Value-based pricing: the wrong medicine for the nation?

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May 2013

2020 HEALTH
WELLBEING
RESPONSIBILITY

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This paper tries to explore the potential impact of introducing an additional pricing scheme for new medicines on patients, who are usually blissfully unaware of pricing negotiations. It takes the approach of asking what concerns would the public still have if a new system of "value-based pricing" were introduced, despite the negotiations and new promises to include patients further in deliberations. In no way do we seek to disparage the hard work undertaken by researchers, health economists and civil servants who have been tasked with trying to make 'value-based pricing' (VBP) work. Our purpose is twofold: to ensure that people have as rapid access as possible to new medicines in the UK, and to give the UK the best possible environment to continue to attract research and development across all life sciences.

Introduction

In countries where the cost of prescription medicines is met wholly or partly from public funds, a system for negotiating drug prices between the government and pharmaceutical sector must be in place. In order for everyone to benefit from the buying power of the state, the arrangements need to apply nationally. In the UK, pricing is not a devolved power so whatever the government does applies as much in Cornwall as it does in Edinburgh. Normal free market forces are not a solution because patented medicines often have only one supplier.

Pharmaceuticals take many years of high expenditure to develop. Typically several years of laboratory testing are carried out on a potential new medicine before it is ready to be tested in humans. The testing in people generally then takes five to ten years before the product is ready to be made widely available for doctors to prescribe. The total research and development (R&D) expenditure on each successful drug incurred before launch is typically between £20m and £300m. Only a small minority of potential new drugs in R&D makes it to the market. At least 100 and sometimes over 1000 drugs are usually studied in the laboratory for each one that is eventually tested in people. On average about one drug eventually reaches the market for every ten that is tried in humans.

R&D expenditure per successful drug is much higher than the figure of £20m to £300m mentioned above owing to the expenditure on drugs that fail because they turn out to be inferior to alternative products, they have unacceptable side effects or competing R&D companies come up with something sooner or better. R&D per drug, allowing for failures, is often in the region of £500m to £1bn and can be higher than this.

The cost of manufacturing most drugs is a small proportion of the selling price. The main element in drug pricing is paying enough to give pharmaceutical companies a reasonable return on their R&D expenditure. New drugs have been a major factor behind the increased longevity and improved health in past decades. Very few new medicines have been developed outside the pharmaceutical industry. The main compromise to be made when considering pricing is between the availability of public money and a desire to continue to encourage drug companies to make the huge financial commitment and take the high risks involved in the lengthy process of developing drugs.

The current UK drug pricing system has been in place for over fifty years and is called the Pharmaceutical Price Regulation Scheme (PPRS). The aim of the scheme, which has been regularly updated as circumstances have changed, is to give each company a fair profit in the UK in relation to its R&D and other activities. The price of individual drugs is not controlled, but as companies are subject to a cap on UK profit their total revenue from the NHS is limited. This freedom of pricing means companies may have to reduce the cost of existing drugs to the NHS when they have a new product for which they want to charge a premium. Total NHS expenditure on pharmaceuticals cannot therefore exceed the total of the revenue caps for all the companies.

The former Secretary of State for Health, Andrew Lansley, instigated radical plans to change the system for pricing new drugs as from 2014. The new scheme, known as value-based pricing (VBP), is planned to apply only to new products. Established drugs will continue to be covered by the PPRS. It is highly unusual to have two parallel systems of pricing in place in any one country. Negotiations have begun between the pharmaceutical industry and the Government on VBP and at present exactly how it would work is still undecided. However, in theory, value-based pricing can take into account the following:

1. The medical value of a drug to the patient by extending his life or improving his quality of life. A statistical average often has to be worked out because most drugs are more effective in some patients than others.

2. Cost savings (if any). For example, a drug may be able to cure patients who would otherwise require expensive hospital treatment.

3. Wider Societal Benefit (WSB) e.g. reducing the burden on carers or getting people back to work sooner, as opposed to the (current NICE) NHS and personal social care perspective.

VBP rewards those companies with important new drugs being launched. These are not the companies in most danger of cutting R&D in the UK, with its knock-on effect on jobs, expertise and clinical trials. This paper looks at the risks involved in introducing VBP and asks whether they should be taken, particularly from the point of view of patients.

Background to 2020health.org's previous publications on drug pricing

In September 2009, 2020health.org published their interim report on 'value-based pricing' (VBP), the new pricing mechanism for medicines described in the Office of Fair Trading report of 2007. The concept of 'value', what it actually means and how VBP is perceived and defined by those from the front-line of health to high level stakeholders were explored in this first publication.

