Commission on Health and Prosperity

OUR GREATEST ASSET

THE FINAL REPORT OF THE IPPR COMMISSION ON HEALTH AND PROSPERITY

Chris Thomas, Jamie O'Halloran, Henry Parkes, Dave Hawkey, Annie Williamson, Parth Patel, Efua Poku-Amanfo and **Harry Quilter-Pinner**

September 2024

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NOTE

The IPPR Commission on Health and Prosperity presents its final report to stimulate vital public debate. All members of the commission agree with the broad thrust of the arguments made in this report, though they should not be taken to agree with every word or recommendation. Chairs and commissioners serve in an individual capacity, and this report should not necessarily be seen as representing the views of any other organisation with which they are affiliated.

ABOUT THIS PAPER

This paper constitutes the vision document of the final report of the IPPR Commission on Health and Prosperity. It provides the schematic for a new way of approaching health policy – backed by tangible policy ideas, developed over the last three years of the commission.

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SUMMARY

The term the 'sick man of Europe' is often used to describe countries going through severe economic turmoil or social unrest. In Britain today, it has become a more literal reality. We lag our peers on health outcomes, the number of people with a long-term condition is rising, and people are spending longer in poor health. And health is worsening throughout the life course – bringing real challenges for children, adolescents, working-age adults, and those who have retired.

That is, the nation's health challenges have reached historic proportions. Change is needed. Led by an understanding that the boldest health reforms only come when there is a strong social *and* economic case for them, this commission has spent the last three years testing one simple idea: that better health is Britain's greatest untapped route to prosperity.

At a time when pessimism would be easy, this final report of the IPPR Commission on Health and Prosperity finds that better health is exactly the medicine our economy needs. Reporting on three years of analysis, qualitative work, commissioner debate and stakeholder engagement, we find that better health could help meet the UK's biggest specific economic challenges.

- **Labour supply:** We identify 900,000 workers who were missing from work due to sickness – above what we would have otherwise expected on pre-pandemic trends – as of the end of 2023. Economic inactivity due to sickness could rise to new heights of 4.3 million by the end of the next parliament, if post-pandemic trends continue.
- **Productivity:** People with one or multiple health conditions are as much as twice as likely to take sick days or experience lower productivity when working through sickness – likely due to poor job design, work culture or financial means to take sick days when they are needed.
- **Earnings:** Better health has the potential to significantly boost people's earnings, after nearly two decades of stagnant real wage growth. Indicatively, we find that avoiding a preventable long-term condition is worth up to £2,200 in annual earned income.
- **Public finances:** Poor health means avoidable expenditure in the NHS and welfare system, and lower tax receipts (as fewer people are in work). We estimate that the 900,000 'missing workers' identified above translates to lost tax receipts of almost £5 billion, and that better population health could save the NHS £18 billion.
- **Regional balance:** The UK is a highly unbalanced economy, with growth, disposable income and productivity concentrated in London and the South East. We find better health would benefit the economy everywhere but would disproportionately boost the labour market and wages in the north of England and Wales.

Put simply, if the UK needs new and innovative strategies to revitalise the economy, then we contend that better health could be exactly the strategy required. And in reducing the costs associated with sickness, we could also build a fairer, more inclusive and happier nation.

We will not achieve better health by persisting with today's health policy status quo. Demonstrably, our current approach to the nation's health is not leading to

healthier lives. This report's central contention is that better health will only be possible if we move from a **sickness model** of health policy to a **health creation** one. It is achieving this shift that should define the implementation of the new government's health mission.

We define the sickness model as one in which government avoids intervention while people are 'well' – instead, considering 'health' a matter of personal responsibility – and that only decisively intervenes once someone experiences highly acute need (ie through the NHS, at the 'point of delivery'). This might have been appropriate when need was often acute, but today it severely limits our scope for health creation and our ability to meet the defining health challenges of the 21st century: chronic conditions, multiple morbidity, worse mental and social health outcomes, and higher proportions of lives spent in sickness.

