for women. These are:
- the increase in pension age from 60 for women who were first insured before 1 January 1975 to 65 for later members; this is in addition to allowing for the subsequent increase to age 67 mentioned in C.2
 - the gradual run-off of the group of women who were married before 1 April 2001 and who have elected not to pay contributions; as these women leave the labour force, they are assumed to be replaced by women who pay the full rate of contributions

We have made consistent allowances where necessary in 2021 but the majority of these effects have now been realised.

- A.14 A summary of the proportions of the population that are assumed to contribute in 2022 is given in the following table (excluding those for whom employer contributions only are paid). For comparison, the corresponding proportions assumed for the 2017 review are shown in brackets.

Table A.3 - Summary of the proportion of the male and female populations assumed to be paying Class 1 or Class 2 contributions in 2021, with the equivalent figures from the 2017 review in brackets

Age group	Men	Men	Women	Women
	Class 1	Class 2	Class 1	Class 2
15 to 29	66% (64%)	1% (1%)	62% (61%)	1% (1%)
30 to 39	87% (86%)	6% (6%)	78% (77%)	3% (2%)
40 to 49	77% (75%)	12% (13%)	75% (72%)	4% (3%)
50 to 59	68% (67%)	16% (19%)	62% (57%)	5% (4%)
60 to 69	27% (21%)	9% (8%)	16% (12%)	1% (1%)

- A.15 In general, the proportions are broadly similar to those applied at the 2017 review. The most significant changes are an increase in the proportion of population paying Class 1 contributions in the 50 to 59 and 60 to 69 age groups. The changes are a consequence of the latest data received on contributor numbers. In particular, the data indicated that the proportion of older people of both genders, who pay Class 1 contributions has been increasing over recent years.
- A.16 These proportions will vary in future years. In particular, the proportions will increase further for the 60 to 69 age group as a result of the increases to state pension age. Also, the proportions of women at age 44 and above who pay Class 1 contributions will increase. This reflects the run-off of the group of women who were married before 1 April 2001 who have elected to pay no contributions and their replacement by women paying full Class 1 contributions⁴.
- A.17 The following two charts show the proportion of the working age population⁵ that is assumed to pay Class 1 and Class 2 contributions, by gender, over the projection period, based on the +325 net annual in-migration scenario. For comparison, the equivalent figures are shown for the 2017 review, also based on +325 net annual in-migration considered at that review. The proportions will vary slightly under the different migration scenarios since it will change the age and gender profile of the population.

⁴ In contrast, women under age 44 in 2021 generally already pay full Class 1 contributions because they were married after April 2001.

⁵ For this purpose the working age population is defined as being from age 15 to 64 in 2019 and before, and rising to 66 in 2031 and later.

A.18 There is a visible kink in the lines around 2021 which is due to temporary changes to the contribution requirements during the Covid pandemic, in particular the temporary drop in number of people paying class 2 contributions, and deferral of some class 2 contributions.

Chart A.1: Proportion of the working age population assumed to pay Class 1 contributions, based on the +325 net migration scenario, with the equivalent figures from the 2017 review

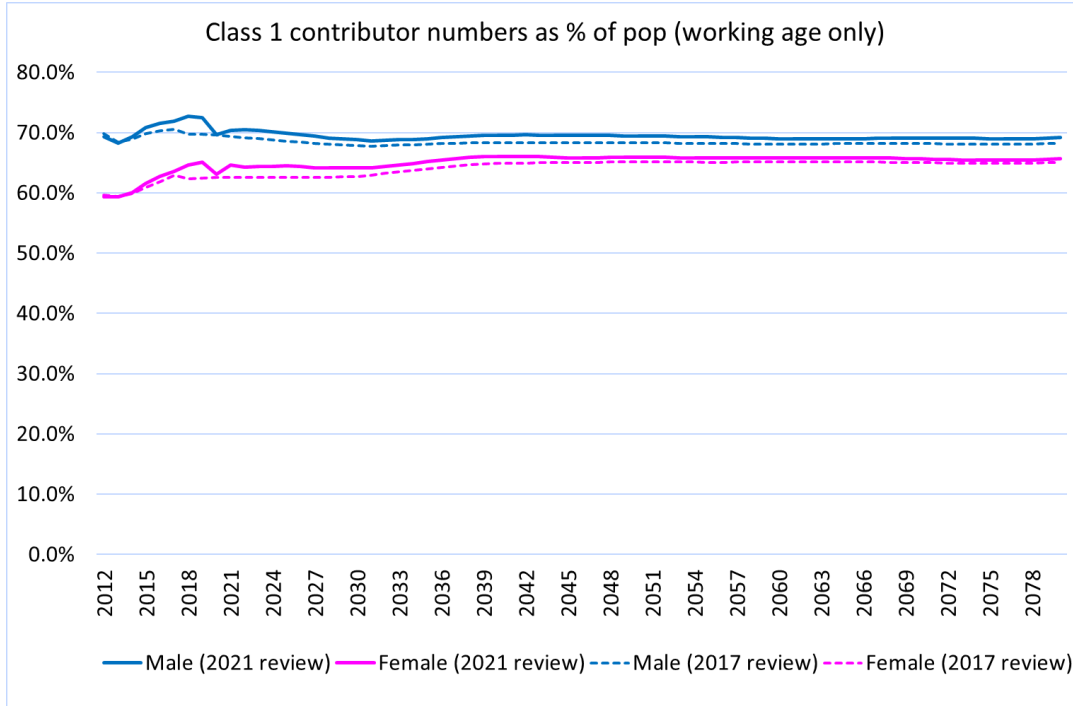
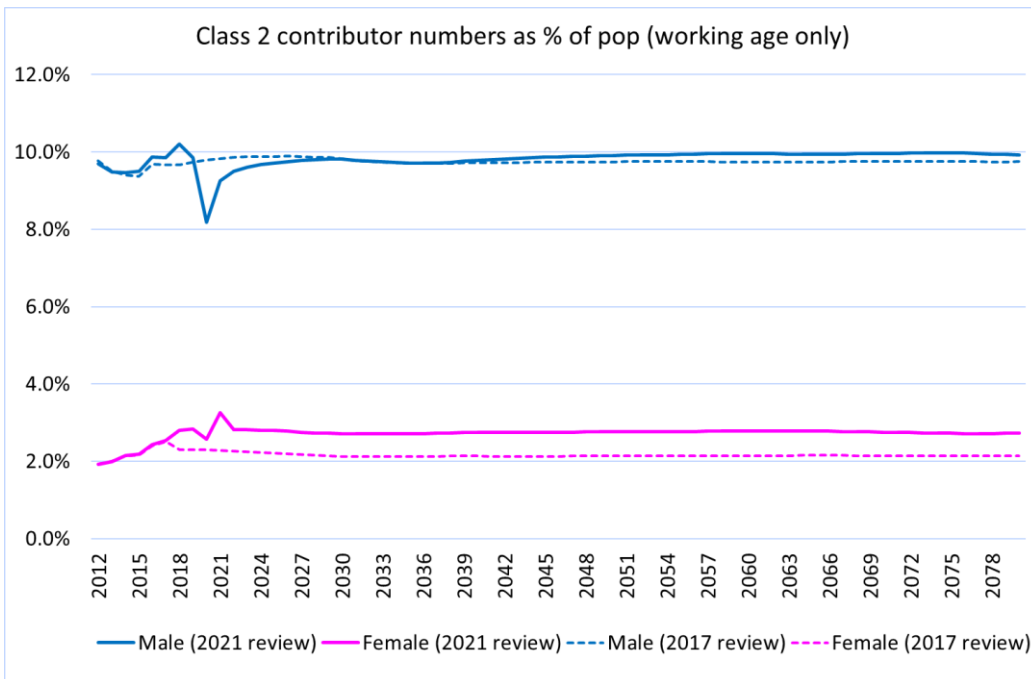


Chart A.2: Proportion of the working age population assumed to pay Class 2 contributions, based on the +325 net migration scenario, with the equivalent figures from the 2017 review



- A.19 The proportion of the workforce projected to be contributing for the 2021 review is therefore similar to that projected for the 2017 review. There is a small increase in the proportion of men and women assumed to pay Class 1 contributions across all ages, and more so at older ages. There is also a slight increase in the proportion of Class 2 contributors.
- A.20 Future contribution income was projected by combining the future numbers of contributors, estimated in line with the approach described above, with distributions of earnings levels by age and sex, based on data for 2021. Allowance was made for the effect of the contribution limits. The emerging contribution cash-flow was aligned with 2021 contribution information provided by the Government of Jersey.