Our second report in 2010 examined both the opportunities and limitations of VBP as applied to innovative medicines. It also sought to identify the barriers to be overcome if it is to be introduced in ways that would genuinely enhance the UK's overall approach to the pricing and sale of patented medicines. We worked closely with Panos Kanavos of the London School of Economics and his team as well as with David Taylor of London University.

This paper tries to explore the potential impact of introducing a new, parallel pricing scheme on patients, who are usually blissfully unaware of pricing negotiations. It takes the approach of asking what concerns would the public still have if value-based pricing were introduced, despite the negotiations and new promises to include patients further in deliberations. Our purpose is twofold: to ensure that people have as rapid access as possible to new medicines in the UK, and to give the UK the best possible environment to attract research and development.

Patient concerns

1. The public could see the pricing of medicines made into a political issue.

The UK drug pricing system is not currently subject to hot political debate. Certainly, the PPRS (the current Pharmaceutical Price Regulation Scheme) means little to the general public. Despite occasional criticism of how much the NHS (and therefore we, the taxpayer) pays for medicines, the actual proportion of the NHS budget spent on drugs has been falling in recent years and is now around 10%. We think introducing a controversial new pricing system could turn drug pricing into a political football and that criticism would soon mount. Just recently we have seen cancer charities express concerns over the lack of involvement of patients in discussions on access to medicines (Prostate Cancer UK, 2012 and 2013) (Sharp, Theodore, Mallender, 2012).

To patients, the availability of medicines can be a matter of life or death. The Press and charities sympathise with the feelings of those unable to secure the best treatment for their loved ones. To the pharmaceutical industry, UK drug pricing is a very major factor in decisions about investment, job creation and employment security (Docteur, 2008). The industry sees drug pricing as the most important indicator as to how serious a country is about offering encouragement. Historically UK drug pricing has not been a major political issue chiefly because the current system (the PPRS) has been guided by the same principles for over 50 years with support from both major parties (for most of this period) and with a good track record of robust negotiations with industry (Sykes, 2011). With the Government proposing to introduce value-based pricing (VBP) in 2014 the political tempo is set to change, especially with a General Election scheduled for 2015. VBP could work out like the Health and Social Care Act: initial acceptance of the idea followed by growing disquiet as the uncertainties become more widely known. Patients could become political pawns, in the way that hospitals are now. Persons whose drugs are deemed too costly for the NHS may have their cases picked up by the press, a political party or an MP. The opinion of the National Institute for Clinical Excellence (NICE) will not offer any political protection if at the time the pricing system is being radically changed. Political opponents may question whether the NHS is being comprehensive and universal.

2. Patients would know that value is subjective

Patients and their carers can become distressed and frustrated if they are denied medicine that they perceive to be of benefit. The National Institute for Clinical Excellence (NICE) has on occasion faced fierce criticism for delaying and refusing access to some new medicines. Sometimes NICE has had a genuine, well founded case for preventing access, but at other times they have been challenged by patient groups and health professionals who feel that the wrong decision has been made. An important example of this was the successful challenge to NICE's restrictive decision on the drug Lucentis for wet-macular degeneration, a severe, sudden cause of blindness which needs rapid intervention.

The principle of "no decision about me without me" applies as much to drugs as to any other form of medical intervention. Drugs typically offer better value for money than labour-intensive treatments. Further complexity arises from the great variation in the circumstances of patients, their responses (Magid, 2009) to treatment and their own opinions as to what side effects and symptoms are tolerable – in other words, what is ultimately of value to them. The worth of a drug cannot be reduced to a single number and to suggest otherwise is fudging the issues. A host of questions need to be answered (Wishart, 2009). Does the life of a new-born baby have the same value as that of a senior businessman? How much more is an expensive drug worth to a patient who is allergic to cheaper alternatives than to a patient for whom the cheaper products would be just as good? Does not the quality of life of a patient receiving long-term treatment with a drug depend on what side effects he as an individual experiences? Value-based pricing sounds like an excellent idea with a well-researched methodology. On further examination the cracks begin to appear. The apparent sophistication of value-based pricing calculations cannot avoid an avalanche of problems because the real concerns of patients, doctors and carers are only hidden from view.