A health creation system would make healthier lives a cross-society, cross-economy mission – and would focus intervention on the places where people really spend their time. While we might spend a few weeks or months of our lives in hospitals, we'll spend tens of thousands of hours in work, thousands of hours in schools, and most of our time in our homes, communities and with friends or loved ones. It is in and through these spaces that a health creation system should be founded, which would support us through our lives – from 'cradle to grave' rather than just 'at cradle' and 'at grave'.

We set out five foundational pillars for a new British health creation system – as bold a health agenda for the 21st century's specific challenges as the NHS was for those of the 20th century. These pillars are shifts:

1. from work that harms health to work that creates it
2. from tolerating health harms to an active industrial strategy for health
3. from waiting for sickness to health creation at the start of life
4. from places that make us sick to empowered, healthy communities
5. from reactive services to preventative, primary care-led healthcare.

Progress could be measured through an expanded version of the 'Health Index' - playing the equivalent role for health that GDP does for the economy.

Against these shifts we make a range of policy recommendations, summarised in the table below. Taken together, these policy recommendations form a first outline of what a new health mission (linked to wider growth and opportunity aspirations) could aim to deliver in the next parliament. They form a coherent policy schematic – and the first major submission to the government's new missions – to reimagine health, deliver better lives and boost growth and prosperity in the next five years.

FIGURE S.1: POLICY SUMMARY

Work	Work that creates health	*A healthy work employer standard, with adoption supported by a Wellbeing Premium cut to business taxes*
	Support back into appropriate work when we fall sick	*Bespoke skills in supporting disabled people and people with long-term conditions in job centres, focussing on appropriate work not just any work, and supported by a new NHS 'back to work' national programme*
Markets	Protection from products that make us sick	*New levies and regulations on health harming products*
	Genuinely healthy, affordable and enticing choices of food and leisure	*A National Health Investment Bank to reinvest proceeds from health levies into health vital industries*

Families	World leading support for families at the start of life	*Restart Sure Start by restoring funding and infrastructure to 2010 levels*
	Financial security for families and enough good food to eat	*Free school meals for primary school children and an end to the two-child limit*
Places	Access to core community spaces, like libraries and swimming pools	*New investment and powers to restore (or protect) the community assets key to healthy lives*
	A real say in how places with poor health and low opportunity transform for the better	*A new local power to designate 'HAPI' Neighbourhoods – modelled on Clean Air Zones – with national investment and new powers*
Services	Access to a local, neighbourhood health centre	*Build a Neighbourhood Health Centre in every part of the country – a one-stop shop for diagnostics, primary care, mental health and public health*
	Access to a brilliant health service when we do need it	*Modernising reforms of the health service, to make sure we continue to have access to appropriate care at times of acute need in the years and decades to come*

