# Health Foundation response to the House of Lords Economic Affairs Committee inquiry into the funding challenges of the social care system in England

October 2018

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## Section One: What are the funding challenges for social care in England, and how can they be overcome?

While NHS funding has increased since 2009/10, social care spending was cut by 13% in real terms between 2009/10 and 2015/16[1]. This is despite the number of people aged over 65 increasing by more than a million over that period. The result is at least 400,000 fewer people could access care by 2013/14. Age UK estimated that in 2016/17 1.2 million people aged 65 and over, had some level of unmet care needs, up from 1 million in 2015/16.[2]

The Dilnot commission estimated that around 10% of people aged over 65 faced long-term care costs of over £100,000[3]. The current system in England provides public funding only to those with the greatest need and the lowest means. A person will not qualify for any level of public funding until their assets are below £23,250 and will not receive full funding until their assets are below £14,250. If someone requires care in a residential or nursing home, their assets are likely to include the value of their home. Over recent years the threshold of need has increased and the real value of the means test has fallen 12% since it was set in 2010/11.

Long-term demographic trends that make calls for major social care reform are becoming more and more urgent. There are two complementary trends at work:

- the demographic 'bulge' of people – the baby boomer generation – born in the 1920s or so years after the Second World War, who are now reaching retirement in the first decades of the 21st century;
- the increased longevity of that population, with life expectancy at birth now 79.5 years for men and 83.1 years for women.

As a consequence, the population aged over 75 years is projected to double in the next 30 years and the number of people aged over 85 years in the UK is predicted to more than double in the next 23 years to over 3.4 million.

As the population ages, it is predicted that by 2030 there will be:

- 45% more people living with diabetes
- 50% more people living with arthritis, coronary heart disease or stroke
- 80% more people (nearly two million in total) living with dementia.

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[1] Figures in this draft are in real terms for 2018/19 using the most recent September 2018 GDP deflator with the exception of the numbers in and directly following, table 1 below, which use the March 2018 deflators.
[2] Briefing: Health and Care of Older People in England 2017, Age UK, February 2017 https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/the_health_and_care_of_older_people_in_england_2017.pdf
[3] http://webarchive.nationalarchives.gov.uk/20130221121534/http://www.dilnotcommission.dh.gov.uk/our-report/

These population trends have important, well-reported, impacts on health and social care demand. They have been exacerbated by related trends in working-age disability, with more disabled people surviving longer and the costs of their support increasing. As a result, social care for people of working age now costs local authorities (LAs) about as much as that for older people.

Spending reductions have affected providers of social care services, with an increasing number of LAs reporting suppliers handing back contracts. A report by the Competitions and Markets Authority, published in November 2017, said that 'Many care homes, particularly those that are most reliant on local authority funded residents, are not currently in a sustainable position'[4].

The ability to recruit and retain a skilled workforce is also under pressure, with high vacancy and turnover rates in the social care sector. The Care Quality Commission, which regulates care providers, said in 2016 that the system was at 'tipping point' and in 2017 that it 'remained precarious'.

About 110,000 jobs in adult care in England are left vacant, a rise of 22,000 in a year, according to data from Skills for Care[5] – from an estimated 6.6% in 2017 to 8% in 2018. The statistics also show 31% of carers left or changed jobs in 2017 to 2018.

In March 2018, the NHS Agenda for Change pay award provided the lowest paid NHS staff across England pay rises of up to 29% over the next three years. Social care providers and commissioners are concerned that an unintended consequence of this pay award will be further pressures on both recruitment and retention of care staff in the social care sector, if similar wages are not available. The Associated Directors of Adult Social Services estimate the cost of a comparable increase for social care staff at £3bn a year. Without significant increases in social care budgets this would only be afforded if there were substantial further cuts to eligibility.