3. Patients would have valid concerns about fairness.

We anticipate that doctors and patients will regard many aspects of value-based pricing as unfair. The complexity and opacity of the process (in a climate that promotes transparency) will fuel concerns about whether VBP will be used to ration the availability of drugs, rather than to find affordable ways of paying for them. The proposed system seems to be directed at preventing the use of drugs with prices above their calculated medical value, even though this calculation is largely arbitrary. It is important to remember that decisions to treat a condition with a particular drug are not simply based on the drug's medical effectiveness, but also on how effective it is compared to the price. The original motivation behind the establishment of NICE was to remove from Government the difficult decision making on whether the NHS should use a particular drug or device, taking into account other demands on its budget.

Many drugs available from several companies (e.g. after patent expiry) will have prices driven down by competition to levels well below their true value. VBP would aim to stop any drugs being priced at above their perceived value. With some drugs priced below value and none above, VBP has the perverse effect that the NHS is bound to pay less for drugs in total than their perceived full value. This fact may seem unfair to patients denied expensive drugs. VBP obstructs the use of expensive drugs but puts nothing back in the pot when it gets drugs cheaply.

Patients will also question the fairness of being denied an expensive drug if they have called on the NHS very little in the past as a result of a healthy lifestyle, or if denial of treatment would result in being unable to function properly e.g. a mother looking after young children. People may feel that the Government does not value responsible behaviour. Patients may also consider unfair a lack of products approved and available abroad. Any delays in making a drug available to patients as a result of slow decision taking will also be upsetting (Richards, 2010). An example would be not responding promptly to new robust evidence supporting a change in the value-based price that a product can justify. Challenges to VBP decisions could also come under the auspices of the Equality Act (2010).

4. Patients know that value alone cannot determine drug prices because commercial competition imposes a ceiling

The price of a drug cannot reflect value throughout its commercial life because prices are affected by commercial factors independent of value e.g. patent expiries and time lags between new evidence and price changes (Adams, 2011). While a patent is in place, pharmaceutical companies have the opportunity to obtain a financial return from research and development costs for a medicine; but once the patent expires, copies can be made by other companies and the price usually drops sharply. The medicine is no less valuable to the patients who use it, but the price no longer represents the true value, which in theory should remain the same until a better medicine comes on the market for the same condition.

When James Dyson launched his first vacuum cleaner, it was more than three times the average price of other models, but it was also without comparison (Kelly, 2011). Bagless, light and super-efficient, it became hugely popular and the price has remained high because people value the product. Dyson still has 23% of the vacuum cleaner market in the USA; the market would only pay more for something even more effective, and competition keeps the price accessible. The price the NHS pays for a medicine has not remained static. Even before a drug goes off-patent, if the company develops another drug it may reduce the price of its other products as the existing PPRS puts a cap on the profits a pharmaceutical company can make.

5. The public would soon realise that value-based pricing cannot easily be applied to the most important medical breakthroughs

There is a lack of intellectual honesty (Michel and Pfaffli, 2012) in the value-based pricing system, which is particularly apparent when considering how any truly exceptional discoveries with a major impact on mankind would be priced. Patients know that there is a limit to what a drug company can reasonably demand for a single product, not only because of commercial competition but also because of what would happen if there was a dramatic, medical breakthrough. An example would be a cure for cancer, if ever one turns out to be feasible. Whatever the VBP pricing system concluded, such a drug would have a true value well above £5 billion per annum (Geoge, 2008) in the UK, because this is the amount that the NHS currently spends treating cancer patients. A respected American study (Morphy and Topel, 2006) has suggested that the capital worth (present value) of a cure for cancer in the USA alone would be about $50 trillion ($50,000 billion). This enormous sum of money represents approximately the annual income of the world's entire population. The Government would obviously not pay the true value of the product but would instead operate a system that would pay out much less. Drugs from history where similar considerations would have applied include smallpox vaccine and the first widely used penicillin. We therefore think that doctors, charities and the media may see value-based pricing not as something in which the Government believes, but rather as a way of hiding behind jargon and intellectual dishonesty in order to justify what will increasingly feel like largely arbitrary rationing of expensive drugs.

