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From Ambition to Delivery: How the Next Scottish Government Can Transform Health

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Contents

Executive Summary

The party that wins the Scottish parliamentary election in May will gain both a transformative opportunity and a critical responsibility: to reimagine the Scottish health system as one that is data-driven, preventative and better aligned to citizens' needs.

Scotland has structural advantages that make it well-placed to test and adopt new technologies at pace. It has a density of academic and clinical expertise, strong public-health infrastructure, and relatively direct lines of accountability between the organisations delivering health care and politicians who are responsible for delivery. This enables Scotland to act cohesively.

By taking advantage of technological advances and innovation, the next government must grasp the opportunity to move to a more sustainable, citizen-centred model of care, that improves access, enhances quality and supports people to stay healthier for longer.

Despite this potential, the Scottish people have struggled to see results. Healthy life expectancy has fallen to a ten-year low and productivity has declined even as staffing and budgets have risen.[1,2] This deterioration is now directly affecting Scotland's labour market, with the number of Scots out of work due to long-term sickness or disability both at 20-year highs.[3] The next government must now convert long-standing ambition into delivery.

Ahead of the election, this paper sets out practical recommendations for the next government. It does not aim to offer a comprehensive solution to every challenge facing the NHS in Scotland. Instead, it focuses on the core digital and data foundations needed to build a modern, prevention-focused NHS – one that is responsive and convenient for citizens and capable of driving economic growth.

This report makes ten recommendations for the next Scottish government:

Recommendation: *Deliver MyCare.scot as a fully functional app available to all Scots.*

Specifically, a future government should:

- **Define a team** within the Digital Health and Care Division that is directly accountable to the cabinet secretary for health and social care.
- **Streamline the usual requirements for business case** process relating to MyCare.scot.
- **Update the strategic purpose of MyCare.scot** and publish a more detailed delivery roadmap.
- **Focus attention on the digitising-prescriptions programme** and accelerate its completion.
- **Define core functions of MyCare.scot**, and ensure the central team owns and controls the core technical architecture behind it.

Recommendation: *Drive forward plans for the Digital Health and Care Record (DHCR) at pace and bring into effect the Care Reform (Scotland) Act 2025 provisions on digital health records, information-sharing schemes and information standards.*

A future government should:

- **Prioritise data to incorporate into the DHCR**, ideally beginning with data that enable a specific use case, such as maternity data.[4]
- **Urgently adopt a set of data standards** that align with England and Europe, leveraging work conducted on standards by UK Health Data Research Alliance (UKHDRA) and the Professional Record Standards Body (PRSB).
- **Make compliance mandatory** by including adherence to the DHCR data and interoperability standards as a condition of all new IT and electronic health record (EHR) contracts.
- **Enable citizens to add "write-in" data** to their DHCR for some defined use cases.

Recommendation: *Reduce the number of health boards (currently 14) to accelerate the process of aligning interoperability and data standards.*

Recommendation: *Adopt a campaigning mindset to explain the purpose and safeguards of the DHCR to the public.*

This should include:

- **Launching a national "Your Health, Your Record" campaign** explaining how integrated data improve care and how privacy is protected.
- **Publishing an annual transparency report on data use** as a resource for public consumption.

Recommendation: *Accelerate the adoption of digital-health technologies.*

Specifically, a future government should:

- **Boost Centre for Sustainable Delivery (CfSD) capacity and streamline Accelerated National Innovation Adoption (ANIA).** Provide targeted funding to expand assessment capacity and streamline business-case requirements to compress timelines.
- **Create an expedited track for National Institute for Health and Care Excellence (NICE)-recommended technologies.**
- **Set up a dedicated horizon-scanning unit within the Scottish Health Technologies Group (SHTG)** to systematically identify high-impact digital-health technology candidates and feed them into ANIA with pre-packaged evidence summaries.
- **Signal clear demand to the market** through coordinating between SHTG, CfSD and Innovation Design Authority, and publishing priority use cases which signal key areas of unmet need in Scotland (for example digital weight-management support).

- **Establish a dedicated digital-health adoption fund.** Create a ring-fenced fund within the Digital Health and Care budget by reallocating a small proportion of the NHS budget (about £50 million – roughly 0.3 per cent of annual health spending) to support the national rollout of clinically proven digital-health technologies.
- **Prioritise patient-facing services and integrate with MyCare.scot** to build popular buy-in and enable people to manage their own health without adding to traditional NHS pressure points.

Recommendation: *Boost digital maturity and reduce variation in digital capability.*

Specific actions:

- **Consolidate the number of health boards** to reduce duplication and variation, and remove barriers for scaling successful digital services across larger populations.
- **Provide central-government funding** to this smaller number of health boards for agreed programmes (for example, Near Me and Hospital at Home) enabling them to meet national targets without repeated bidding rounds.
- **Implement a "Once for Scotland"** approach to technology adoption, identifying and removing unnecessary duplication in approval and assurance processes.
- **Increase and ring-fence investment in digital infrastructure** to ensure that digital systems can deliver government ambitions, including DHCR and technology adoption, and introduce a national digital maturity assessment.

Recommendation: *Embed macroeconomic analysis in health-spending decisions, ensuring prevention is embedded in fiscal and economic strategy.*

Recommendation: *Accelerate nationwide rollout of anti-obesity medications (AOMs) through a national digital-first delivery programme.*

The future government should also take steps to:

- **Explore innovative financing models** for preventive medicine (beginning with AOMs), including outcome-based, employer-shared and welfare-contingent funding.
- **Leverage Scotland's research and life-sciences strengths** to forge ambitious industry partnerships that expand access to preventive medicines and generate real-world evidence.