Staffing issues will be critical over the coming years. At present, around 95,000 social care staff come from European Economic Area (EEA) countries. The Migration Advisory Committee (MAC) was commissioned by the Home Secretary to report on the current and likely future patterns of EEA migration and its impacts, to provide an evidence base for the design of a new migration system following the UK's exit from the EU. Its report recommends that there isn't an explicit work route for 'low-skilled' migration, with the possible exception of seasonal agricultural workers schemes. It recognises that social care is a sector that struggles to recruit and retain workers and that this is a concern as demand is rising. It also notes the important contribution made by EEA workers, but argues that the

[4] https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homes-market-study-summary-of-final-report

[5] https://www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/publications/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx

sector's workforce problems are not primarily migration-related.[6] The basic underlying problem is poor wages, which makes it unattractive to both UK residents and migrants alike, in turn caused by the difficulty in finding a sustainable funding model. After the UK leaves the EU, without a work route for lower paid social care workers, the need to address pay and terms and conditions will be even greater. We agree with the MAC that pay and terms and conditions are the fundamental problem. For example, nearly one in four workers on a zero hours contract in the UK work in health or social care[7]. But if government is not prepared to increase funding levels it is hard to see how the sector can sustain quality and access to care.

Public concern about the state of social care is increasing, at least in part because of several high-profile scandals involving abuse or neglect in the care of older people. The collapse of care home provider Southern Cross Healthcare in 2011 and the withdrawal from the publicly funded home care market of several major suppliers has also focused concern on the sustainability of the market for providing social care.

However, the ageing society is of concern not just because of current and expected demand for services, but also because it implies fewer working-age people paying tax to fund public services generally. The baby boomer generation is now retiring and there will be more of them and fewer people to support them in that retirement. In 2016, there were an estimated 308 people of pensionable age for every 1,000 working-age people. By 2037, this is projected to increase to 365 people.

Pressures were recognised with new funding announced in the 2015 comprehensive spending review. This included a new 'precept' which allowed councils to add 2% onto council tax to pay for social care services, later raised to 3% for certain years. Additional funding from central government was also provided through the Improved Better Care Fund (IBCF). With later increases announced, this meant over £2bn of additional funding was available in 2017/18, rising to £3.6bn by 2019/20, above what would have been spent (2018/19 prices). As a result, public spending on adult social care is expected to rise by an average of 2.5% a year between 2015/16 and 2019/20.

However, this continues to lag behind growth in pressures, which are rising by at least 3.7% a year in real terms. Relying on the precept – and the move towards greater retention of business rates – also creates concerns about the level and equity of funding available for social care between different LAs.

The Institute for Fiscal Studies (IFS) recently drew attention to these localised disparities in funding[8]. Changes in social care spending per adult between 2009/10 and 2015/16 varied

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6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/741926/Final_EEA_report.PDF

7 https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/contractsthatdonotguaranteeaminimumnumberofhours/april2018

8 https://www.ifs.org.uk/uploads/publications/comms/R128.pdf

widely across England, with around 1 in 10 LAs cutting spending by more than 25%, while another 1 in 7 increased spending. Cuts have been far larger, on average, in London (18%) and the metropolitan districts (16%) covering other urban areas such as Greater Manchester, Tyneside and Greater Birmingham, than in the rest of the country. Outside these areas, cuts have been larger in the north of England than the south, on average.

Cuts have been greater in areas that seem to have relatively high levels of spending needs. LAs that had higher levels of deprivation, more working age disability benefit claimants and more adults on pension credit, and therefore were assessed to have relatively high levels of spending need in 2009/10, made larger cuts to adult social care spending, on average, over the subsequent six years.

Whilst national data on expenditure for 2017/18 is pending release at the time of writing, the Associated Directors of Adult Social Care Budget Survey of Directors confirms the precarious position continues to this time. Only nine directors felt optimistic about the financial state of the wider health and social care economy in their area over the next 12 months. This perhaps reflects the fact that the extra short-term funding made available will not present a long-term solution to the significant cost pressures facing adult social care as outlined above. Nor are directors optimistic about their ability to manage within expected resources in the future, with just 28% of respondents fully confident that planned savings for 2018/19 will be met.

The £240m emergency injection of funding announced by the Secretary of State in October 2018 will provide some welcome relief to the annual winter pressures experienced in A&E departments, but with a funding gap of at least £1.5bn projected for 2020/21 – this falls well short of a complete solution, even for this year and the next.