Benefit assumptions

- A.21 A summary of the benefit assumptions is included as an appendix at the end of this section

Benefit assumptions: number of GP consultations that attract a medical benefit

- A.22 At the 2017 review it was noted that the average number of GP consultations recorded as attracting a medical benefit for each person in a year had been falling, from around 5 in the late 1990s to a little over 4 around 2010. The average number of these GP consultations for each person in the population is then stable at around 3.5 between 2013 to 2016 before gradually decreasing to 3.2 in 2021.
- A.23 This fall appears to be consistent with the SPPP staff's expectation in 2017 that this was likely to represent an actual step change in the rates of recorded GP consultations, as a result of the expansion of contracted services and schemes that do not include the medical benefit as part of the overall remuneration package to GP surgeries. Some of these services are provided by GPs and some by other healthcare professionals working within a GP surgery.
- A.24 The decrease in the period 2018-2021 may be due to changes in the process relating to new services in respect of cervical screening and flu vaccinations and the large drop in 2020 due to the COVID19 pandemic. Rates for 2021 are comparable so we have taken the 2021 rates as the appropriate level.
- A.25 The table below shows the scales for men and women by age group, based on experience over 2021.

Table A.4: Scale of annual number of GP consultations attracting a medical benefit per head by age and sex

Age group	2017 review		2021 review	
	Men	Women	Men	Women
0-4	4.7	4.2	4.1	3.8
5-9	1.4	1.5	1.5	1.4
10-19	1.1	1.7	1.2	1.9
20-29	1.4	3.0	1.6	3.3
30-39	1.8	3.6	1.8	3.9
40-49	2.2	3.5	2.1	3.5
50-59	2.9	3.7	2.7	3.6
60-69	3.7	4.1	3.5	3.9
70-79	5.7	6.1	4.5	5.0
80-89	7.4	7.8	6.3	6.7
90 +	10.8	10.0	8.8	9.0

A.26 The assumption for the 2021 review is lower than that adopted at the 2017 review, for both sexes and in most age groups. However, the shape by age and the relative magnitudes of male and female rates are very similar.

Summary

Future rates of GP consultations that attract a medical benefit	In line with age distribution of 2021 experience
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Benefit assumptions: Medical benefit – cost per GP consultation that attracts a medical benefit

A.27 We have derived the level of medical benefit by dividing the total cost by the insured population, these past values are set out in Table A.5.

Table A.5: Medical benefit – Implied cost per consultation

	2017	2018	2019	2020	2021
Implied Medical benefit	£20.00	£20.00	£20.00	£20.09	£20.05

A.28 The benefit in each year is very close to the rate published on gov.je. Therefore we have retained the assumption of £20.28 as an initial (2021) value.

A.29 This benefit has not increased since around 2012. Inflationary increases over the longer term would still be expected and so we assume the cost per consultation increases with RPIY.

A.30 Summary

GP consultations: Initial rate	£20.28 per consultation in 2022
Future increases	In line with RPIY

Benefit assumptions: Pathology benefits

A.31 The total benefit has been assumed to increase in line with the medical benefit paid for GP consultations. This implicitly assumes that the monetary rate of the pathology benefit increases in line with the medical benefits for GP consultations and the number of payments increases in line with the number of GP consultations.

A.32 Summary of proposals

Future Pathology benefit

Proportion of medical benefit, as an average over 2017 – 2021 which is equal to approximately 14% of the amount of GP consultations.

Benefit assumptions: Other Primary Care services

A.33 Since the last review, an increased focus has been placed on providing contracted schemes and services to support targeted areas of primary care service. In many cases these services can be provided equally by a GP or by another appropriate health professional.

A.34 Whereas individual services will not always be available to the whole population, the overall demand for such services can reasonably be expected to vary in line with the expected number of GP consultations that attract a medical benefit.

A.35 In addition to the services provided through GP surgeries, the same assumption can be made for the contracts relating to flu vaccinations (provided jointly by GPs and pharmacies) and diabetic supplies (provided by pharmacies).

A.36 Most of these contracts have been in place for a relatively short period, so the full year cost of the 2021 contract payments has been used as an initial rate for future years.

A.37 The approach taken to estimate future costs of other primary care services (i.e. excluding medical benefit above in A.28) is to derive a rate as a proportion of number of GP consultations, as follows:

- a. A total cost of patient benefits in the most recent year, 2021, (excluding pharmaceutical benefit) is calculated by totalling costs of providing medical benefits, pathology benefits, JQIF, Cervical screening, Flu vaccines, Diabetes, Remote services, HAS, Allied Health Care Professional Activity fees and workforce package, using 2021 data
- b. The total value is divided by the number of GP consultations that attract a medical benefit to determine an overall “cost per GP consultation”.
- c. The cost of GP consultations in A.28 and pathology benefits in A.31 [is deducted from this figure](#) to derive a unit rate for “other primary care services”. This rate is projected in line with population changes and increasing by RPIY each year.

Summary

Other primary care services (excl GP consultations). Initial rate

£17.02 per consultation in 2022

Future increases

In line with RPIY

Jersey Care Model & Covid support

A.38 In 2020 the HIF funded transfers for Covid support and in 2021 the HIF funded a transfer to the Jersey Care Model and Digital Care Strategy. We note that there are no further planned payments from the HIF from 2022 onwards.

Benefit assumptions: Pharmaceutical benefit – number of prescription items per consultation

A.39 The biggest item of expenditure from the Fund is on pharmaceutical benefit, with the payments for the cost of drugs being around 40% of Fund expenditure on average, over 2017-2021, excluding transfers to the Consolidated Fund. The dispensing fees paid to pharmacists were around 22% of average Fund expenditure over the same period. However, there are no data on either the number of prescription items or the cost of drugs, by sex or age of patient. The projection methodology therefore uses an assumption for the number of prescription items for each visit to a GP reimbursed by medical benefit, and an average cost of items provided and dispensing fees. The assumption for the average number of prescription items for each such GP visit comprises an assumption of an initial value for the average number of prescription items, and an assumption about the rate of increase in that number.

A.40 The 2017 review noted that the average number of prescription items for each GP visit had increased almost continually for each year at 4% annual increase over 2013-2017, reaching 5.8 prescription items per visit in 2017.

A.41 The increases continued into the period 2018 to 2021, with the average standing at 6.0 in 2018, 6.3 in 2019, 7.8 in 2020 and 6.7 in 2021. It should be noted that the large increase in prescription items per GP consultation between 2017 and 2021 coincides with a decrease in the number of GP consultations reimbursed by a medical benefit as described in paragraphs A.22 to A.25 above and the increased use of contract services which do not attract a medical benefit (so not counted in GP consultation numbers).

A.42 The average annual rate of increase over 2017-2021 is around 4.6% a year. There was a sharp rise in 2020 followed by a drop in 2021 (coinciding with the Covid pandemic). Aside from 2020-2021 there is a trend of an increasing number of items per visit. We assume the 2021 figure of 6.7 prescriptions per consultation as the starting level.

A.43 The increase in prescribed items may be unique to the last few years and so may not continue to increase at this rate.

A.44 We assume a rate of increase of 2.5% a year.

Summary

Number of prescription items: Initial rate	6.7 items, based on 2021 experience
Future increases	increases of 2.5% a year

Benefit assumptions: Pharmaceutical benefit – prescription costs (prescribed items)

A.45 Detailed information on prescription numbers and costs and dispensing fees were given in Jersey Government Health Insurance Fund Statistics up to 2021 and are shown in Table A.6 below. We understand all amounts are net of any “claw-back” of discounts obtained by pharmacists.