Recommendation: *Launch a Digital Health Check through MyCare.scot to modernise validated NHS screening and improve uptake.*

Recommendation: *Build on the Population Health Framework by developing a Healthy Scotland Platform that leverages digital and data tools to encourage healthier behaviour, incentivises private- and third-sector innovation, and supports more effective population health management.*

01

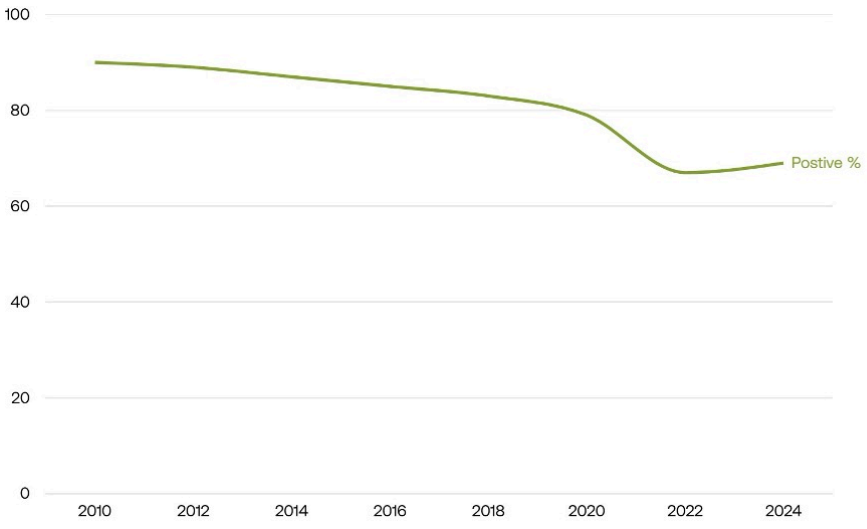
The State of Health Care in Scotland

Scotland's Health Challenges

Scots will need no reminder of the pressures facing their health service. Waiting lists are high, primary care is difficult to access and public health is deteriorating. Accordingly, public satisfaction with the NHS has fallen. The proportion of Scots reporting an overall positive experience of GP practices, for example, fell to 69 per cent in 2024, down from 85 per cent in 2016 (and 90 per cent in 2010).[5]

FIGURE 1

Scots' positive experiences of general practice have declined since 2010



Source: Public Health Scotland

Like many governments, ministers in Scotland have repeated rhetorical commitments to prevention and shifting investment upstream to reduce pressure on hospitals. Yet outcomes continue to move in the wrong direction. Adult obesity rose from 24 per cent in 2003 to 31 per cent in 2024; diagnosed diabetes is at a record high and 39 per cent of Scots now live with a limiting long-term condition.[6,7]

Meanwhile, resources continue to flow disproportionately towards the acute sector. In 2023–2024, hospital-based services accounted for 56.5 per cent of NHS Scotland's £17.2 billion day-to-day health budget – the highest share since 2015–2016.[8] By contrast, real-terms spend on primary care has grown by just 3.8 per cent since 2013–2014, which is less than the increases seen in hospital and community sectors.

For a long time, it was assumed that workforce shortages were the primary constraint, yet despite a steadily rising headcount, performance has not improved. Analysis by the Institute for Fiscal Studies (IFS) shows that NHS hospitals in Scotland now employ 13 per cent more consultants and 12 per cent more nurses and midwives than before the pandemic. Despite this, hospital activity remains well below pre-pandemic levels, leading to a doubling of waiting lists and poor A&E performance.[9] The IFS analysis, which assessed a range of key performance metrics in 2024, concludes that NHS Scotland performance is continuing to decline, compared to evidence of improvement in England.

FIGURE 2

Based on key NHS performance metrics, Scottish health care has been in decline since Covid-19

	Scotland	Scotland	England	England
	Relative to pre-pandemic	Relative to 2024	Relative to pre-pandemic	Relative to 2024
Elective care: length of waiting list	Worse	Worse	Worse	Better
Elective care: number of patients treated within 18 weeks of referral	Worse	Worse	Worse	Worse
Elective care: number waiting more than 1 year	Worse	Worse	Worse	Better
Emergency care: number waiting more than 4 hours at A&E	Worse	Worse	Worse	Better
Cancer care: number waiting fewer than 62 days from referral to treatment	Worse	Worse	Worse	Better
Diagnostic tests: number waiting 6 weeks or less	Worse	Better	Worse	Better

Source: Institute for Fiscal Studies

The deeper issue is that the system's incentives and organisation have not changed. More people are employed but are working in ways that are increasingly inefficient. Productivity has fallen because processes are fragmented, bed capacity is constrained and disjointed IT systems lead to duplication of work. Managers are judged on short-term throughput, while health-care professionals face rising administrative load and limited autonomy.

In primary care, the government has tried to expand the workforce through GP recruitment. So far, these efforts have been unsuccessful, with Audit Scotland concluding that promises to increase GP numbers have not been delivered.[10]

The result is a larger and more burned-out workforce, and one that is being held back from improving performance and outcomes by a broken system. Simply increasing budgets or headcount will not fix systemic health-care challenges.

In our paper *Governing in the Age of AI: A New Model to Transform the State*, we argued that technology offers a route out of the "doom loop" of worsening public services funded by ever-increasing taxes. Recent years have seen a rapid emergence of technological development in health care, and the growth of artificial intelligence brings even greater possibilities for improving access to and the quality of health-care provision. Other similar-sized countries (see case study below) are taking advantage of these developments to deliver modern health services that are more personalised, faster and more cost-effective.