The government recognises that social care is under long-term pressure and needs fundamental reform, and has committed to a green paper. This was first promised in the March 2017 Budget, to be published in Summer 2017, but has been delayed three times and is now planned for this Autumn.

**Section two: Why have successive Governments been reluctant to address challenges in the delivery of social care?**

Our joint report with the King's Fund 'A fork in the road' looked at public attitudes to social care through a series of deliberative workshops and questions in the National Centre for Social Research's British Social Attitudes Survey[9]. The findings offer clues as to why social care has been so hard to reform, revealing that the public has little understanding of how social care operates and even less understanding of how it is funded.

The reaction to the current funding model was unanimously negative. People were often shocked when the details of the means test were explained to them. One of the political challenges with social care is therefore that the government must first raise awareness of

[9] https://www.health.org.uk/publication/fork-road-next-steps-social-care-funding-reform

the problems with the current system. Raising awareness of these problems is a risky thing to do, especially as there aren't any easy solutions. But you can't have a conversation about solutions to the social care challenges unless the public is informed.

Many people think the current funding system is more generous than it actually is, with some thinking that social care will be free at the point of use, as with the NHS. Recent polling conducted on behalf of Deloitte LLP showed that 63% of people think the NHS provides social care services for older people and just under half (47%) of the public think social care is free at the point of need[10].

Any proposed solution that is not free will be viewed negatively while there is low public understanding. When people are given more detailed information about how social care works, they recognise that there is a significant problem and believe the current system is not fit for purpose.

Combined, increasing demand for services and the increasing 'dependency ratio', have focused attention not just on how we can develop a better, fairer social care funding system but also on how we can pay for it.

But attempts to resolve the issue have created controversy. During the 2010 election campaign, there was a heated debate over the Labour Party's consideration of a tax on people's estates – a so-called 'death tax' – to pay for social care. The issue was then addressed by the 2011 Commission on Funding of Care and Support (Dilnot Commission), which proposed a reformed means test and a cap on the lifetime cost of care that a person might face. The proposal for a cap was enacted in the 2014 Care Act. This legislated for a cap of £72,000 and an increase in the upper means test threshold to £118,000 for care home residents whose property is included in the means test, or £27,000 for others and the lower limit from £14,250 to £17,000. However, implementation of the legislation for this was first delayed and then postponed indefinitely.

The findings of our deliberative work for 'A fork in the road' backed up the British Social Attitudes survey, which found that a majority of people (55%) were willing to see social care as a responsibility shared between themselves (and their families) and the state, yet there was hostility expressed towards the idea of using housing assets to pay for care.

[10] Shrimpton H, Cameron D, Skinner G. State of the State 2017-18: austerity, government spending, social care and data. London: Ipsos MORI on behalf of Deloitte LLP; 2017. Available from: www.ipsos.com/ipsos-mori/en-uk/public-perceptions-austerity-social-care-and-personal-data (accessed 9 May 2018).

During the 2017 general election there was a negative response to Conservative Party proposals that would have made the system more generous with a floor and including, as a late addition, by introducing a cap on costs.

To find and implement a solution to social care funding, public understanding needs to improve and awareness-raising measures must be part of any implementation. Mistrust of government, however, means a traditional education campaign is unlikely to be enough.

A second reason why governments may have been reluctant to take action on social care is that they have effectively saved money by doing nothing. The complexity of the system has allowed the government to go unnoticed in making fiscal savings by reducing the number of people eligible for publicly funded social care.

Through the government not changing the threshold for social care eligibility during a period of inflation, over 400,000 fewer older people accessed publicly funded social care in England in 2013/14 than in 2009/10 – a drop of 26% [11].

Funding for the adult social care system in England was at its highest point in 2009/10 with total spending of £348 per head of the population in real terms. By 2015/16 it had fallen in real terms to £305, a drop of 13%. Spending per head in 2015/16 in England is significantly below that in Scotland, Wales and Northern Ireland at £453, £410 and £449 respectively.