Table A.6: Prescription costs over the period 2017 to 2021

	2017	2018	2019	2020	2021
Total no. of items prescribed during year (000s)	1,979	2,036	2,068	2,158	2,191
Average cost of a prescribed item (£)	6.55	6.17	6.36	6.46	6.84
Total cost of prescribed items (£000)	12,954	12,561	13,155	13,949	14,994
Pharmacy dispensing fees (£000)	6,874	6,888	7,240	7,786	7,472
Total Cost (£000)	19,828	19,449	20,395	21,735	22,466

A.46 The average cost of a prescribed item (the cost of the item as opposed to the dispensing cost) has fluctuated over the period within the range £6.17 to £6.84. There is no clear rationale for these fluctuations and the previously noted decline in average costs (ascribed in large part to a move from branded to generic drugs) does not appear to be continuing. We use an assumed average cost of prescribed items to be in line with recent experience, at a rate of £6.80 from 2022. It seems reasonable to assume that, as with most other items, the average costs will rise in future. We assume increases are in line with earnings, which is consistent with the previous review.

A.47 Due to the likely sensitivity of results to this assumption we show a variant scenario where the item cost increases at earnings + 2%.

A.48 The starting assumption for the cost of a prescribed item of £6.80 in 2022 is slightly higher than the rate assumed for that year in the principal projections made for the 2017 review (£6.70).

Summary

Prescription costs: Initial rate	£6.80, based on 2021 experience
Future increases	In line with earnings

Benefit assumptions: Pharmaceutical benefit – prescription costs (dispensing fees)

A.49 For the 2017 review the Social Security Department instructed us to assume that there are increases in the dispensing fees paid to pharmacies from 2020 in line with RPIY, starting at £3.13 and £3.51 for each item dispensed (with the higher rate paid in respect of the first 50,000 items a year for each pharmacy).

A.50 Table A.7 shows the average rate in each year from 2017 to 2021.

Table A.7: Average dispensing fees in the period from 2017 to 2021

	2017	2018	2019	2020	2021
Total no. of items prescribed during year 000s (A)	1,979	2,036	2,068	2,158	2,191
Pharmacy dispensing fees £000 (B)	6,874	6,888	7,240	7,786	7,472
Average Cost (B/A)	£3.47	£3.38	£3.50	£3.61	£3.41

A.51 The methodology includes the implicit assumption that the split between the two rates will remain unchanged. Therefore, total expenditure on dispensing fees is assumed to rise in line with the number of items dispensed, itself driven by number of GP visits covered by medical benefit and increasing number of prescriptions per visit.

A.52 We have assumed initial rates of £3.51 and £3.13, increasing in line with RPIY (from 2022 onwards).

Summary

Dispensing cost: Initial rate	Higher rate - £3.51 per item (first 50,000 items)
	Lower rate - £3.13 per item
Future increases	In line with RPIY

Benefit assumptions: Gluten-free vouchers

A.53 The Fund also provides vouchers to those who require a gluten-free diet. The numbers claiming the benefit and the total value of vouchers used increased rapidly over the period from 2012 to 2017. However, following the introduction of control measures on eligibility in 2017, the number of claimants dropped to around 440 and has remained stable for the 3 year period 2019-2021.

A.54 We have increased this figure in line with the total number of people eligible to receive benefits from the Fund. This will see the spending on the vouchers will increase in line with the growth in the total eligible population.

- A.55 At the last review it was assumed that expenditure would increase in line with inflation. The value of gluten free vouchers has remained the same at £14p/w. We would still expect the benefit to increase in line with inflation over the long-term and so we have assumed RPIY increases.

Summary

Gluten free vouchers: Initial rate	£14 per week
Future increases	In line with RPIY

Administration costs

- A.56 A projection of administration costs for the period 2022 to 2026 have been provided. As shown in the table below, administration costs are expected to gradually rise from £2.5m to £2.7m. This is an increase from the 2021 figure of £2m.

- A.57 Administration costs include the cost of collecting income, making benefit and contractual payments and maintaining the Primary Care Governance Unit.

- A.58 Beyond 2026 we will assume these costs increase in line with RPIY.

Table A.8: Projected administration costs in the period from 2022 to 2026 (£)

£ thousand	2022 (based on September forecast where relevant)	2023 forecast	2024 forecast	2025 forecast	2026 forecast
Administration costs (including actuarial fees and PCGT costs)	2,485	2,611	2,675	2,741	2,741

- A.59 A summary of the core benefit assumptions is set out in the table below, with the corresponding assumptions made at the previous review as at 31st December 2017.

Table A.9: Summary of the core assumptions (benefits)

Benefits	2017 review	2021 review
Rate of Medical Benefit (payments toward GP consultation charges)	Fixed at £20.28 (including component for administration) in 2018 and 2019, and increase thereafter in line with RPIY	Fixed at £20.28 (including component for GP administration) in 2022 and, increase thereafter in line with RPIY

Benefits	2017 review	2021 review
Number of consultations per head	In line with age and sex based on consultation numbers in 2017. A reduction of 3,000 consultations a year was applied from mid-2018 to reflect a change in the approach to paying for cervical smears	In line with age and sex based on consultation numbers in the 2021 calendar year.
Pathology benefit	Expenditure increases in line with increases in other medical benefit paid for GP consultations (pathology benefit is assumed a constant proportion of medical benefit, with that proportion based on the average seen in 2013 to 2017 inclusive).	Expenditure increases in line with increases in other medical benefit paid for GP consultations (pathology benefit is assumed a constant proportion of medical benefit, with that proportion based on the average seen in 2017 to 2021 inclusive).
Expenditure on other primary care services –	<p>JQIF payments – £2.0 million in 2018 increasing in line with prices (RPIY) thereafter</p> <p>The cervical smear programme results in a reduction of 3,000 GP consultations reimbursed as medical benefits a year</p> <p>Other than the effect of cervical smears, it is assumed that the primary care activities have no knock-on effect on the level of other medical benefits</p> <p>Variant rates of increase for expenditure on primary care activities of</p> <ul style="list-style-type: none"> • RPIY + 2% a year • RPIY + 5% a year <p>6.0 in 2018</p>	<p>A combined unit cost was derived covering</p> <ul style="list-style-type: none"> - JQIF payments - Flu vaccinations - Cervical screening - Diabetic supplies - Health Access Scheme - Remote services - Allied healthcare professional activity - Workforce package <p>Costs are expected to increase in line with RPIY and the number of GP Consultations that attract a medical benefit (in line with population changes)</p> <p>6.7 in 2022 calendar year</p>
Average number of pharmaceutical items per visit	6.0 in 2018	6.7 in 2022 calendar year
Future Increase in number of prescription items per consultation	<p>Two variants of</p> <ul style="list-style-type: none"> • 1.0% a year • 2.5% a year 	<p>2.5% a year</p> <p>A variant of 1% to be combined with costs rising in line with earnings</p>
Average ingredient cost of drugs (for each prescription item)	£6.70 in 2018.	£6.80 in 2022.
Increase in average ingredient costs of drugs	In line with earnings increases. A variant of (earnings + 2% a year) to be	In line with earnings increases. A variant of (earnings + 2% a year) to be

Benefits	2017 review	2021 review
	combined with 2.5% a year increase in average items	combined with 2.5% a year increase in average items
Increase in average dispensing cost of drugs (that is, the remuneration of the pharmacist)	Dispensing fees of £3.50 for 2018 and 2019 has been assumed, with increases for future years in line with RPIY	Dispensing fees of £3.50 for 2018 and 2019 has been assumed, with increases for future years in line with RPIY
Increase in expenditure on gluten-free vouchers	In line with prices and growth in the total membership of the Fund	In line with RPIY and growth in the total membership of the Fund

Table A.10: Summary of other payments including administration

Other payments and administration	2017 review	2021 review
Expenditure on other activities – Jersey Quality Improvement Framework (JQIF) and HIF contracts for items such as flu vaccinations and cervical screening	<p>General payments – £2.0 million in 2018 increasing in line with prices (RPIY) thereafter</p> <p>The cervical smear programme results in a reduction of 3,000 GP consultations reimbursed as medical benefits a year</p> <p>Other than the effect of cervical smears, it is assumed that the primary care activities have no knock-on effect on the level of other medical benefits</p> <p>Variant rates of increase for expenditure on primary care activities of</p> <ul style="list-style-type: none"> • RPIY + 2% a year • RPIY + 5% a year 	<p>Expenditure on other primary care services is set out above</p> <p>Assume no one off transfers from the Fund. We have not allowed for any policy changes announced after 31 December 2021</p>
Administration	Projected as a 6.0% of benefit expenditure including JQIF expenditure	In line with Table A.8 and then increased in line with RPIY

Appendix B: Fund accounts

B.1 A summary of the transactions of the Health Insurance Fund in the period since 31 December 2017 appears in Table B.1. These figures are taken from the Fund's audited accounts and Minister's report.