CASE STUDIES

How Denmark and Finland Are Developing Modern, Tech-Enabled Health Services

Denmark

Operates a single national digital platform, Sundhed.dk, through which every citizen can access their medical record, test results, prescriptions, referrals and vaccination history, as well as book appointments and communicate with clinicians. The system connects general practice, hospitals and other local services, ensuring information follows the patient across all settings.[11] This national infrastructure empowers citizens and gives health professionals the right information to provide quality care. The citizen-facing portal also offers ten recommended health apps, which are approved by a Health Apps Board after evaluating usability, impact and value for money.

Finland

Emerging as a European leader in digital therapeutics and blended models of care that combine online and face-to-face support. Building on the national Kanta record and e-prescription system, the Helsinki Digital Health Village platform offers more than 400 digital care pathways to more than 5 million people.[12,13] This allows patients to navigate between digital and physical care, enhancing traditional treatments and promoting self-management.

At the Tony Blair Institute for Global Change we have argued that a patient portal and digital health records (DHR) represent two of the building blocks of modern health services. We have also advocated for digitally enabled prevention policies and for health systems to be more ambitious about how they use AI. Here we turn our attention to Scotland, to illustrate the opportunities for scaling up digital health care. Scotland's integrated health system, advanced research base and strong life-sciences sector give it advantages in harnessing these opportunities. Taking full advantage of these strengths is vital to improve the health and wellbeing of citizens, as well as being strategically important for strengthening the UK's record in health and life sciences and driving economic growth.

The next Scottish government has an opportunity to use these new technologies as a lever to tackle Scotland's health challenges head on, drive shifts towards preventative care and improve health outcomes for citizens.

Scotland Has Made Progress and Should Build on Existing Strengths

Scotland has a strong track record of digital leadership in health. Its early adoption of digital therapeutics such as Sleepio and Daylight made it one of the first countries in the world to make evidence-based mental-health tools available nationally and free at the point of use. It has rolled out technologies nationally, such as video consultations through the Near Me platform, which now supports more than 33,000 virtual consultations per month.[14] Similarly, government has scaled technology to support clinical operations, such as the Picture Archiving and Communication System for medical imaging. It is currently in the process of rolling out Infix, a digital tool for optimising theatre scheduling, across all health boards following successful pilots.[15]

These are important foundations and show how Scotland's smaller size can be an advantage in scaling digital technologies nationally.

However, progress has been slow on the government's flagship digital-health initiatives: MyCare.scot (formerly the Digital Front Door programme) and the Digital Health and Care Record (DHCR). MyCare.scot is intended to

be the national patient portal (as the NHS App is in England), enabling citizens to access services, view health information and manage their care from their phones. The DHCR aims to create a nationally consistent record spanning health and social care, so that information follows the individual wherever they receive care.

While people living in England have been able to use the NHS App since 2018, Scots are still waiting for an equivalent patient portal north of the border. The initiative has faced multiple delays and, while launched in December 2025, it is currently available in only one region with very limited functionality. Meanwhile, proposals for a DHCR were referenced in the government's 2023 digital-health delivery plan. However, in a recent update this work was described as "originally due for delivery in March 2026", but currently "delayed".[16]

It is true that the smaller size of Scotland's market can make procurement for complex technical programmes more challenging. However, Scotland also has great advantages which it is currently failing to exploit. It has demonstrated the ability to scale innovation faster than larger countries and has some building blocks already in place – for example the use of Community Health Index (CHI) numbers as unique patient identifiers. The challenge for the next government is to turn these foundations into a genuinely modern health service, fit for the age of AI.

02

The Need for a Patient-Facing App

At the centre of a modern digital-health system is a high-quality patient portal.

In England, the NHS App has operated as a national patient portal since 2018 and has been downloaded by approximately three-quarters of adults. People use it as part of their day-to-day lives; for example, more than 5 million prescriptions per month are ordered through the app. It can also provide users with access to their GP health records, enable appointment bookings and facilitate communication with health-care providers.

In our recent paper *The NHS at a Crossroads: The App That Can Transform Britain's Health*, we made the case for further development of the NHS App, drawing on analysis of high-performing app around the world. We set out the four key functions of high-performing patient portals:

1. Access to personal health information
2. Administrative control
3. Care navigation
4. Clinical management

When patient portals incorporate functionality across these four categories, they can be an effective first port of call for millions to interact with their health services without needing to travel to a physical location or spend time on hold. When effectively integrated into clinical pathways, these portals can generate positive health outcomes.

There is also huge potential to save clinical-administration time by enabling patients to use their portal to organise their appointments and manage their prescriptions.

In Scotland, a health-and-care app has been long promised but repeatedly delayed. First committed to in 2021,[17] the government's latest statement confirmed that MyCare.scot began its pilot in December 2025. This pilot is

only available for residents in one region (Lanarkshire) and for one specialty (dermatology), and the app itself initially offers very limited functionality, focused on viewing personal information.[18]

In the same update, the government outlined some high-level timelines for the app's development up to 2030. However, these are vague and relatively unambitious. The timeline does not set out dates by which Scots will be able to fulfil specific use cases (such as ordering prescriptions or booking appointments) through the app.[19] Two material risks follow:

1. MyCare.scot fails to incorporate practical uses that create public buy-in.
2. MyCare.scot progresses too slowly and is rendered out-of-date by the pace of technological progress elsewhere.

