Why the Who Pays Series Exists

Delivering patient access to approved treatments

Compiled 13 October 2026

A medicine or technology can be approved by NICE, wanted by every clinician who has seen it work, and still reach almost nobody for two years.

The gap is rarely clinical. It is a question of which pound pays, under which clause, approved by whom — and of whether anyone has the clinic time, the pharmacy capacity or the procurement route to turn a recommendation into a treated patient.

That gap is where this series lives.

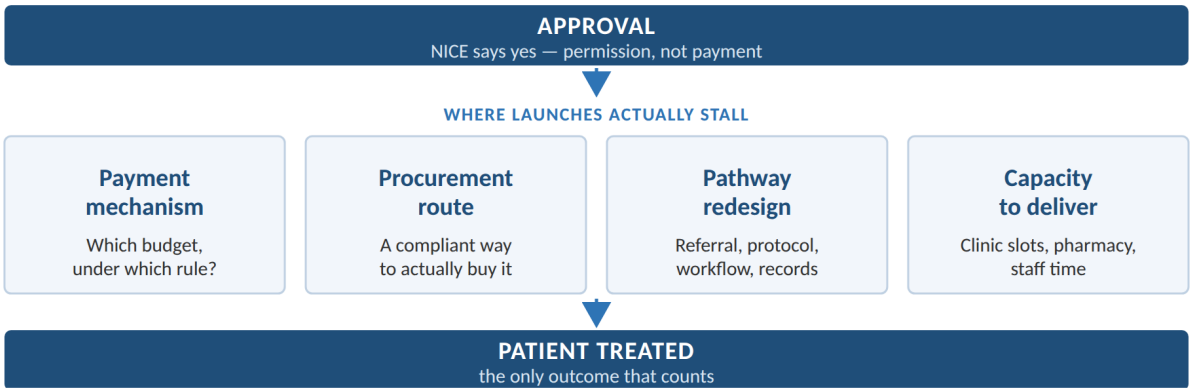


Figure 1. Four gates sit between a positive recommendation and a treated patient. Each is decided by different people, on different timetables, under different rules — and a launch stalls at the first one nobody planned for.

What each briefing does

Each one takes a single question and answers it end to end: the named mechanism, the clause or fund it sits in, the people who sign it off, and what usually goes wrong.

Not "engage the ICB". The budget line, the payment route, the approval form, the committee, the tender, and the date it closes.

What "framework" means here

The word does three different jobs in the NHS, and conflating them is the fastest way to lose a room.

A **procurement framework** is a buying agreement — a pre-competed list of suppliers a Trust can purchase from without running a full tender. A **Modern Service Framework** is a national statement of what good clinical care looks like in one condition area. And a **policy or planning framework** is a document that sets how the money moves and what organisations are held to.

This series is mostly about the third kind. Eight of them govern the money for every product type in England, whether it is a medicine, a device or a piece of software:

- **NHS Payment Scheme** — the statutory prices and payment rules, and what sits outside them
- **Strategic Commissioning Framework** — what an ICB is now for, and how it decides what to buy
- **NHS Standard Contract** — where national policy becomes a binding local obligation
- **Medium Term Planning Framework** — the three-year targets and the financial envelope
- **Better Care Fund** — the pooled NHS and local government budget
- **Quality and Outcomes Framework** — what general practice is paid to do
- **NHS Oversight Framework** — what every organisation is publicly measured and ranked on

- **Modern Service Frameworks** — the national clinical standards, by condition

Each does exactly one job: compel, fund, plan, measure, or pay. Five verbs, eight documents. Almost every failed access argument is a funding argument made to an audience that only measures, or a compliance argument made to someone the clause does not bind.



Figure 2. The eight policy and payment frameworks, grouped by the one job each does. Citing the wrong one for the job at hand is the commonest way an access argument fails.

Knowing which one carries your case — and which one will be quietly ignored — is most of the work.

What it changes

The conversation. Industry and the NHS routinely talk past each other, because one side speaks about the product and the other has to speak about the contract. These briefings supply the NHS's own vocabulary — the clause rather than the concept, the metric rather than the benefit, the fund rather than the ask. A case built on "NICE approved it" loses to a finance director. One that names the budget line, the payment mechanism and the approval route does not.

It corrects internal conversations first. A team that believes a recommendation means funded money will mis-brief its own field force, set the wrong forecast, and spend two quarters being surprised. Correcting that early is cheaper than correcting it in front of a commissioner.

Access. The series does not open access. It shortens the distance to it, and shows which doors are actually unlocked. It names the four places access fails — payment mechanism, procurement route, pathway redesign and capacity — so they become plannable before the first meeting rather than discovered at month six. It separates funding from procurement, which stops teams watching the wrong tender while the one that decides their volume runs under a different regime on a different timetable. And it makes account selection evidence-based, because segmentation, failing metrics and financial position tell you which organisations have the headroom to say yes.

There is an equity consequence. Resource follows the areas performing worst, not the site already doing well. A team that understands that stops courting the enthusiast — which happens to be the behaviour that narrows variation rather than widening it.

Outcomes. Here the claim has to be careful, so it is made carefully.

The series produces no outcomes. What it addresses is the distance between a positive recommendation and a treated patient, and that distance is administrative rather than clinical. In several of the areas covered here, large numbers of eligible patients remain untreated behind a positive recommendation — because of funding mechanism, phasing and capacity, not because the evidence is missing.

Anything that shortens the time from approval to a funded, staffed, contracted pathway converts into patients treated. But no briefing series can claim a share of that; the chain runs through too many hands to attribute. The honest claim is narrower: fewer launches that stall for reasons nobody in the room could name, and fewer months lost arguing the wrong thing with the wrong person.

Why it is free

Publishing it openly changes who holds the map. A company without a market access function gets the same architecture a large one has. And NHS teams read it too — which matters, because this is as much a description of the system to itself as it is an industry asset.

How it is written

AI does the retrieval and the first draft. Every material claim is traced to a primary source and linked. The framing, the judgement and the warnings are mine, and each briefing publishes what it could not verify rather than smoothing it over.

AI is very good at answering. It does not know what to ask.

Each page carries the date it was compiled, because the NHS in England is in the middle of its largest structural change since 2012. The names, boundaries, contacts and prices in these briefings will move. The mechanisms and the logic will not.

Not advice — a map.

Work with me

Delivering patient access to approved treatments is the work, and the briefings and the commercialisation work are the same skill set — from map to delivery. If you have a product approaching or past approval and the pathway is not yet funded, staffed or contracted, that is the conversation I have.

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