Table B.1: Income and outgo of the Health Insurance Fund in the period from 1st January 2018 to 31st December 2021 (£ thousands)

Year ending 31 st Dec	2018	2019	2020	2021
Fund at year start	93,627	93,979	107,657	107,898
Contributions	34,805	35,922	34,527	35,686
Net gains and income on investments	(2,824)	10,278	5,836	5,506
Total Income	31,981	46,200	40,363	41,192
Medical Benefit (including pathology benefits)	7,754	7,812	6,424	7,922
Other primary care services ⁶	2,095	2,111	4,086	4,563
Pharmaceutical benefit (net of prescription charges)	19,450	20,395	21,736	22,466
Gluten-free food vouchers	451	328	300	281
Transfer for Covid support	0	0	5,322	0
Transfer for Jersey Care model	0	0	0	6,322
Administration costs	1,879	1,876	2,254	1,993
Accounting adjustment ⁷	-	-	-	5,799
Total outgo	31,629	32,522	40,122	49,346
Excess of income over outgo	352	13,678	241	-8,154
Fund at year end	93,979	107,657	107,898	99,744
Ratio of mean Fund/outgo in terms of months (ignoring transfers for primary care funding)	36	37	37	34

B.2 Before allowing for transfers for Covid support, Jersey Care Model and the Digital Care Strategy, contribution income exceeded expenditure in each of the years 2018, 2019 and 2020 and was slightly less than expenditure in 2021. The average Fund balance was between 2.8 and 3.1 times annual expenditure at year end.

⁶ Including JQIF payment, Flu vaccinations, Cervical screening, Diabetic supplies and Health Access Scheme,

⁷ We have been informed of an erroneous investments adjustment in the 2021 accounts that will be corrected in 2022. We have allowed for this in our 2022 estimate.

- B.3 Whilst completing our review, there was an error identified in the distribution of contribution income between the HIF and the SSF. We have been instructed that this will be rectified as an adjustment to the 2023 accounts. We have allowed for this adjustment as part of our projections in 2023.
- B.4 A summary of the assets held in the Health Insurance Fund as at 31st December 2021 is given in Table B.2 below.

Table B.2: Summary of the market value of the assets of the Health Insurance Fund as at 31st December 2021

	£million	%
Equity Class Assets	35.8	41
Fixed Income Class Assets	38.6	44
Cash Class Assets	13.1	15
Total	99.7	100

- B.5 After the review date, the investment strategy of the Health Insurance Fund changed, after taking advice from the Fund's investment advisors. This was done with the aim of protecting the current balance of the HIF and reducing risk in the investment strategy. The expected asset split is shown in Table B.3

Table B.3: Summary of expected asset class makeup of the Health Insurance Fund based on Fund strategy

	2021 (%)	2022 onward (%)
Equity Class Assets	40	0
Fixed Income Class Assets	45	50
Cash Class Assets	15	50
Total	100	100

Appendix C: Summary of contributions, benefits and other payments

C.1 This appendix summarises the principal provisions regarding the benefits and contributions set out in the Health Insurance (Jersey) Law 1967 as at 31 December 2021 on which the estimates in this review have been based. This summary concentrates on those aspects of the benefit entitlement and contributions payable that are significant in financial terms.

Contributions

Class 1 contributions Class 1 contributions are required from everyone on the Island between school leaving age and pension age who works for an employer and has earnings in excess of the minimum earnings threshold, with some exceptions. Employees and employers both pay Class 1 contributions, based on the employee's earnings.

The contribution to the Jersey Health Insurance Fund is 2% of earnings up to the SEL, split 1.2% from the employer and 0.8% from the employee. There is no States contribution.

The employee does not need to pay contributions if they are over pension age or meet certain other conditions.

Class 2 contributions Those who do not pay Class 1 contributions pay Class 2 contributions, unless they are exempt.

The contribution to the Jersey Health Insurance Fund is 2% of the SEL, or 2% of actual earnings up to the SEL where the individual is eligible to pay earnings-related contributions. There is no States contribution.

A self-employed person does not pay contributions if they are over pension age, or meet certain other criteria.

C.2 Table C.1 shows the main features of the overall Social Security contribution system with values applicable in 2023.

Table C.1: Main features of the contribution system

Class 1	
Minimum earnings threshold	
Weekly	£115
Monthly	£499

Standard Earnings Limit (annual)	£60,720
Upper earnings Limit (annual)	£276,864
Employee rate up to Standard earnings limit	6.0%
Employer rate up to standard earnings limit	6.5%
Employer rate – above standard earnings limit and up to Upper earnings limit	2.5%
Class 2	
Minimum earnings threshold	
Weekly	£115
Monthly	£499
Standard Earnings Limit	£60,720
Upper earnings Limit	£276,864
Standard rate up to Standard earnings limit	12.5%
Upper rate– above standard earnings limit and up to Upper earnings limit	2.5%

Benefits

C.3 Table C.2 shows the benefits and services in force in 2023.

Table C.2: Benefit rates

Eligibility	To be eligible for the benefits, the individual must have been resident in Jersey and paid the appropriate social security contributions (unless exempt) for at least six months. In effect we understand and assume that the Fund covers all those who have been resident in Jersey for at least six months.
Medical benefit (refunds in respect of GP consultation charges)	The scheme provides a payment towards the cost of consultations with a general practitioner (GP). This benefit has been £20.28 for the whole period covered by the review. The patient is required to meet the difference between the doctor's actual charge and the rate of Medical benefit. Since 2015 £20 is paid direct to the GP and £0.28 paid separately to a central GP organisation to cover certain administrative costs – the distinction in destination of the amounts is not material in projecting the finances of the HIF, and for the purposes of the calculations for this report, a figure of £20.28 will be used.

Pathology benefit A pathology benefit is paid in respect of the charges made for tests relating to haematology and clinical chemistry at a rate of £10.35 for the whole period of the review.

Pharmaceutical benefit The Social Security Department provides a benefit from the Health Insurance Fund in respect of approved drugs prescribed by GPs, non-medical prescribers or dentists and dispensed by community pharmacists. In addition to meeting the cost of the drug itself, the Department pays a dispensing fee for each prescription dispensed, and a formula is applied to the value of discount achieved by the pharmacist, to create the total remuneration package.

The scheme pays the full dispensing cost of drugs prescribed. The prescription charge (the part of the drug cost met by the patient) was set to zero in February 2008. Drugs must be on the “prescribed list” designated by the Minister for Social Security in order to qualify for support from the Fund.

Dispensing fees are paid under a two-tier rate. A pharmacist receives a basic dispensing fee of £3.51 for the first 50,000 items he or she supplies, and a basic dispensing fee of £3.13 for each further item dispensed in the period.

Amounts shown for the pharmaceutical benefits in the Minister’s Reports are net of amounts of notional discount clawed back.

Gluten-free vouchers Vouchers are provided for individuals who cannot take gluten in their diet. The value of the voucher is £14 a week for each beneficiary. Conditions for receiving the vouchers were tightened in 2017.