The next government needs to deliver MyCare.scot to faster timescales and ensure the app provides genuine use to people.

Delays in delivering this programme have been driven in part by a lack of clarity about the strategic purpose of the app. Until the September 2025 update, there was little public communication explaining how the app would deliver tangible benefits.

There has also been confusion over leadership and accountability. In the 2024–2025 delivery plan, several different organisations were described as leading development: NHS Education for Scotland, the Digital Health and Care Division (DHCD), the Convention of Scottish Local Authorities, Social Work Scotland and NHS Health Boards.[20] It is not surprising that the programme has been beset by delays when responsibility and accountability have been spread so thinly.

A future Scottish government should therefore define a team within the DHCD for which delivering MyCare.scot is the sole priority. The team should be directly accountable to the cabinet secretary for health and social care, and the health secretary should publicly commit to delivery as a personal priority for building a health service fit for the future.

The next government should therefore streamline the usual business-case requirements relating to MyCare.scot. It has long been declared a government priority and public servants' time should be spent on supporting its delivery rather than producing documentation to satisfy process-heavy governance requirement.

Upon convening this team, the cabinet secretary for health and social care should confirm – and, if necessary, update – the strategic purpose of MyCare.scot. The cabinet secretary should then task the team to produce a more detailed delivery roadmap, prioritised by use case. This roadmap should identify which use cases Scots will be able to fulfil by respective dates. The roadmap should also identify the essential dependencies upon which successful delivery depends.

More generally, while a phased, prioritised approach to delivery is sensible, there is space to move more quickly in the delivery roadmap. The government should acknowledge – and communicate – that the app will remain in continuous development through versioned releases.

The delivery team should learn from research conducted on the NHS App in England. A 2024 report polled users of the app and found that ordering repeat prescriptions was the most used feature.[21] To build similar public support, enabling this feature through MyCare.scot should be a priority. This will require replacing the current paper dispensing system with digital prescribing, a reform already in progress but not yet delivered.[22,23] This should be a relatively easy win: an incoming government should focus ministerial attention on the digitising-prescriptions programme and ensure it is on track. This will require sufficient funding to ensure the appropriate technology is in place. The government should also engage innovative small and medium-sized enterprises working in this field, which should reduce the tendency towards risk aversion.

One advantage of the app being at an early stage of development is that the next government can pursue a strategic approach to its architecture. For core functions – such as identity verification, viewing health information, care navigation and basic care management – apps are typically more

effective and user-friendly when owned by a central digital function and delivered in-house, rather than relying on third-party integrations (to deliver online consultation and triage tools, for example). Government should harness private-sector innovation by licensing certain capabilities, rather than outsourcing functionalities across a fragmented mix of providers. The government should define the core functions to be owned by a team within the DHCD, ensure that this team control the core technical architecture behind it and put in place transparent open standards.

After proving value through initial use cases, MyCare.scot is likely to grow its user base and secure public buy-in. Development can then progress towards more advanced functionality so the app evolves beyond a "front door" into an intelligent, personal health assistant.

Ultimately, MyCare.scot will only ever be as powerful as the data that sit behind it. A high-performing app relies on access to NHS clinical information, real-world data (for example, from wearables) and data input by citizens – which together can provide a full picture of an individual's health. This is why the government's DHCR programme must be developed in parallel.

Recommendation: *Deliver MyCare.scot as a fully functional app available to all Scots.*

Specifically, a future government should:

- **Define a team** within the DHCD for which delivering MyCare.scot is the sole priority. The team should be directly accountable to the cabinet secretary for health and social care, who should commit to delivery as a personal priority.
- **Streamline the usual requirements for business-case process** relating to MyCare.scot.
- **Update the strategic purpose of MyCare.scot** and publish a more detailed delivery roadmap that explicitly identifies use cases.
- **Focus attention on the digitising-prescriptions programme** and accelerate its completion.

- **Define the core functions of MyCare.scot**, and ensure the central team owns and controls the core technical architecture underpinning it.

03

Delivering a Digital Health Record

A patient portal will reach its full potential only if it is underpinned by seamless access to complete health and care data.

We made the case for a DHR in our paper *Preparing the NHS for the AI Era: A Digital Health Record for Every Citizen*. Each person's DHR would be an authoritative, longitudinal record of their health and care data, bringing together data which are currently scattered across hospitals, GP practices, pharmacies and personal devices.

That report argued that benefits would be wide-ranging:

- It would make individuals' health data portable and transparent, empowering them to choose from a range of providers without having to remember and repeat their condition in detail.
- It would allow clinicians and health-care professionals to work with the same up-to-date information, supporting safer and better continuity of care.
- It would provide health systems with rich population health data and enable enhanced risk identification and tailored interventions.