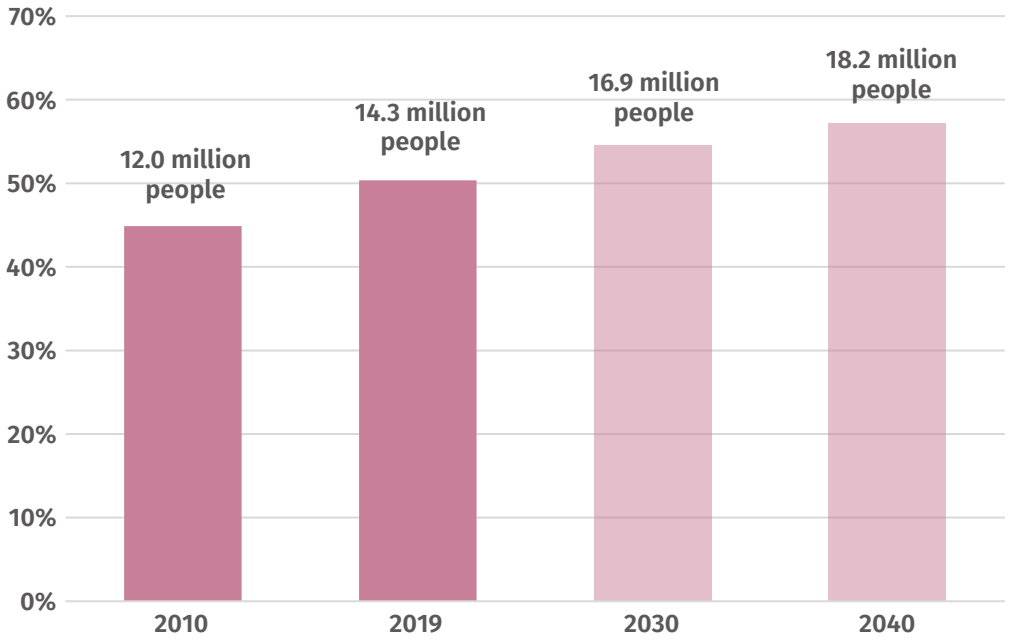
PREFACE

Covid-19 demonstrated the vital importance of the nation's health to our individual lives and to society. Across the UK, the pandemic caused hundreds of thousands of deaths. Millions of us were bereaved, often without being able to properly see or mourn lost loved ones. All of us were impacted by social distancing and lockdowns. And the effects of the pandemic are not gone today: two million people in Britain are living with the symptoms of long-Covid (ONS 2024j).

The pandemic also made clear that our livelihoods depend on the nation's health. Covid-19 saw a great many businesses close, taking jobs with them. In aggregate, it led to the biggest one-year fall in economic output (GDP) to hit the UK in 300 years. Not since Europe's Great Frost decimated a then largely agrarian economy in the early 1700s had GDP fallen so far and so fast. Health policy is a matter of life and death, but importantly also of livelihoods, growth, prosperity and wellbeing.

FIGURE 1.1: THE NUMBER OF ADULTS WITH ANY LONG-TERM CONDITION HAS RISEN, EVEN AFTER ACCOUNTING FOR POPULATION GROWTH

Proportion of adults aged 30 years or older with a long-term health condition, 2010, 2019, 2030 and 2040



Source: Authors' analysis of Health Foundation 2023a
Note: To identify those without a long-term condition, individuals need to have a Cambridge Multimorbidity Score (CMS) of zero. The CMS assigns a weight or 'score' to 20 conditions based on how the illness affects their use of primary care, emergency health services and the patient's likelihood of death.

Such recent and visceral collective memory of how important the nation's health is means growing evidence that Britain's health crisis runs far deeper than Covid-19 should alarm us all. While it might be reassuring to think that

poor health in Britain began and ended with the pandemic's peaks, the truth is that rising sickness in Britain is a trend that goes far further back. As figure 1.1 shows, the number of British adults living with a health condition is rising, and set to rise yet further. This commission has also found evidence of a decline in the proportion of our lives spent in genuinely good health – even as lives have grown longer.

This rising sickness is not only visible in official datasets, but across our institutions and public services, and our workplaces and communities. Perhaps its impact is most obvious in the rising demand faced by an NHS that is struggling to keep up. Most of us will have witnessed this first hand, whether because we've been kept on hold in the 8am telephone rush to get a GP appointment, been stuck in day-long A&E queues, or faced an anxious wait for a delayed ambulance to come and save a loved-one's life.

But the nation's health crisis is not limited to the NHS and its hospitals and clinics. We can also see it in our schools and universities. The likelihood of young people having a mental health problem has increased by 50 per cent in recent years (NHS Digital 2023). Eating disorder diagnoses are also up, particularly among young men and women between the ages of 17 and 19 (Ibid). And in the face of these rising challenges, school leaders and teachers say they have not got the resources, specialised support or training required to meet need (Menzies et al 2023).

We can see the crisis in our benefits system, as sickness blocks more and more people from finding or staying in work. There has been a striking uptick in the number of adults of all ages claiming health-related benefits in the last decade (Institute for Fiscal Studies 2023). Put another way, a combination of sickness and woefully inadequate employment support means more people face greater barriers to meeting their potential. This is feeding through into national economic indicators: UK growth has become increasingly dependent on the size of the labour force, and more people out of work will make growth much harder to come by, particularly in the short term.