Other Primary Care Services provided from the Fund

a) Jersey Quality Improvement Framework

In 2015 the Minister for Social Security introduced the Jersey Quality Improvement Framework (JQIF) under which payments are made to GP practices under a standard contract with the aim of encouraging high quality outcomes for patients. All GP surgeries participate in the framework, which distributes payments according to whether practices meet some or all of around 35 clinical and organisational measures. The budgeted amounts increased from £1.6 million in 2017 to 1.9 million in 2021. Future funding commitments for JQIF will increase funding to £2 million in 2022, £2.2 million in 2023 and £2.5 million in 2024.

b) Flu vaccination service

In 2017 the Minister for Social Security introduced a flu vaccination service under which payments are made to GP practices and community pharmacies to provide flu vaccinations to indicated groups. GP surgeries and community pharmacies provide the service. The amounts paid were around £252k in 2017, £278k in 2018, £331k in 2019, £838k in 2020 and £653k in 2021.

Costs of the vaccination campaign increased during 2020 and 2021 in response to increased costs incurred by delivering a vaccination service during the Covid pandemic:

- Groups eligible for vaccination were expanded to include those aged 50 to 64
- Vaccinations were fully funded. Prior to 2020 a £10 co-payment was charged but in 2020 and since then the patient fee has been absorbed into the fees paid by Government
- Provider costs for undertaking the service increased considering the need to maintain social distancing and other infection control mechanisms

c) Cervical Screening Service

In 2018 the Minister for Social Security introduced the cervical screening service under which eligible patients receive regular cervical screening check-ups, free of charge. The aim is to encourage high take up of screening services and take up has increased since the service was introduced. All GP surgeries participate in the service. The amounts paid were around £0.05 million in 2018, £0.2 million in 2019, £0.15 million in 2020 and £0.3 million in 2021.

d) Diabetic Supplies Scheme

In November 2018 the Minister for Social Security introduced the Diabetic Supplies Scheme under which patients with a diagnosis of diabetes receive supplies necessary for testing blood glucose levels free of charge. Supplies include testing strips, lancets, syringes and continuous monitoring systems. The supplies are available from community pharmacies with the pharmacies also monitoring use and providing regular advice and guidance. All community pharmacies participate in the Scheme. The amounts paid were £420k in 2020 and £570k in 2021.

e) Remote services contract

In 2020 the Minister for Social Security introduced the Remote Services contract under which GPs are provided with a fixed fee when undertaking a “remote” consultation. This contract was introduced during the Covid pandemic when physical access to GP surgeries was restricted. The contract has remained in place since then offering flexibility to both patients and GPs. All GP surgeries participate in the Scheme. £1.3 million was paid in the first full year of operation in 2020.

f) Health Access Scheme

In December 2020 the Minister for Social Security introduced the Health Access Scheme under which payments are made to GP practices under a standard contract with the aim of supporting the cost of access to GP services for lower income households. All GP surgeries participate in the Scheme, which caps the cost of an adult surgery consultation with a GP at £12 with surgery visits free to under 17s. The amounts paid were £1.3 million in the first full year of operation in 2021.

g) **Workforce package**

In 2022 the Minister for Social Security introduced a Workforce Package to support the broadening of the GP practice workforce. This includes phased funding support (running from 2022 to the end of 2024) for the employment of approved healthcare practitioners and ongoing activity funding for services provided by these practitioners.

The amount paid was £0.6 million in 2022. Estimates for 2023 and 2024 are £2 million and £1.3 million.

h) **Allied health professional Activity Fee**

In July 2022 the Minister for Social Security introduced a new contract where an activity fee is paid each time an allied health care practitioner undertakes a consultation with an insured islander. Fees paid are £20.28 for consultations delivered by pharmacists, nurses and paramedics employed by general practice and £10 for Health Care Assistants similarly employed.

Transfers from the Fund following States Assembly decisions

a) **Covid 19**

In 2020 a one off transfer of £5.3 million was made to the Minister of Health and Social Services in respect of primary care services organised by the Health and Community Services department during the pandemic.

b) **Jersey Care Model and Digital Care Strategy**

In 2020 and 2021, the States Assembly approved in principle transfers of up to £11.3 million and up to £13 million respectively, from the Health Insurance Fund to the Consolidated Fund for the purpose of supporting the development of the new Jersey Care Model and Digital Care Strategy. Following these decisions, the Social Security Minister approved a £6.3 million transfer from the Health Insurance Fund in 2022, to cover the actual costs incurred in 2021. There are no plans to make any more transfers.

Appendix D: Population projections for Jersey

- D.1 A key driver of the results of the social security reviews of the Social Security Fund (SIF) and the Health Insurance Fund (HIF) is the assumed size and profile of the Jersey population over the projection period.
- D.2 There are no recent official population estimates or long-term population projections for the Island of Jersey. As a result, GAD have been asked to produce both historic population estimates for the years between the 2011 and 2021 censuses and population projections which cover the review periods. The HIF and the SSF have different review periods but we believe it is appropriate to use the same projections for both reviews.
- D.3 The future population projections use Jersey population estimates at the 2021 census date rolled back to 1 January 2021 as the starting population.
- D.4 These estimates have been projected forward, using mortality and fertility rates from the national 2020-based population projections for England (published by the Office for National Statistics), adjusted to reflect differences between England experience and the derived Jersey experience, for the period 2011-21. The profile of migrants by age and sex were derived from Jersey experience for the years between the 2011 and 2021 censuses by considering a roll-forward between the intercensal populations assuming no migration and comparing the resulting population with that at the census date.
- D.5 The projections include an allowance for the emergence of the COVID-19 pandemic. In particular, this is one of the factors resulting in projected mortality rates that are generally higher at most ages than the corresponding mortality rates in the projections used for the 2017 review.
- D.6 The following paragraphs provide more detail on the assumptions.

Mortality

- D.7 The actual number of deaths by 5-year age group for Jersey for the period 2011-20 has been compared to the expected number had mortality rates in Jersey been the same as those experienced in England over these years.
- D.8 Table D.1 shows the mortality adjustment factors used for these projections compared to those used in the 2017 projections. Note that in those projections the adjustment factors were set by Statistics Jersey.

Table D.1: Adjustment factors for Jersey mortality projections

Age group	Male factor		Female factor	
	2021 review	2017 review	2021 review	2017 review
0-15	1.00	1.00	1.00	1.00
16-29	1.00	1.00	1.00	0.90
30-54	0.90	1.00	0.85	0.90
55-59	0.95	1.00	0.85	0.90
60-64	0.95	0.95	0.85	0.90
65-74	0.95	0.95	0.90	0.90
75 and over	0.95	0.95	0.90	0.95

- D.9 Table D.2 shows the projected cohort expectations of life in Jersey at age 67 for the 2021 assumptions and those used in the previous review. Cohort life expectancy allows for future changes in mortality as a person ages through time and hence is the length of time someone would be expected to live, on average, if future age specific mortality rates are as projected.
- D.10 Projected life expectancies have reduced since 2017 due to changes in the projected mortality rates for England used as the comparators for this review and the projections used in the previous review. This reflects both the lower improvements in mortality in recent years compared to those projected for those years and also changes in the factors applied to estimate Jersey mortality rates.

Table D.2: Cohort expectation of life at age 67

Sex	Year age 67 attained	2021 review	2017 review
Male	2021	18.7	20.9
	2041	20.4	23.0
	2061	22.1	25.1
Female	2021	21.3	23.2
	2041	22.9	25.1
	2061	24.5	27.1

Fertility

- D.11 For fertility we have compared Jersey experience to that of England & Wales over the period 2011 to 2021. Historical fertility rates for England & Wales have been used as a proxy for those for England as the latter were not available – it is assumed the adjustment factors derived from this comparison would be very similar to those from a comparison against England only. Table D.3 shows the resulting adjustment factors applied to the projected fertility rates in the ONS 2020-based interim principal population projections for England to derive projected fertility rates for Jersey.

Table D.3: Adjustment factors for Jersey fertility projections

Age of mother	Factor 2021 review
15-19	0.60
20-24	0.60
25-29	0.75
30-34	0.95
35-39	0.95
40-44	0.80
45+	0.15

D.12 The assumed total fertility rates for 2022 and 2052 are shown in Table D.4 together with those assumed for the previous review. The table also shows the comparative figure from the national projections for England used as the base for the 2021 review.