Scotland, in theory, is well positioned to deliver such a record. Its NHS remains a single national system, with health boards directly accountable to ministers; the population is smaller, and every citizen already has a unique CHI number that links data across care settings. The Scottish government has long recognised this opportunity: successive strategies have committed to a national, integrated digital record that joins up health and social care.[24]

Scotland has also put important policy and legislative prerequisites in place. For example, to reduce the data-sharing risks and liabilities borne by individual GPs, the government made NHS Scotland a co-data controller, which should facilitate more effective data sharing.[25] In addition, the new Care Reform (Scotland) Act 2025, which gives ministers explicit powers to facilitate a digital care record, should remove legal obstacles.[26]

Despite these advantages, progress has been slow. Scotland set the goal of a unified DHR more than a decade ago,[27] yet delivery has stalled. The current programme, announced in 2023, is already behind schedule, according to the latest delivery plan.[28]

England provides a useful comparison. While it is true that the government has not yet successfully delivered health-data sharing at the national scale, there is a more mature baseline for record sharing at regional level.[29] All 42 Integrated Care Systems (ICS) now operate a Shared Care Record (ShCR) platform. Coverage and functionality vary, and cross-regional interoperability remains patchy, but these platforms integrate data across care settings within ICS geographies, providing a practical foundation for a national record. Scotland does not yet have data-sharing arrangements to this extent and is limited to the Emergency Care Summary (ECS). However, the ECS is narrow in scope – containing basic health data on allergies and medications, similar to the Summary Care Record in England[30] – and citizens cannot access it or easily update it themselves.

One reason for Scotland's failure to achieve better record-sharing is that the 14 separate territorial health boards have faced limited incentives to invest in local data-sharing initiatives (such as ShCRs) or develop interoperable systems with other health boards. Another reason is risk aversion and a lack of pace within the centre of government. For example, on data standards, a May 2025 update described deliberations over "options for resourcing the pilot of the Data Standards Sub-board"[31] and in July noted that the "sub-board are preparing to undertake a pilot to test the proposed governance approach".[32] This is an example of the government correctly identifying both the problem and the solution, but not taking the decisions needed to actually deliver.

There are strong arguments that Scotland does not need to reinvent the wheel on this issue. NHS Scotland and other Scottish public bodies are members of the UK Health Data Research Alliance (UKHDRA), which supports adoption of internationally recognised data standards across the UK. Digital Health and Care Scotland is a member of the Professional Record Standards Body (PRSB), which works with clinicians, citizens and health systems to develop standards for health and care records.[33] The Scottish

government should leverage ongoing work across these organisations to inform its decision-making about appropriate data standards, rather than starting from scratch.[34]

Recommendation: *Drive forward plans for the DHCR at pace and bring into effect the Care Reform (Scotland) Act 2025 provisions on DHRs, information-sharing schemes and information standards.*

Specifically, a future government should:

- **Prioritise the data to incorporate into the DHCR**, ideally beginning with data that enable a specific use case. There is a strong case to prioritise maternity services, because most health boards already use the same electronic health record (EHR) system (BadgerNet) for maternity data.[35]
- **Urgently adopt a set of data standards** that align with England and Europe, by leveraging work conducted on standards by UKHDRA and the PRSB.
- **Make compliance mandatory** by including adherence to DHCR data and interoperability standards as a condition of all new IT and EHR contracts. These standards should be open, enabling supplier competition and innovation.
- **Enable citizens to add clearly labelled, structured "write-in" data** to their DHCR for defined use cases (that is, certain information that citizens manually enter themselves, rather than being limited to "view-only").

Recommendation: *Reduce the number of health boards (currently 14) to accelerate the process of aligning interoperability and data standards.*

Recommendation: *Adopt a campaigning mindset to explain to the public the purpose and safeguards of the DHCR.*

This should include:

- **Launching a national "Your Health, Your Record" campaign** explaining how integrated data improve care and how privacy is protected.

- **Publishing an annual transparency report on data use** as a resource for public consumption.

04

Utilising Clinically Proven, Patient-Centred Digital Health Technologies

Scotland has an opportunity to lead the UK in driving the next wave of digital transformation in health care. At TBI we have consistently argued that new, clinically proven digital tools can reshape how and where care is delivered. Their advantage is scalability: once validated, they can reach large populations at low marginal cost. While not a silver bullet, sensible digital reforms to care pathways can ensure face-to-face time remains available to those who need it most, while enabling digitally confident patients to manage their health with fewer barriers.

In this respect, Scotland benefits from both a smaller population and a direct relationship between government and health-care providers. This means that when government chooses to act, people can feel the impact quickly. For example, a 2021 government decision meant that Scotland became the first country to offer fully digital therapeutics for anxiety (Daylight) and insomnia (Sleepio) free at the point of use.[36] More than 110,000 patients have since accessed treatment[37] – equivalent to one in 50 Scots.

These successes could be replicated at greater scale if government created a policy environment that fully supported adoption of proven innovations.

The main existing public source of digital health-care tools in Scotland is the Right Decision Service. Although designed as a citizen resource, its tools remain largely analogue and generic, which limits uptake and impact. For example, the ten-week pain programme is essentially a set of web pages and YouTube links rather than an interactive, outcomes-tracked intervention.[38]

This approach now feels outdated, particularly in the age of AI. Digital therapeutics are evolving into adaptive, data-driven tools that continuously learn from patient behaviour and clinical outcomes. AI is already enabling more personalised interventions to support, treat and manage a growing range of conditions. While mental-health and musculoskeletal disorders are currently the most established use cases, the scope of conditions that digital therapeutics can address is expanding. When used safely within a clear regulatory framework, these technologies could become key scalable assets for improving health-care access, self-management and prevention in Scotland.

One vehicle a future government could utilise to drive faster nationwide adoption is the Accelerated National Innovation Adoption (ANIA) pathway – Scotland's main mechanism for moving clinically validated products from evidence-gathering to national rollouts. Two institutions play key roles in the pathway:

1. **Innovation Design Authority (IDA):** senior Scottish government and NHS leaders who assess value for money and approve national implementation and funding.
2. **Centre for Sustainable Delivery (CfSD):** manages the day-to-day ANIA process, including quality assurance, business cases and reporting to the IDA.[39]

The Scottish Health Technologies Group (SHTG), within Healthcare Improvement Scotland, also scans for promising innovations, appraises evidence and advises NHS Scotland on adoption.