We can also see it in our workplaces. Today, in a workplace with 25 staff, eight people will have at least one long-term condition on average (compared to six in 2014). In a larger workplace of 1500 staff, 470 people will have at least one condition (compared to 359 in 2014) (ONS 2024d). In many cases, those will be conditions that could have been prevented entirely (as a great many major conditions can), or could at least have been diagnosed earlier, and treated more effectively. And even if not, more inclusive workplaces, a greater supply of appropriate work, fit for purpose employment support, and more accessible built environments could all reduce the individual risk associated with impairment or long-term conditions.

Covid-19 made brutally clear that our livelihoods – as well as our lives – rely on the health of the nation. That we can see the impacts of Britain's declining health in places far beyond hospitals and A&E departments suggests this is a truth that transcends shock events like pandemics. Our ability to find and stay in work, to take new opportunities, to get on at school – as well as to achieve wellbeing – all depend on the health of the nation; health is about our capacity to thrive, not just survive.

To point out that Britain's health is also about individual prosperity and the national economy is not to undermine that the most important reason to care about health is because it supports wellbeing. Rather, it is to say that understanding the full value of health will support better policy and bigger change. The boldest health reforms have always come at times when the social justice and the economic case for better health have both been strong. Victorian

public health reforms and the 1940s creation of the NHS relied on both social justice and economic arguments to become possible. In a comparable time of health crisis, understanding the full impact of sickness and the full value of health is a precondition for adequately bold and lasting solutions.

That's why in early 2022, as the UK began its shift to a 'living with Covid' strategy, we launched the Commission on Health and Prosperity, to better understand how the nation's health and economy interact. Our formative idea was that a healthier[1] country is a more prosperous one. We have sought to understand it through three years of quantitative and deliberative research, literature review and stakeholder engagement. Our ambition has been not just to explore the relationship between health and prosperity, but also to set out a blueprint through which the UK can optimise that link.

We recognise that Britain is not alone in facing rising sickness. A rise in long-term conditions and a fall in the proportion of life spent in good health can be seen in most comparable countries. But our comparison of Britain's health with that of other G7 countries shows that the problem is more acute and growing more rapidly in Britain. Indeed, our outcomes are so poor that the 'sick man of Europe' – a moniker which is often used to describe states experiencing economic turmoil – has been a more literal reality. In other words, we face the greatest health challenges and social and economic consequences of that poor health, and we seem to have among the least well-developed solutions.

We believe this commission would have had use even if Britain's health and economy were doing well. If growth was high, living standards were rising and poverty falling, it would still be useful to know the extent to which better health could help us boost prosperity. But that our enquiry comes at a time the UK economy faces profound economic challenges – low growth and productivity, challenges on living standards, rising destitution and food insecurity, rising in-work poverty – only strengthens its relevance. Others have convincingly argued that the UK needs new strategies to revitalise the economy, to break from the stagnation that has defined the last 15 years. Our question is simple: could better health provide this strategy?

Increasingly, government has shown a willingness to both accept and act on these arguments. In the last few months, the Department of Health and Social Care has pledged to reorientate itself as a growth department. New health, growth and opportunity missions could provide a vehicle to increase ambition on population health and national prosperity. Given this, our report also provides a full policy blueprint for the next parliament – to make good on that aspiration. This is the first, full outline of what a fully aspirational health mission might strive to deliver.

The members of this commission come from different walks of life and political viewpoints. They have approached our task from different perspectives, often with different constituencies in mind. Given that breadth, we have reached a remarkable degree of agreement through this commission. We believe this strengthens the case that better health can be the foundation of a plan for prosperity and renewal that we can all get behind – across party politics, across society and across the economy.

In putting forward this final report, the commission draws on four interim reports covering issues as broad as health inequality, the design of national government and missions, the role of places and communities, and the role of industry, employers and innovation. Each of those reports included their

1 Our definition of health is intentionally broad, giving parity between physical health, mental health and social health.

own consultations with stakeholders and experts. We are grateful to the many organisations and individuals who have contributed to the development of our ideas over the last three years.

While this is the final report of our commission, it is by no means the final word. As successive governments have found, changing health and economic realities is no easy task. There is no magic bullet or single piece of legislation that will solve the scale of the challenges we face. The plan we put forward speaks to the bold ideas we will need from policy makers – but also to the sustained effort we will need from communities, employers, businesses, investors, innovators, civil society and local leaders, if this agenda is to succeed.