Table D.4: Projected total fertility rates

	2021 review		2017 review	
	Jersey	England	Jersey	England
2022	1.28	1.55	1.55	1.85
2052	1.37	1.62	1.55	1.85

D.13 The 2020-based projections for England assume that the total number of births in a year is divided between the sexes in the ratio of 105 males to 100 females, in line with recent experience. The experience for Jersey over the period 2011 to 2021 was very similar so this ratio has been assumed for these projections.

Migration

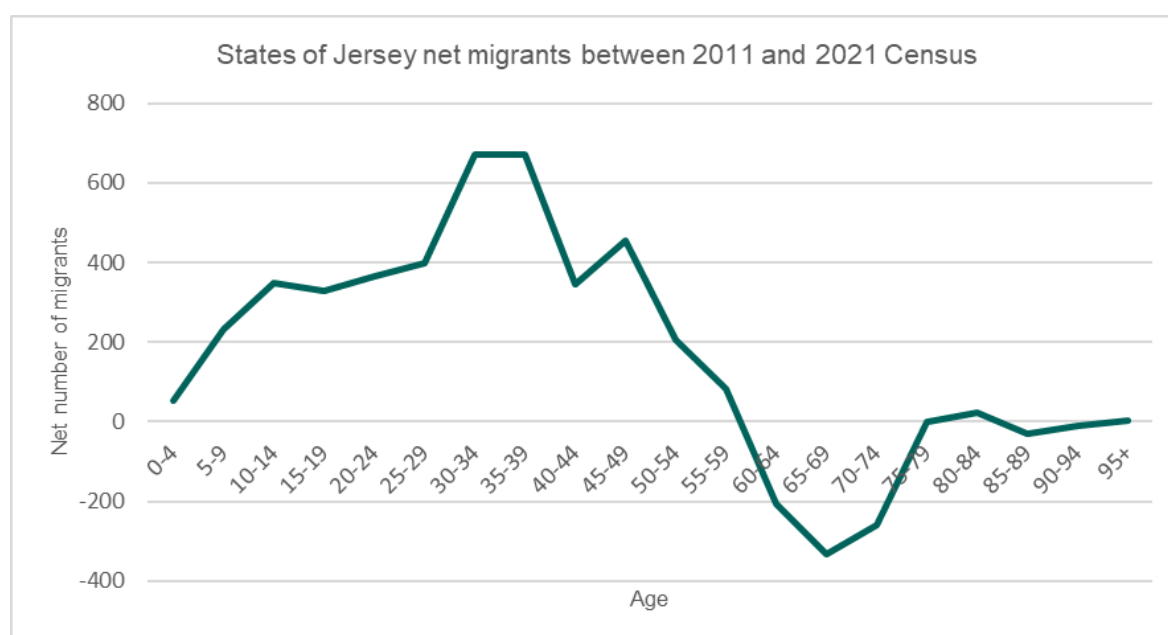
D.14 The total number of migrants between the 2011 and 2021 census dates has been estimated by rolling forward the 2011 census resident population estimate to the 2021 census date using estimated total births and deaths over that period and comparing to the 2021 census resident population estimate. The difference provides an estimate of the number of migrants over the intercensal period.

D.15 This calculation suggests that there was a net inward migration of around 3,340 people over the intercensal period. Overall, these figures suggest that there has been an annualised net inward migration of around 335 people a year over the latest intercensal period.

D.16 For comparison, at the last review, according to Statistics Jersey's 2017 estimate of the resident population, net inward migration averaged 1,080 a year over the five years 2013 to 2017, and 880 a year over the ten years 2008 to 2017.

- D.17 As part of this review, we have been asked to produce figures on net nil migration, 325, 700 and 1,000 net inward migrants per year. All of these (except for the net nil migration which is a new addition) are the same migration assumptions as for the 2017 review.
- D.18 We have analysed the Jersey population data for the period 2011 to 2021 to derive an assumed age and sex distribution of migrants. Chart D.1 shows the age distribution of the net migrants over the intercensal period who were in Jersey at the 2021 census (note that the age distribution of migrants assumed is consistent with 2021 Census report).

Chart D.1: Number of migrants between 2011 and 2021 census dates in Jersey at the 2021 census date by age at the 2021 census date



- D.19 We have set out the assumed age distribution of migrants in Table D.5. As Statistics Jersey produced the last set of population projections we have not been able to provide last time's distribution for comparison.

Table D.5: Age distribution of migrants assumed for the 2021 review

Age range	325 net inward migration		700 net inward migration		1,000 net inward migration	
	Males	Females	Males	Females	Males	Females
0 – 4	5	2	12	3	16	6
5 – 9	9	13	20	29	29	42
10 – 14	19	17	40	34	55	50
15 – 19	19	13	42	30	59	42
20 – 24	21	14	46	31	64	43
25 – 29	14	24	32	52	45	73
30 – 34	33	35	68	77	102	106
35 – 39	33	31	67	68	97	95
40 – 44	12	20	25	45	35	64
45 – 49	22	22	47	48	69	69
50 – 54	12	7	26	16	38	23
55 – 59	6	1	14	1	18	4
60 – 64	-8	-14	-17	-30	-25	-40

Age range	325 net inward migration		700 net inward migration		1,000 net inward migration	
	Males	Females	Males	Females	Males	Females
65 – 69	-17	-15	-35	-35	-50	-50
70 – 74	-16	-7	-36	-17	-50	-24
75 – 79	-1	-1	-1	-2	-2	-3
80 – 84	0	0	0	0	0	0
85 +	0	0	0	0	0	0

Net nil migration

D.20 The annual nil migration scenario is more subjective. We have assumed the same outflows as in the annual 325 in-migration assumption. The outflows at younger ages were then reduced to give an annual net nil migration population projection. Table D.6 shows the assumed net migration numbers by age group for this scenario. The total net-migration over all ages is zero for both males and females.

Table D.6: Age distribution of migrants assumed for the 2021 review in the net nil migration scenario

Age range	Net nil migration	
	Males	Females
0 – 4	0	0
5 – 9	0	0
10 – 14	0	0
15 – 19	1	1
20 – 24	5	3
25 – 29	1	4
30 – 34	16	17
35 – 39	12	10
40 – 44	4	2
45 – 49	4	4
50 – 54	0	0
55 – 59	0	-4
60 – 64	-9	-14
65 – 69	-17	-15
70 – 74	-16	-7
75 – 79	-1	-1
80 – 84	0	0
85 +	0	0

Population projections

D.21 The population of Jersey has been projected to 2082 on four migration bases: nil net migration per year, 325 net inward migration per year, 700 net inward migration per year and 1,000 net inward migration per year.

D.22 Tables D.7 to D.10 provides details of the projected future population of Jersey by age and sex.

Table D.7: Projected population at 1 January, assuming nil net in migration per year

Year	2022	2032	2042	2052	2062	2072	2082
Male							
0-9	5,078	3,928	3,702	3,568	2,938	2,618	2,490
10-19	5,317	5,076	3,925	3,700	3,568	2,937	2,618
20-29	5,845	5,350	5,112	3,968	3,743	3,611	2,985
30-39	6,871	5,981	5,493	5,259	4,122	3,898	3,769
40-49	7,472	6,958	6,086	5,614	5,384	4,262	4,044
50-59	8,339	7,305	6,817	5,985	5,537	5,324	4,232
60-69	5,967	7,702	6,782	6,359	5,607	5,209	5,026
70-79	3,916	4,814	6,363	5,667	5,372	4,773	4,476
80-89	1,898	2,428	3,128	4,273	3,973	3,885	3,580
90-99	308	484	685	999	1,457	1,508	1,583
100+	9	10	17	31	54	88	108
Total male	51,020	50,036	48,110	45,423	41,755	38,113	34,911
Female							
0-9	4,817	3,748	3,527	3,397	2,799	2,497	2,378
10-19	5,268	4,815	3,745	3,527	3,397	2,798	2,494
20-29	5,511	5,300	4,847	3,779	3,563	3,435	2,838
30-39	6,878	5,687	5,478	5,030	3,965	3,749	3,621
40-49	7,538	6,973	5,794	5,590	5,144	4,088	3,877
50-59	8,351	7,448	6,898	5,745	5,554	5,121	4,081
60-69	6,266	7,861	7,023	6,515	5,417	5,252	4,837
70-79	4,409	5,446	6,938	6,243	5,827	4,855	4,745
80-89	2,508	3,165	4,023	5,253	4,871	4,650	3,968
90-99	663	839	1,153	1,604	2,223	2,247	2,264
100+	28	36	50	79	131	201	238
Total female	52,237	51,318	49,476	46,762	42,891	38,893	35,341
Total population	103,257	101,354	97,586	92,185	84,646	77,006	70,252