6. Questions could be asked about the logical inconsistency with value-based pricing and pricing methods in other industries

The public does not expect goods and services to be priced on the basis of value, or in other words, costs or suffering that have been averted. For example, no plumber would fix his prices according to the damage that would result if he declined to attend an emergency. If in response to a leaking bath a plumber said, "Well, if I don't come the leaking will cause the floor to give way, the ceiling to collapse and the kitchen below to be damaged so that's £7,000, thank you!", most of us would be outraged. In most industries prices are determined by: supply and demand (Davies, 2012); by looking at the charging structure of other suppliers; by adding a reasonable mark-up to costs; or by following a formula in a contract. The last of these approaches is essentially what we have now in the PPRS, which is much closer to normal practice in other industries than VBP. The PPRS formula is designed to give higher financial returns to companies that help fulfil public policy objectives. The formula could be adapted to take a more up-to-date view of societal and medical policies without changing the basic PPRS approach. The logical consequences of pure value-based pricing seem to be more like paying a plumber based on the damage that he prevents.

7. We may be an Island but we are not cut off from global reality

Booze cruises used to be commonplace. Knowing nice wines and beer were cheaper in France meant that many people used to cross the channel to stock up for Christmas or a party. As an optional commodity, people didn't mind. But imagine if that's what you had to do to get a new medicine or treatment? Companies in the UK operate elsewhere in the world and commercial realities limit the Government's flexibility in fixing individual drug prices. None of us want to see valuable NHS funds wasted. If a drug is priced much more highly in the UK than in other EU countries, wholesalers supplying UK pharmacies will buy the drug more cheaply abroad (European Union, 2003; MHRA, 2012). The benefit of the high price will largely go to wholesalers as they sell on the products to pharmacies, rather than going to the originator of the product. NHS money would thus be wasted.

On the other hand, if the UK price is much lower than elsewhere in Europe, pharmaceutical companies may decline to supply the UK rather than have their EU pricing structure eroded by cheap imports from the UK. As a result, valuable medicines may be unavailable in the UK or subject to supply shortages, leading to distress and

health risks among patients. It is a fine line, and changes in exchange rates mean that prices can fluctuate without any action by pharmaceutical companies. Owing to the current system of free-pricing in the UK, companies are well disposed to launching their products in the UK first. This is not only of potential advantage to patients (depending on whether the NHS makes the drug available) but has also resulted in the UK becoming a price reference point for about 40% of other countries globally. To lose this advantage could mean that patients in the UK have to wait longer to access new medicines as they are launched first elsewhere; this would achieve the exact opposite of what is intended with VBP.

8. People could think an average price rather unfair: one product can have many uses and dosage regimes which are of different 'value' to different people

Many drugs can be used to treat more than one illness. Some have different degrees of effectiveness when used at different stages of a disease and others require doses that vary between patients, or work best when given alongside other drugs. All these factors contribute to products having different values under different circumstances. However, a drug cannot have more than one price for the same formulation under the dispensing arrangements in force in the UK. Changing these arrangements would be costly, reduce patient confidentiality (by, for example, including details of each patient's illness on his prescription), increase workload and bureaucracy by requiring pharmacies to keep complex records, add to the time taken for doctors to write prescriptions and have implications for the freedom of pharmacies to purchase drugs from the cheapest available source.

The 'solution' of having an average price for a drug would be highly problematical in a VBP setting. Imagine a drug being of low efficacy for one condition but having a high price owing to its radical efficacy in another condition. Under the PPRS companies can choose the price that best fits the circumstances and whatever is decided the total cost of the company's drugs to the NHS will be largely unaffected. Under VBP companies are meant to be rewarded for meeting an important unmet medical need through a higher price for the new drug. If the same drug has another use where the benefits are low there is at present no way of preventing doctors from prescribing the expensive product in circumstances where the benefits to patients do not justify the expense. Again the logic of VBP breaks down.

9. We shouldn't claim that we can truly know value when we can't

Despite an extensive literature about such esoteric subjects as QALYs (Weinstein, Torrance and McGuire, 2008; Schlander, 2009; Mortimer and Segal, 2007) (quality-adjusted life years) and ICERs (incremental cost-effectiveness ratios), valuing a drug is just not a precise science. Perfectly reasonable estimates for the value of a product can easily vary by a factor of two or three. In addition, no pricing guidelines can possibly take into account every possible dose (O' Sullivan, undated) or set of medical circumstances that could apply in an individual patient. Who can truly know what the quality of another person's life is? How can anyone claim to have the one true answer about the order in which a list of drugs rank by value if the products treat completely different complaints? Yet value-based pricing requires, in effect, answers to questions about the relative value of drugs to treat conditions as varied as severe attacks of migraine, vomiting in cancer patients, movement difficulties in Parkinson's disease sufferers and sexual dysfunction. The necessary comparisons are bound to depend on personal opinions.