While ANIA has made a constructive start, there are three issues that the next government should address:

1. **Pace of approvals is too slow.** Timelines do not match the speed of technological progress or pressures on the health service. For example, CfSD targets three months to develop strategy cases and six months for a full value case:[40] these stages could (and should) be merged and shortened.

2. **Scale of programmes is too small.** For example, the £4.5 million Digital Diabetes Programme (approved March 2025) is due to support only about 3,000 patients over three years from January 2026[41] – roughly 1 per cent of people with type-2 diabetes in Scotland.[42] Teams report that limited budgets push them towards narrowly scoped technologies that are not necessarily the most effective.
3. **Insufficient focus on technologies ready to be rolled out.** After approving the Digital Diabetes Programme, the government issued a procurement notice inviting bids for delivery.[43] This seems to be the wrong way around. At a time when many technologies have functioning services set up and ready to go, the government should focus on which of these should be made available to citizens, rather than defaulting to lengthy procurement processes.

Recommendation: *Accelerate the adoption of digital health technologies.*

Specifically, a future government should:

- **Boost CfSD capacity and streamline ANIA.** Provide targeted funding to expand assessment capacity, conditional on adopting lighter-weight business-case requirements (for example a version of NHS England's Short-Form Business Case)[44] and compressing timelines accordingly.
- **Create an expedited track for National Institute for Health and Care Excellence (NICE)-recommended technologies.** Where NICE has recommended a technology as clinically and cost-effective for use in the NHS in England, this should be treated as "trusted" evidence in Scotland. The ANIA pathway should retain a role in assessing Scotland-specific implementation and costs.
- **Set up a dedicated horizon-scanning unit within SHTG** (aligned to CfSD Strategic Priority 6, a national pathway for accelerating health-technology adoption) to systematically identify high-impact technology candidates and feed them into ANIA with evidence summaries. "High impact" could include technologies that meet unmet clinical need, offer higher-quality treatment than pharmacological provision, or address key drivers of economic inactivity.

- **Signal clear demand to the market.** By coordinating between SHTG, CfSD, and IDA, the next government should shape market incentives by publishing priority use cases which signal key areas of unmet need in Scotland (for example digital weight-management support). These priority areas could include technologies that address major burdens such as obesity, release clinician time and have proven digital clinical models (for example, cognitive behavioural therapy and other digital mental-health therapeutics).
- **Establish a dedicated digital-health adoption fund.** Create a ring-fenced fund within the Digital Health and Care budget by reallocating a small proportion of the NHS budget (about £50 million – roughly 0.3 per cent of annual health spending) to support the national rollout of clinically proven digital-health technologies.
- **Prioritise patient-facing services and integrate with MyCare.scot.** This will build popular buy-in and enable people to manage their own health without adding pressure to traditional NHS services. In the medium term, adoption should be channelled through MyCare.scot, which should evolve into a personal health companion by the end of the next parliament.

Applying this approach will help to accelerate adoption of proven technologies at scale to support patients and health systems.

05

Improving Digital Maturity and Reducing Variation Across Scotland

Even the best-designed programmes will struggle to achieve their impact while digital capability remains underpowered and uneven across Scotland.

Scotland's 14 territorial health boards are responsible for planning and delivering most NHS services. While this structure allows for local flexibility, over time it has led to substantial variation in how digital technologies are adopted and embedded. All health boards are accountable to the government, yet Holyrood has not used this structural advantage to drive consistent digital transformation across the system. Some boards have embraced innovation at pace, while others remain dependent on traditional models of care.

In England, the government publishes digital-maturity assessments for each Integrated Care Board, helping to identify regional capability gaps. Scotland has no equivalent benchmarking framework, making progress harder to measure and improvement efforts harder to target. To understand variation, therefore, it is necessary to look at available data from specific national digital health programmes.

CASE STUDIES

How Digital Health-Care Technologies Have Delivered Promising but Inequitable Improvements

Near Me

Scotland's national video-consultation service, used across primary, community and secondary care. It enables patients to attend appointments by video rather than in person, improving convenience and reducing unnecessary travel. Originally developed by NHS Highland and scaled nationally during the Covid-19 pandemic, it is now embedded as part of routine care. The service supports more than 80 specialties, with around half of all activity in mental health. Caller satisfaction remains extremely high, with 97 per cent of respondents reporting they would use it again.[45]

Despite its success, adoption varies across health boards. In 2023, the average rate was about 6,700 consultations per 100,000 people, but some boards reported usage of half this figure (3,100 in Forth Valley) or lower (2,000 in Ayrshire and Arran).[46] Some variation is inevitable, reflecting differences in rurality and local service models, but the current provision risks inequitable access for patients who would prefer or benefit from remote consultations.

Digital Hospital at Home

Scotland's Hospital at Home programme enables older people to receive acute care at home for conditions that would otherwise require admission. Evidence from Healthcare Improvement Scotland shows that in 2024–2025 the service prevented more than 15,000 hospital stays, saved an estimated £56 million and delivered an improved patient experience.[47]

However, coverage and maturity vary substantially between health boards. NHS Lanarkshire, the longest-established service, offers more than 200 beds per 100,000 people aged over 65, while boards such as Tayside and Dumfries and Galloway provide fewer than ten.[48] Some operate seven-day multidisciplinary models with point-of-care testing, while others have limited hours or rely on short-term staff. A 2025 self-assessment found that two-thirds of health boards lack recurrent funding to deliver Hospital at Home services and fewer than one-third offer equitable access across their geography.[49]

The Scottish government has already shown that it can deliver digital transformation at national scale. Following pilots that increased operating-theatre productivity by up to 20 per cent in some specialties, the government agreed a single national contract with software provider Infix.[50] This consistent national approach enabled every health board to adopt the same system within months.