Table D.8: Projected population as at 1 January, assuming 325 net in migration per year

Year	2022	2032	2042	2052	2062	2072	2082
Male							
0-9	5,092	4,120	4,090	4,129	3,634	3,443	3,452
10-19	5,352	5,368	4,395	4,368	4,408	3,913	3,722
20-29	5,874	5,717	5,735	4,768	4,741	4,780	4,290
30-39	6,908	6,323	6,171	6,194	5,232	5,205	5,250
40-49	7,496	7,301	6,728	6,590	6,614	5,670	5,648
50-59	8,361	7,598	7,421	6,881	6,763	6,801	5,885
60-69	5,968	7,793	7,129	7,001	6,532	6,457	6,519
70-79	3,916	4,815	6,441	5,972	5,942	5,610	5,614
80-89	1,898	2,428	3,129	4,329	4,193	4,313	4,218
90-99	308	484	685	999	1,479	1,596	1,767
100+	9	10	17	31	54	89	116
Total male	51,182	51,957	51,941	51,262	49,592	47,877	46,481
Female							
0-9	4,831	3,924	3,892	3,932	3,456	3,272	3,281
10-19	5,297	5,089	4,182	4,151	4,192	3,718	3,535
20-29	5,542	5,586	5,382	4,476	4,446	4,487	4,014
30-39	6,917	6,082	6,130	5,924	5,024	4,995	5,035
40-49	7,575	7,394	6,570	6,621	6,422	5,527	5,503
50-59	8,366	7,735	7,566	6,765	6,826	6,636	5,759
60-69	6,266	7,923	7,346	7,210	6,455	6,539	6,368
70-79	4,409	5,446	6,993	6,543	6,474	5,825	5,958
80-89	2,508	3,165	4,023	5,297	5,113	5,174	4,770
90-99	663	839	1,153	1,604	2,247	2,368	2,535
100+	28	36	50	79	131	204	251
Total female	52,402	53,219	53,287	52,602	50,786	48,745	47,009
Total population	103,584	105,176	105,228	103,864	100,378	96,622	93,490

Table D.9: Projected population as at 1 January, assuming 700 net in migration per year

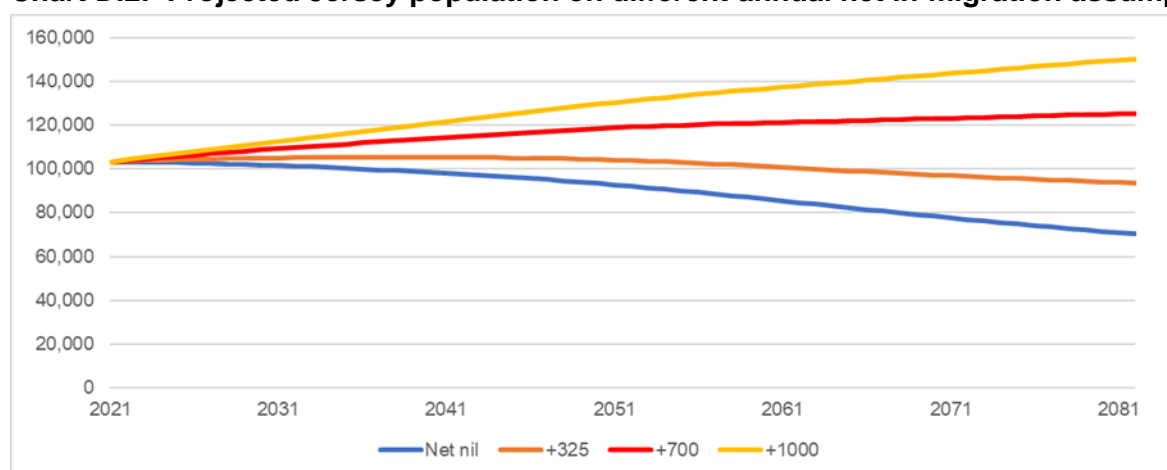
Year	2022	2032	2042	2052	2062	2072	2082
Male							
0-9	5,108	4,432	4,695	4,973	4,645	4,657	4,818
10-19	5,395	5,702	5,026	5,290	5,571	5,243	5,255
20-29	5,918	6,222	6,532	5,859	6,124	6,403	6,076
30-39	6,977	6,902	7,210	7,521	6,856	7,122	7,402
40-49	7,536	7,877	7,811	8,126	8,441	7,790	8,060
50-59	8,385	7,978	8,325	8,282	8,613	8,940	8,317
60-69	5,943	7,791	7,465	7,842	7,848	8,210	8,558
70-79	3,894	4,506	6,155	5,979	6,398	6,497	6,913
80-89	1,898	2,380	2,896	4,108	4,172	4,626	4,868
90-99	308	484	667	923	1,412	1,594	1,913
100+	9	10	17	28	49	84	116
Total male	51,371	54,284	56,799	58,931	60,129	61,166	62,296
Female							
0-9	4,847	4,194	4,443	4,706	4,396	4,412	4,559
10-19	5,330	5,399	4,747	4,996	5,258	4,947	4,964
20-29	5,585	5,981	6,051	5,399	5,650	5,915	5,604
30-39	6,996	6,793	7,190	7,260	6,614	6,865	7,130
40-49	7,629	8,106	7,909	8,309	8,383	7,745	7,999
50-59	8,378	8,116	8,596	8,416	8,827	8,909	8,286
60-69	6,230	7,789	7,569	8,064	7,917	8,345	8,445
70-79	4,397	5,153	6,611	6,484	7,002	6,925	7,387
80-89	2,508	3,132	3,781	4,988	5,057	5,593	5,659
90-99	663	839	1,139	1,501	2,122	2,355	2,765
100+	28	36	50	79	123	193	253
Total female	52,591	55,538	58,086	60,202	61,349	62,204	63,051
Total population	103,962	109,822	114,885	119,133	121,478	123,370	125,347

Table D.10: Projected population as at 1 January, assuming 1,000 net in migration per year

Year	2022	2032	2042	2052	2062	2072	2082
Male							
0-9	5,119	4,647	5,134	5,600	5,415	5,567	5,866
10-19	5,425	5,953	5,483	5,970	6,436	6,249	6,402
20-29	5,950	6,592	7,120	6,651	7,140	7,608	7,425
30-39	7,040	7,396	8,043	8,572	8,109	8,600	9,068
40-49	7,567	8,382	8,742	9,391	9,922	9,477	9,971
50-59	8,402	8,299	9,107	9,482	10,144	10,688	10,270
60-69	5,920	7,768	7,727	8,543	8,953	9,641	10,203
70-79	3,879	4,263	5,912	5,981	6,799	7,261	7,983
80-89	1,898	2,341	2,708	3,921	4,153	4,903	5,422
90-99	308	484	654	861	1,350	1,593	2,043
100+	9	10	17	28	47	81	117
Total male	51,517	56,135	60,647	65,000	68,468	71,668	74,770
Female							
0-9	4,862	4,406	4,870	5,314	5,137	5,286	5,572
10-19	5,360	5,672	5,218	5,682	6,126	5,949	6,097
20-29	5,617	6,275	6,589	6,137	6,601	7,045	6,869
30-39	7,049	7,296	7,954	8,268	7,819	8,284	8,730
40-49	7,669	8,633	8,879	9,539	9,857	9,415	9,885
50-59	8,393	8,430	9,392	9,649	10,316	10,644	10,220
60-69	6,206	7,726	7,797	8,760	9,040	9,725	10,068
70-79	4,387	4,941	6,368	6,507	7,461	7,785	8,497
80-89	2,508	3,109	3,604	4,790	5,064	5,954	6,355
90-99	663	839	1,128	1,425	2,041	2,369	2,959
100+	28	36	50	78	116	185	257
Total female	52,742	57,363	61,849	66,149	69,578	72,641	75,509
Total population	104,259	113,498	122,496	131,149	138,046	144,309	150,279

D.23 Chart D.2 shows the projected total population under the different migration scenarios.