A view does not become correct just because it is backed by one committee of experts, processed mathematically in a particular way and supported by academics who earn a living from perpetuating valuation methodologies. Future decisions over the value of drugs by NICE will always be controversial (Erntoft, 2010; Raftery, 2006; Wagstaff, 2008; Devlin and Parkin, 2003; Hoey, 2007). People who see the suffering, incapacity or death of loved ones or who work for charities that help patients with particular illnesses are not necessarily going to see the value of what a drug does in the same way as NICE. The problem is not the skills base of NICE; the organisation is respected globally as having arguably the most expertise of any operation in its field. The problem is that valuing drugs is not a science capable of precision or consensus conclusions. No brief to NICE can change this fact, and there is no solution that has yet emerged that seems to improve on NICE's approach of 'informed deliberation'. It is also true that NICE lacks the manpower to carry out a full commercial evaluation of all new drugs itself without risking inappropriate delays to patients, again, something that VBP was seeking to avoid. If, on the other hand, NICE contracts work out, the organisation's reputation for independence of the type expected from a government agency or regulator may be compromised.

10. The public have been told that politicians are staying out of the NHS, so this change could seem like hypocritical interference

Most people have never heard of the PPRS, partly because they do not work within the pharmaceutical sector, but also because it has been a remarkably successful process adhered to and refined by successive governments. Bringing wholesale change to pricing introduces very significant risks.

The contributions of James Raftery to BMJ Group blogs in recent months discuss a range of difficult questions concerning equality and the allocation of resources between age groups, the sexes and diseases. Such issues are politically sensitive.

The subjective element in value judgements gives too much scope for political interference by a future hostile government. Patients do not want the availability of medicines to be subject to the whims of politicians (Persson, 2011; Jack, 2011). The public want doctors to choose drugs with as little rationing as is consistent with an affordable system.

11. Patients could mistake value-based pricing for a commitment to make more medicines available

A value-based pricing system in no way guarantees that the Government will be prepared to make more products available. We must not mislead patients into thinking that value-based pricing implies a willingness to pay for all drugs. On the contrary, it is a drug rationing system. The thinking behind VBP was always to make more medicines available, and sooner, but so far we can't see how this system could deliver that.

12. Losing 'patient access schemes' will reduce not improve access to medicines

The NHS needs flexibility in handling negotiations when a drug company is unwilling to accept the price offered, and this has historically been achieved through 'patient access schemes'. These are arrangements between the NHS (or Department of Health) and drug companies under which a specially low price is privately negotiated for the supply of a drug when used under defined circumstances in a way that does not make the product generally available at that price to the NHS. The drug company may also offer a rebate to the NHS in respect of NHS patients who do not respond to the product or who satisfy other criteria. Pharmaceutical companies will not offer an abnormally low price for the whole UK market because, as discussed above, wholesalers would export the product cheaply from the UK and so undermine the EU price structure. In addition, many countries use the UK as a "reference" market. They effectively determine their prices by reference to those in the UK.

The only way around this impasse in a value-based pricing environment is for a deal to be struck between the Government and the pharmaceutical company with terms that do not permit wholesalers to participate and obtain the product to export cheaply to other countries. Private deals between health service providers and drug companies are normal practice internationally. A pure value-based pricing system that lacks flexibility for the Government to negotiate patient access schemes privately would be a backward step. Any pricing scheme requiring total transparency over all decisions will also reduce the willingness of drug companies to cooperate.

13. Value-based pricing appears to be neither in the patient interest nor the national interest

UK drug prices (O'Neill, 2012) and drug spending per capita have traditionally been below the average in advanced countries. The money saved has helped with other spending priorities of benefit to patients in the NHS. At the same time the pharmaceutical industry has enjoyed better relationships with successive UK governments than in the case of many other countries. In part this is because UK doctors are often better informed about cost-effective prescribing than some foreign counterparts. This position must continue through appropriate continuous professional development. However, the main reason for the relatively attractive (low) UK drug prices is that the existing pricing system (Whitehead, 2011) gives drug companies a structure that they value for other reasons. The pharmaceutical industry and successive UK governments have been able to agree in the past on certain policies to be supported through the pricing system. These have included: helping drug companies to afford to continue research and development (R&D) during barren periods; making the UK an attractive base for R&D and production; and allowing drug companies to fix their own prices on individual drugs with the controls effectively relating to the average price across a company's entire product range.