**Section three: How can a sustainable funding model for social care supported by a diverse and stable market be created?**

Our joint report with the King's Fund 'A fork in the road' considers the introduction of five potential funding policies. They were chosen to reflect solutions commonly raised in the debate around social care funding:

- improving the current system, the current system has had, through fiscal drag, a reduction in real terms funding of 13% from 2009/10 to 2015/16. Some estimate that this has led to 400,000 fewer people being eligible for publicly funded social care.
- introducing free personal care, a model that has been implemented in Scotland since devolution of social care policy to national government at the beginning of the 21st century.
- introducing a cap on costs and a revised 'floor' to the means test, similar to the conservative offer of the 2017 General Election.

[11] For example, if you lived in England in 2014/15 and had assets of £23,040 then you were eligible for government funded care. Say in the next year your assets appreciated by 2%, and at the same time inflation was 2%. Your assets would then be worth £23,500 in nominal terms but in real terms there would be no change. However, you would become ineligible for funded care, without having gained any wealth.

- introducing a hypothecated tax for social care
- introducing a single budget for health and social care.

We are clear that these options are neither directly equivalent nor mutually exclusive, and that they tackle very different aspects of the social care funding challenge. They are also not an exhaustive list of the possible models that policymakers could consider.

Our report discusses the likely cost implications of these options, as well as the required increase in taxes to cover the bill.

**Table 1: Costs of alternative models for social care funding in England**

| | | **Current system** | | **Reforms** | |
|---|---|---|---|---|---|
| | | Maintaining at 2015/16 levels | Restoring to 2009/10 levels | Cap and floor[1] | Free personal care |
| 2020/21 | Projected cost pressures | £21bn | £27bn | £25bn | £26bn |
| | Increase from 2015/16 spend of £17.1bn | £4bn | £10bn | £8bn | £9bn |
| | Additional cost above maintaining 2015/16 | N/A | £6bn | £4bn | £6bn |
| | Projected funding available | £19bn | | | |
| | **Extra funding required** | **£1.5bn** | **£8bn** | **£5bn** | **£7bn** |
| 2030/31 | Projected cost pressures | £29bn | £39bn | £35bn | £37bn |
| | Increase from 2015/16 spend of £17.1bn | £12bn | £22bn | £18bn | £20bn |
| | Additional cost above maintaining 2015/16 | N/A | £9bn | £6bn | £8bn |
| | Projected funding available | £23bn | | | |
| | **Extra funding required** | **£6bn** | **£15bn** | **£12bn** | **£14bn** |

[1] A cap of £75,000 and a floor of £100,000. The actual level of the cap has not been specified and costs will depend greatly on this.

Retaining the current system would involve minimal disruption to the administrative system, compared with implementing a new model, and no transition costs. However, it would require additional funding. Simply maintaining 2015/16 levels would require an extra £1.5bn in 2020/21, rising to £6bn by 2030/31. However, this or even more substantial levels of additional funding would not fix problems including issues around complexity and fairness, nor would it protect people against catastrophic costs.

Major improvement under the current system, that is, returning to the level of quality and access observed in 2009/10, while meeting demand pressures since then, would require much greater levels of investment. Compared with our estimated budget rising by 2.1% a year, this option would increase the funding gap to £8bn in 2020/21, and £15bn in 2030/31.

The cap and floor offer prioritises protecting people from having to sell all their assets or facing catastrophic lifetime care costs. We estimate this would increase the estimated funding gap to £5bn in 2020/21 and £12bn in 2030/31. While being more generous, this option creates 'winners and losers'. More people would receive state-funded residential care but fewer would receive funding for domiciliary care.

Introducing free personal care for all older people with eligible needs would increase access to free care, and with it, remove one of the systematic barriers to integration with health. This would increase the estimated funding gap to £7bn in 2020/21 and £14bn in 2030/31. Though this is the more expensive of the two reform options, it is not more expensive than investing to restore access to levels seen in 2009/10.

In reforming social care, a critical question is, which attributes of a reformed system a government should seek to prioritise: equity/fairness, economic efficiency/value for money, sustainability and resilience, acceptability and accountability, clarity/ease of use or costs of implementation? In practice, successful reform will need to balance each of these attributes.

All the options that we analysed require more money and none are capable of immediately address the prevailing issues in social care. The question that needs answering is, which aspect of the system do we need to prioritise as a first step to producing a lasting solution?