The speed and consistency of the Infix rollout contrast sharply with the fragmented finance and governance arrangements of programmes such as Near Me and Hospital at Home, which have produced variable uptake and delivery.

At present, for example, the government has set a national target of 2,000 Hospital at Home beds by 2026, yet boards are still forced to compete for short-term funding to deliver it. Teams report that the absence of recurrent funding remains a key barrier to establishing provision. Requiring 14 separate boards to prepare bids, rather than dedicating scarce time to developing services, is self-defeating, particularly when the government has already endorsed the model's value.

Some variation across health boards will always exist, reflecting geography and the need to integrate with local pathways. But the current degree of divergence is unnecessary and ineffective. A future government should deliver a more consistent national offer by addressing the structural and financial barriers that prevent scaling successful models.

Much of this variation stems from the way NHS Scotland is structured. Each health board operates as a separate legal entity, with its own information-governance (IG) rules, project-management processes and approval requirements. Consolidating the number of boards would help, but would not in itself remove barriers to adoption. Government should therefore identify unnecessary duplication in the approval and assurance of health technologies – such as repeated IG checks or overlapping elements of Digital Technology Assessment Criteria – and implement a "Once for Scotland" policy so that technologies meeting national standards can be deployed across the country.

More fundamentally, to sustain innovation and adoption of digital health across Scotland, the government must increase baseline investment in digital infrastructure. When basic IT infrastructure is ageing and difficult to use, the system struggles to support new innovations. Digital investment represents only 0.5 per cent of all health and social-care spending, and in recent years it has been raided to meet the funding needs of more urgent pressures.[51, 52] If the next government intends to deliver the ambitions in digital health and care that have been set out (including a DHCR and wider adoption of technology), then it will need to increase and ring-fence capital investment in the digital systems and infrastructure which will underpin delivery.

Recommendation: *Boost digital maturity and reduce variation in digital capability.*

Specifically, a future government should:

- **Consolidate the number of health boards** to reduce duplication and variation, and remove barriers for scaling successful digital services across larger populations.
- **Provide central-government funding** to this smaller number of health boards for agreed programmes (for example Near Me and Hospital at Home) enabling them to meet national targets without repeated bidding rounds.
- **Implement a "Once for Scotland"** approach to technology adoption, identifying and removing unnecessary duplication in approval and assurance processes, so that technologies meeting national standards can be deployed consistently across health boards.
- **Increase and ring-fence investment in digital infrastructure** to ensure that digital systems can deliver government ambitions, including DHCR and technology adoption. Progress should be monitored by a biannual national digital maturity assessment, to identify gaps and ensure investment is directed where it is most needed.

06

Revamping Scotland's Prevention Offer

Finally, Scotland must deliver tangible improvements on prevention.

Despite increasing rhetoric and programmes focusing on prevention, Scotland is becoming less healthy. The latest Public Health Scotland figures show that healthy life expectancy has fallen to a ten-year low: Scots can expect about 60 years of good health.[53]

Unsurprisingly, this is felt most acutely in the most deprived communities, with some areas recording average healthy life expectancy of just 52 years. These trends are not only bad for Scots – they also harm Scotland's economy. Chronic ill health keeps people out of work, drives up public spending and suppresses growth. This is increasingly visible in the welfare system, with the number of people receiving Adult Disability Payments projected to rise from 379,000 in 2024–2025 to 703,000 in 2030–2031.[54]

Scotland risks falling into the same vicious cycle described in TBI's *Prosperity Through Health: The Macroeconomic Case for Investing in Preventative Health Care in the UK* report: poor health weakens economic growth, which in turn limits public investment in improving health. Reversing this trend will require a fundamental shift towards prevention, supported by a stronger macroeconomic framework for health.

Taking a Macroeconomic Approach to Prevention

TBI modelling showed that a 20 per cent reduction in the incidence of six major chronic diseases (cancer, cardiovascular disease, diabetes, mental health, musculoskeletal and respiratory illness) would increase UK GDP by 0.74 per cent within five years, rising to nearly 1 per cent within a decade. Fiscal savings from higher tax receipts and lower welfare payments could reach £10 billion across the UK within the same period.[55] Applied to Scotland, this could represent a GDP boost of about £1.5 billion and annual

fiscal benefits of up to £800 million within five years.[56] These estimates are likely conservative, as poor health accounts for a larger share of economic inactivity in Scotland than in the rest of the UK.[57]

A future Scottish government should therefore integrate prevention explicitly into its economic strategy, recognising that healthier citizens are essential to sustainable growth and fiscal stability.

It is positive that the government has recently published a Population Health Framework, outlining a cross-government approach to improving Scotland's health over the next ten years.[58] A future government should build on this start and adopt an explicitly macroeconomic approach to prevention, ensuring that the impacts on productivity, employment and tax receipts of preventative-health investments are considered in future budgets.