Support for pricing priorities helpful to the pharmaceutical industry has in the past enabled the UK to achieve very fair drug prices as a part of the overall package. Pricing and tax policies are important in encouraging R&D and investment in the UK, with benefits to jobs and the standing of UK science.

Attempting to support R&D by sending messages about preferred types of innovation via the prices awarded to individual drugs will not work. It is tempting to believe that high prices for drugs favoured under VBP will encourage R&D directed at the discovery of such products. In fact, drug companies are already fully aware of the benefits of innovative R&D. The UK is only 3% of the world drug market and R&D decisions are necessarily taken on a global basis. We can encourage companies to base R&D in the UK, but this becomes harder if the Government tries to influence the nature of R&D politically. A good pricing system should accommodate all but the most absurdly expensive new drugs out of a sensible overall budget, essentially by lowering the price of older drugs and educating doctors about cost-effective prescribing.

Solutions

The confidence of patients and the future of medicine are more important than words

Whilst we acknowledge that the Government has just agreed to more consideration being given to patient group perspectives in the development of VBP, there are only 10 months before it is supposed to be introduced. We therefore urge the government to consider the following solutions to avoid the drug pricing pitfalls described and to give the greatest chance of achieving appropriate policy objectives.

1. **Continue allowing drug companies to fix their own prices for individual drugs** with new controls operating at the higher level of the entire cost of each company's drugs to the NHS. This policy would be implemented in such a way as to ensure that the total NHS drug sales of all companies would be acceptable and affordable. The PPRS achieves this aim mainly by a profit cap but the same objective could be achieved in other ways e.g. a revenue cap, a trading margin cap.

2. Companies would commit to enabling access to their products under the NHS except in extreme cases by adjusting their prices appropriately, for example by **lowering the price of older drugs by enough to accommodate high enough prices for new products.**

3. Provide a fair financial return to all companies, taking into account the broader need to control government spending, the benefit to the UK economy from high-technology investment and the desirability of R&D to ensure that medicine continues to advance. The aim is not to give fabulous returns to highly profitable companies that have recently launched block-buster drugs, but rather to encourage all R&D. Pharmaceutical R&D involves not only great skill, time and dedication over many years but also a large element of luck. **All pharmaceutical companies have barren periods in R&D, during which times a supportive pricing system is particularly important to help encourage them to continue. A pricing system should also encourage companies not to overlook rarer diseases in search of drugs for more lucrative markets, for example, by offering a bonus for drugs treating less common conditions.**

4. **Encourage patient access schemes** to help make drugs available to patients on the NHS at a cost that the drug industry would otherwise find unacceptably low.

5. **The launch of drugs should not be held up to the detriment of patients** by delays caused by pricing negotiations or related bureaucracy or understaffing.

6. Discussions on how the cost impact of health technologies might be extended to reflect a "wider social benefits" or WSBs, as opposed to the (current NICE) NHS and personal social care perspectives should continue. This is a hard nut to crack but there are no reasons why debate should not continue with patients groups with a view to introducing a clearer 'value' component in time into the PPRS.

A strategic system that embraces the above six points will reward the NHS with value for money as well as support other policy objectives. The UK would continue to have a smaller drug bill per capita than most other advanced countries. **The lowest risk way forward would be to update the PPRS rather than to create a value-based scheme for new drugs that seems to us to be intrinsically flawed.**

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May 2013

2020health's mission
Creating a healthy society

2020health is an independent, grass roots think tank whose purpose is to both improve individual health and create the conditions for a healthy society, through research, evaluation, campaigning and relationships.

2020health research and activity includes the following workstreams

Fit-for-school:
To create a holistic picture of wellbeing and what children need in order to thrive at school, and identify ways of enabling more children to flourish and make the most of their education.

Fit-for-work:
To continue looking at the importance of work for health and health for work, and ensure that those who experience illness receive timely and appropriate support, understanding that worklessness impacts on economies and society as a whole.

Fit-for-later life:
To look from active retirement, to increasing dependency and end-of-life care and consider new models of provision, raise the status of caring, embed respect for ageing and ensure inclusion.

Forgotten conditions:
To ensure that people with rare or unusual health conditions have their needs met by the NHS.

Integration:
To promote integrated care that uses technology to empower people and enable management of their healthcare and wellbeing.

International:
To ensure that we continue to share our knowledge of healthcare and learn from those countries that care for people better than we do.

Innovation:
To ensure that people have access to innovation in all its forms and keep the UK at the forefront of R&D.

Social Care:
To find sustainable solutions to ensure people's vulnerable or final years are the best they can be.

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