**Section four: How can the cost of the provision of social care be fairly distributed?**

When presented with the issue of fairness, the public are divided in their response. Throughout a series of deliberative events held by Ipsos MORI, most people favoured the idea of the state having the most responsibility for funding social care. The National Centre for Social Research's British Social Attitudes survey found that the majority of people (55%) favoured options where responsibility was shared, namely 'means tested' (30%) and 'means tested and capped' (25%), whereas 41% favoured 'the government (paid for by taxes)'.

When the means test is explained, almost everyone agrees that the current system is unfair. But what counts as fair is complicated. The House of Commons Health and Social Care Select Committee has raised the prospect of a charge on inheritance tax to contribute to social care. This option has been raised before. In 2010, Andy Burnham proposed a £20,000

compulsory levy on people's estates. The Conservative party dubbed it the 'death tax' and the proposal sunk under the weight of electioneering.

OECD[12] analysis of optimal tax policy and the independent Mirrlees Review[13] all question the current balance of taxation of wealth and earnings. There is also debate linked to this about intergenerational fairness. As the deliberative work shows, the public remain very attached to the idea of home ownership and passing on their home to their children.

Research shows that there is a keen sense of unfairness around any system that asks people to contribute housing wealth to fund social care, as happens now. Most people understood that social care reform might disproportionately benefit older generations. However, they saw this as a consequence of being fair to older generations in a different way – recognising they had already 'paid in' to the system – and because they wanted to protect housing assets. These two latter types of fairness overrode the notion of fairness to younger generations, partly because they were seen to have more time to adjust to the idea and partly because 'we have to start somewhere'. Although people recognised that younger generations faced financial challenges, this was balanced by a strong sense that it is important to be fair to older generations.

Going back to the awkward problem of money and priorities, fixing social care is going to cost money. More than any government could afford after eight years of austerity and sluggish economic growth.

Twenty years ago, the Royal Commission on Long Term care, chaired by Sir Stewart Sutherland couldn't reach a consensus on social care funding; the majority backing the idea of free personal care[14]. The attractions are obvious, but it's expensive – an extra £14bn by 2030 in England. The extra £14bn would go towards helping people with limited income and assets who have pressing needs but are caught below the threshold, which has tightened as austerity has bitten. It would not address the issue of access to care for people on low incomes who are increasingly excluded as the needs test as become more restrictive. Nor would it address quality issues, with the Competition and Markets Authority finding fees paid by LAs for care homes insufficient to sustain current levels of care.

Improving quality and access for the most vulnerable would clearly be desirable and fairer, but also add to cost. If public funding is limited, the central challenge in reforming social care is; if you can't do everything, which unfairness takes precedence?

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[12] https://www.oecd.org/berlin/46391708.pdf
[13] https://www.ifs.org.uk/publications/5353
[14] https://navigator.health.org.uk/content/respect-old-age-long-term-care-%E2%80%93-rights-and-responsibilities-1999

**Section five: What lessons can be learnt from elsewhere in the UK, or from other countries, in how they approach social care?**

a) International comparison

The Health Foundation has funded research from RAND Europe on international comparisons of health and social care funding[15]. The research looked at how 16 other high-income countries have thought about and implemented changes to their funding systems.

It found that most of the reviewed countries fund health care primarily from public sources, such as taxation and mandatory health insurance, but funding of social care often relies more than health care on individuals paying privately. Health and social care funding reforms tend to be incremental rather than radical, are path-dependent, and are catalysed by changes in economic conditions rather than by rising demand for care.

High-income countries have taken diverse approaches to tackling the need to increase health and social care funding and there is no single optimal, or commonly preferred, solution to achieving sustainable revenues.

Overall, it was found that the international evidence does not signpost a single best path to follow for funding health and social care, for the countries of the UK to follow. The reliance on public funding of health care remains strong across all reviewed countries, while social care funding has been at the core of the reform debate in several countries, perhaps more so than the financing of health care. This is reflected, at least in part, by the adoption of mandatory insurance arrangements for funding of (some) social care in a number of countries that originally operated, as the countries of the UK still do, 'safety net' or means-tested systems. These are France, Germany, Japan and Korea.