Recommendation: *Embed macroeconomic analysis in health-spending decisions, ensuring prevention is embedded in fiscal and economic strategy.*

Accelerating Access to Anti-Obesity Medications

As we set out in *Anti-Obesity Medications: Faster, Broader Access Can Drive Health and Wealth in the UK*, these new drugs have the potential to drive transformative improvements in health outcomes. Trials have shown average weight reductions of 15 to 17 per cent; and the medications also show signs of benefits beyond weight loss, including a 20 per cent reduction in major cardiovascular events among high-risk individuals.[59] In economic terms, obesity imposes high costs on society; for the UK as a whole, we have previously estimated this at £98 billion annually.[60]

The Scottish Medicines Consortium has so far taken a slightly more progressive stance than NICE with respect to anti-obesity medications (AOMs), approving use for a broader range of patients with obesity-related conditions. This is positive. However, as we have argued, another major barrier to people receiving AOMs is in the rollout. In England, delivery has been capped at 220,000 patients over three years due to high projected rollout costs, which are equivalent to the annual cost of the medication

itself.[61] There is also a risk that outdated delivery models ultimately cause more harm than good, by preventing people from accessing transformative drugs and failing to prevent avoidable health conditions.

Governments are right to be wary of uncontrollable cost pressures, but making delivery cheaper and more efficient could significantly extend access without having to restrict eligibility as stringently. NHS Scotland should adopt a digital-first delivery model for weight management, using accredited online providers to prescribe and monitor treatment, supported by digital therapeutics and wraparound behavioural tools. This approach would reduce inequalities in access and reduce pressure on general-practice activity.

Alongside digital delivery, the government should explore innovative financing mechanisms that make large-scale prevention fiscally sustainable. Options include: outcome-based contracts with pharmaceutical firms and employer co-funding for working-age adults,[62] as well as funding models under which providers are paid a share of future welfare savings only if they achieve measurable reductions in health-related economic inactivity (so-called welfare-health contingent funding models).[63]

Scotland's well-established life-sciences industry and strong academic research networks make it well placed to lead in this field. This strength is already being recognised through initiatives like the new Scotland CardioMetabolic Impact Study – a collaboration between the Universities of Glasgow, Dundee and Edinburgh, Novo Nordisk and IQVIA – which will recruit up to 5,000 patients across Scotland to examine the real-world impact of weight-loss medicines, particularly in deprived communities.

The study underlines Scotland's appeal as a destination for large-scale life-sciences investment and obesity research. A future government should build on this momentum by striking further partnerships with industry – similar to Greater Manchester's agreement with Eli Lilly[64] – to expand access, generate real-world evidence and align pharmaceutical investment with Scotland's national R&D objectives and prevention agenda.

Recommendation: *Accelerate the nationwide rollout of AOMs through a national digital-first delivery programme.*

A future government should also take steps to:

- **Explore innovative financing models** for preventative medicine (beginning with AOMs), including outcome-based, employer-shared and welfare-contingent funding.
- **Leverage Scotland's research and life-sciences strengths** to forge ambitious industry partnerships that expand access to preventive medicines and generate real-world evidence.

Incentivising Prevention Through Digital and Data-Driven Tools

Prevention must also become part of the everyday experience of interacting with health services. England's NHS Health Check programme (available to people aged 40 to 74) provides a platform for identifying risk factors earlier in life. Scotland has no equivalent, but a future government could leapfrog England by modernising and expanding preventative screening through a Digital Health Check, delivered via MyCare.scot and underpinned by the DHCR.

A Digital Health Check would make existing, clinically validated tests easier to access and increase uptake. Eligible adults could be invited (through app push notifications) or book checks online, order approved home-testing kits for validated biomarkers such as lipids and glycated haemoglobin, and receive digital results reviewed by clinicians. These tools already exist: for example, at-home-testing firm PocDoc has scaled point-of-care testing to identify cardiovascular risk.[65] These tests could be complemented by simple self-reported data (such as weight, lifestyle and family history), NHS data (accessed through the DHCR) and biometric inputs from wearables (provided the data collection is clinically validated).

This would give NHS Scotland a more sophisticated understanding of risks to health at both the individual and population levels. Individuals identified as being higher risk could then be referred to appropriate treatment or support, such as approved digital therapeutics or weight-management services. This approach would increase uptake and support early intervention, while avoiding adding pressure to primary care services.

Over time, this digital and data infrastructure could evolve into a broader Healthy Scotland Platform – a national ecosystem promoting preventative health across Scotland. Citizens could be automatically connected to trusted tools or programmes that encourage healthier behaviour, while private and third sectors could be incentivised to innovate in pursuit of measurable health outcomes. At a population level, aggregated and de-identified data would strengthen Scotland's ability to manage health at the population level and help target interventions where they are needed most.

Recommendation: *Launch a Digital Health Check through MyCare.scot to modernise validated NHS screening and improve uptake.*

Recommendation: *Build on the Population Health Framework by developing a Healthy Scotland Platform that leverages digital and data tools to encourage healthier behaviour, incentivises private- and third-sector innovation, and supports more effective population health management.*

Taken together, these proposals should shift Scotland from recognising the importance of prevention to delivering it in practice – embedding prevention in economic policy, expanding access to new treatments and using digital tools to make healthier living part of everyday life.

Conclusion

Scotland has the ingredients to build a modern, prevention-focused health service: a unified NHS, clear ministerial accountability, and world-class expertise in data, research and technology. Yet progress has been held back by fragmented delivery and the prioritisation of process over outcomes.

The next Scottish government must use these structural advantages not to deliberate further, but to deliver – building national digital foundations, scaling proven innovations and embedding prevention at the heart of economic and health policy. By acting with urgency and focus, Scotland can deliver better health for its citizens and unlock economic progress.

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