Chart D.2: Projected Jersey population on different annual net in-migration assumptions



Population over State Pension age

D.24 Table D.11 shows the numbers of people over pension age in different future years in our principal projection and compares these to the equivalent numbers from our previous review.

Table D.11 – Numbers over pension age at the start of the financial year

Year	2017 review	2021 review	Change
	(000s)	(000s)	(000s)
2021	18.8	18.5	(0.3)
2030	22.6	21.6	(1.0)
2040	27.1	26.6	(0.5)
2050	28.8	29.1	0.3
2060	29.6	29.5	(0.1)
2070	30.5	28.8	(1.7)
2080	N/A	29.2	N/A

Appendix E: Limitations

- E.1 This work has been carried out in accordance with the relevant actuarial professional standards TAS 100 and APS X4 issued by the Institute and Faculty of Actuaries.
- E.2 This report has been prepared in accordance with the Health Insurance (Jersey) Law 1967, which requires an actuary to report on the financial condition of the Health Insurance Fund and the adequacy or otherwise of the contributions payable to support the prescribed benefits. It is not appropriate for any other purpose.
- E.3 This report has been prepared for the Minister for Social Security (“the Client”), although it is understood that the report will be made publicly available.
- E.4 No person or third party is entitled to place any reliance on the contents of this report, except to any extent explicitly stated herein, and GAD has no liability to any person or third party for any act or omission taken, either in whole or part, on the basis of this report.
- E.5 It is anticipated that the results in this report will be used by the Client for information purposes and for considering possible changes to contributions or benefits payable. However, before deciding on any potential changes, further actuarial advice should be sought in order to confirm the potential impact on the finances of the Fund.
- E.6 GAD are not legal or investment advisers and our advice does not constitute legal or investment advice. Advice in these areas should be sought from appropriately qualified persons or sources.
- E.7 This report has been prepared for use by persons technically competent in the areas covered. This report must be considered in its entirety, as individual sections, if considered in isolation, may be misleading, and conclusions reached by review of some sections on their own may be incorrect.
- E.8 We understand that in some circumstances, our report may be translated into other languages. In this case, GAD will not be held responsible for any action taken on the basis of the translated report rather than the English version. Any translation of the report must make it clear that only the original English language version is definitive.

Reliance on data and assumptions

- E.9 In preparing this report, GAD has relied on data and other information supplied by the Client, as described in the report. Any checks that GAD has made on this information are limited to those described in the report, including any checks on the overall reasonableness and consistency of the data. These checks do not represent a full independent audit of the data supplied. In particular, GAD has relied on the general completeness and accuracy of the information supplied without independent verification.
- E.10 We have discussed with the client our approach to using anomalous data. In particular, we have agreed an appropriate approach to contribution data which was found to have errors in the source data.

- E.11 The projections shown in this report depend on the assumptions adopted. While the assumptions adopted form a reasonable basis for the review, in practice the Fund's experience, and hence its financial progress, will be different.
- E.12 The projections only consider income to and expenditure from the Fund and, in particular, make no allowance for any impact these might have on means-tested benefit payments or tax receipts.

Appendix F: Summary of projections

Table F.1: Summary of income, outgo and the projected Fund balance in the Health Insurance Fund in real earnings terms based on the baseline assumptions (assuming +325 net inward migration)

£m	2022	2027	2032	2037	2042
Fund at start of year	93.9	97.4	72.8	23.1	0.0
Contributions	38.2	38.1	37.5	36.8	36.0
Investment return	2.9	3.0	2.1	0.5	0.0
Total income	46.6	41.0	39.7	37.3	36.0
Outgo:					
Medical benefit (all primary care services)	12.4	12.7	12.8	12.9	12.9
Pharmaceutical benefit (total)	22.6	26.2	30.3	35.0	40.2
Gluten free vouchers	0.3	0.3	0.3	0.3	0.3
Administration costs	2.3	2.2	2.2	2.2	2.1
Total outgo	37.7	41.5	45.6	50.3	55.5
Excess of income over outgo	8.9	-0.5	-6.0	-13.0	-19.5
Fund at end of year	102.8	96.9	66.8	10.0	0.0
Mean Fund expressed as months of outgo excluding transfers from Fund	31	28	18	4	0
Break-even contribution rate	2.0%	2.2%	2.4%	2.7%	3.1%

Table F.2: Summary of income, outgo and the projected Fund balance in the Health Insurance Fund in real earnings terms based on the baseline assumptions (assuming +700 net inward migration)

£m	2022	2027	2032	2037	2042
Fund at start of year	93.9	99.8	80.7	39.0	0.0
Contributions	38.5	39.6	40.3	40.8	41.3
Investment return	2.9	3.1	2.4	1.0	0.0
Total income	46.9	42.6	42.7	41.9	41.3
Outgo:					
Medical benefit (all primary care services)	12.5	12.9	13.2	13.5	13.7
Pharmaceutical benefit (total)	22.7	26.7	31.3	36.6	42.8
Gluten free vouchers	0.3	0.3	0.3	0.3	0.3
Administration costs	2.3	2.2	2.2	2.2	2.1
Total outgo	37.7	42.1	47.0	52.6	58.9
Excess of income over outgo	9.1	0.5	-4.3	-10.7	-17.6
Fund at end of year	103.1	100.3	76.4	28.3	0.0
Mean Fund expressed as months of outgo excluding transfers from Fund	31	28	20	8	0
Break-even contribution rate	2.0%	2.1%	2.3%	2.6%	2.9%

Table F.3: Summary of income, outgo and the projected Fund balance in the Health Insurance Fund in real earnings terms based on the baseline assumptions (assuming +1,000 net inward migration)

£m	2022	2027	2032	2037	2042
Fund at start of year	93.9	101.7	87.0	51.7	0.0
Contributions	38.8	40.8	42.5	44.1	45.5
Investment return	2.9	3.1	2.6	1.4	0.0
Total income	47.2	43.9	45.1	45.5	45.5
Outgo:					
Medical benefit (all primary care services)	12.5	13.1	13.5	14.0	14.4
Pharmaceutical benefit (total)	22.7	27.0	32.0	37.9	44.8
Gluten free vouchers	0.3	0.3	0.3	0.3	0.3
Administration costs	2.3	2.2	2.2	2.2	2.1
Total outgo	37.8	42.7	48.1	54.3	61.6
Excess of income over outgo	9.3	1.2	-2.9	-8.8	-16.2
Fund at end of year	103.3	103.0	84.1	42.9	0.0
Mean Fund expressed as months of outgo excluding transfers from Fund	31	29	21	10	0
Break-even contribution rate	2.0%	2.1%	2.3%	2.5%	2.7%

Table F.4: Summary of income, outgo and the projected Fund balance in the Health Insurance Fund in real earnings terms based on the baseline assumptions (assuming net nil inward migration)

£m	2022	2027	2032	2037	2042
Fund at start of year	93.9	96.2	69.4	16.8	0.0
Contributions	38.0	37.1	35.7	34.1	32.5
Investment return	2.9	2.9	2.0	0.3	0.0
Total income	46.3	40.0	37.7	34.4	32.5
Outgo:					
Medical benefit (all primary care services)	12.4	12.5	12.4	12.3	12.2
Pharmaceutical benefit (total)	22.6	25.8	29.4	33.4	37.8
Gluten free vouchers	0.3	0.3	0.3	0.3	0.2
Administration costs	2.3	2.2	2.2	2.2	2.1
Total outgo	37.6	40.9	44.4	48.2	52.3
Excess of income over outgo	8.8	-0.9	-6.6	-13.8	-19.9
Fund at end of year	102.7	95.3	62.8	3.0	0.0
Mean Fund expressed as months of outgo excluding transfers from Fund	31.4	28.1	17.9	2.5	0.0
Break-even contribution rate	2.0%	2.2%	2.5%	2.8%	3.2%



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