Many countries raise taxes for health and/or social care at sub-national as well as national levels. Similarly, throughout the UK, local government contributes a small part of funding to the tax base for social care (via council tax, a form of tax based on house values, and business rates), although it does not raise funds for health care. To do so would be administratively complex and would require funding equalisation arrangements so that areas with more vulnerable populations and/or weaker local tax bases did not lose out. Our international review revealed no clear interest in either increasing the reliance on locally

[15] https://www.health.org.uk/sites/health/files/Social%20care%20funding%20-%20international%20evidence_web.pdf

raised taxes or, conversely, on greater centralisation at the level of national government. There are examples of movement in each of those directions.

b) Four nations' social care:

Unlike health care, funding for social care in the UK comes mostly from private sources.

Not only that, a large portion of social care is provided informally, by family and friends. Estimates from the National Audit Office (NAO) for England in 2014 showed that the informal care being provided was worth between £55 to 97bn, which is much greater than the amount of public spending on social care. [5,16]

LAs have the primary responsibility for public funding of social care in the UK, except in Northern Ireland, where five health and social care trusts have this responsibility. In England in 2016/17 (source: Adult Social Care Statistics)[17]:

- £14.8bn was spent by LAs on adult social care (net current expenditure)
- £2.4bn was contributed by the NHS to social care. Although the NHS focuses on health care, it does contribute to some social care to improve health outcomes.

In England, a Social Care Precept was introduced in 2016/17, allowing local government to increase council tax (a form of tax based on house values) by up to 3% per year to pay for more social care.

Northern Ireland, Scotland and Wales each receive a block grant from the UK government (determined by the 'Barnett formula') and have autonomy to decide how to spend their funds, which are then allocated to LAs and NHS organisations. Each country also has autonomy to set their own limits on the value of assets that a person can have while still qualifying for public funds. That ranges from £23,250 in England and Northern Ireland to £26,500 in Scotland and £30,000 in Wales (for care in Wales in a care home, though an asset limit of £24,000 applies in Wales for care in the recipient's own home).

[16] Morse A. Adult social care in England: overview. HC 1102, Session 2013-14. London: National Audit Office; 2014.
[17] Morse A. Adult social care in England: overview. HC 1102, Session 2013-14. London: National Audit Office; 2014. 6 Adult Social Care Statistics, NHS Digital. Adult social care activity and finance report: detailed analysis. England 2016-17. London: National Statistics, NHS Digital; 2017. Available from: https://files.digital.nhs.uk/pdf/2/m/adult_social_care_activity_and_finance_report.pdf (accessed 16 May 2018).

With the exception of Scotland, social care is not free of charge unless the recipient passes a means test. All countries have charges on residential care that vary by country and the recipient's assessed income.

c) Free personal care: Considerations

Our research on the social care systems of Wales and Northern Ireland is limited.

In Scotland, a lack of means testing for domiciliary social care means that the system is more generous and some consider it to be fairer as it is, at least to some extent, free at the point of use for all who need it.

Our joint report with the King's Fund 'A fork in the Road' [4], we estimate that the costs of implementing free personal care in England would be an extra £5.5bn in 2020/21 and £7.9bn by 2030/31. This would increase the estimated funding gap to £7bn in 2020/21 and £14bn in 2030/31. It is costly, however certainly attracts fewer negative headlines than that in England.

The cost differences due specifically to personal care are difficult to disentangle when the health and social care systems in Scotland and England are diverging.

David Bell, Professor in Economics at the University of Stirling discussed the benefits and costs in a Health Foundation blog[18]: "*The arguments against include costs, though these need to be rigorously assessed. In addition, since it supports a universal benefit, a FPC policy provides free services to some who could afford to pay. Which raises the equity argument about the contrast between those health conditions, such as cancer, which the government is willing to fully insure against and those, such as dementia, where government funding support is much more limited. These arguments stand in stark contrast, but the UK political system has repeatedly failed to generate any significant change in England to a system which is generally viewed as fundamentally unfair and unsustainable*."

**Section six: About the Health Foundation**

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

[18] https://www.health.org.uk/newsletter/free-personal-care-what-scottish-approach-social-care-would-cost-england

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

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