From here, we proceed in three parts. In **Part 1,** we report on our full body of evidence on the links between health and prosperity. We draw together commission findings on health's impact on individual prosperity, on the interaction between health and the labour market, on the extent to which in-work sickness has an impact on productivity, and on the impact of sickness on NHS expenditure and tax receipts. In **Part 2,** we explore why health is not improving on its own, without intervention from policy makers. For 150 years, we have become used to unfaltering improvements in health, but these have now ground to a halt. We set out to understand how to restart them. And in **Part 3,** we set out our blueprint for the future: a policy plan for the next parliament, to set new foundations for a healthier, more prosperous Britain.

PART 1: UNDERSTANDING HEALTH AND PROSPERITY

SUMMARY

Historically, the boldest health reforms have relied on the convergence of both a social justice and an economic case for change.

While international evidence is clear on the link between good health and prosperity, that connection has been lost to domestic policy makers in the 21st century.

In this chapter, we report on the commission's evidence on the link between health and prosperity, showing that not only does good health have a substantial value, but that it is exactly the medicine the UK economy needs - from public finances to productivity, labour market participation and regional inequality.

This evidence is a particularly relevant set of findings for a new government that is going for growth: better health could be this country's greatest untapped route to growth, fairness and prosperity. Our evidence should support willingness to be aspirational on health – in the health mission, but also the growth and opportunity missions.

International evidence has long pointed towards a relationship between a nation's health and its economy. At country-level, the link has been demonstrated repeatedly (Ashraf et al 2009, Stepovic 2019, Trondillo 2016), and research has shown it extends to 'advanced economies' like the UK (Swift 2011).

Despite this, the dependency of prosperity on good health was somewhat lost to British policymakers in the first two decades of the 21st century. During that time, both our health and our economy have weakened concurrently. Challenges around growth, productivity, wages and living standards are now well documented. And life expectancy and healthy life expectancy have stalled for the first time in modern history; long-term illness and preventable death have both risen, as has the complexity of people's health needs (as measured by the prevalence of multimorbidity) (Head et al 2021).

Our contention as a commission is that this is not simple coincidence. Our three years of analysis points to a country where many people experience illness that could have been prevented, treated or otherwise better managed and supported. And it points to a society in which the costs of that sickness are huge – where disabled people and those with long-term conditions experience the injustice of lower earnings, lower wellbeing and worse employment prospects. This suggests a vicious circle, in which a lack of power and opportunity undermine our health, and in which poor health in turn undermines opportunity and prosperity.

The argument we put forward in this chapter is not simply that better health could add tens or hundreds of billions of pounds to Britain's output, as much as this is true. Instead, it is that by enabling more prosperous individual lives, better health could provide a powerful answer to the specific and most profound economic challenges the UK faces. That it is exactly the kind of medicine which Britain's current economic malaise needs.

HOW COULD BETTER HEALTH MEET BRITAIN'S BIGGEST ECONOMIC CHALLENGES?

In this first part of the report, we first explore the extent to which Britain is genuinely getting sicker – providing context for the results that follow. We then explore how that growing sickness interacts with five key economic challenges facing Britain.

The earnings challenge: Britain has experienced stagnation in real earnings growth over the last 15 years. We explore the relationship between individual health and earnings through longitudinal analysis of Understanding Society data.

The labour challenge: Britain's growth model is increasingly dependent on a growing labour force, making the recent drop in economic participation a challenge. We use the Labour Force Survey to explore and better understand recent rises in economic inactivity due to sickness.

The productivity challenge: Productivity growth is key to wage growth and improving living standards. Yet Britain's productivity growth has been sluggish since the 2008 financial crash. We explore the extent to which poor health within workplaces is implicated in low productivity.

The public finance challenge: Britain's public services are under severe financial pressure. We explore the extent to which sickness reduces tax receipts, and the extent to which it creates avoidable cost pressures within both the NHS and the welfare system.

The regional imbalance challenge: Britain is an unbalanced country, with London having high employment, growth, productivity and average disposable income, while other regions perform less well. This means we are not reaching our potential across the whole of the country, and are undermining our overall economic strength and prosperity.

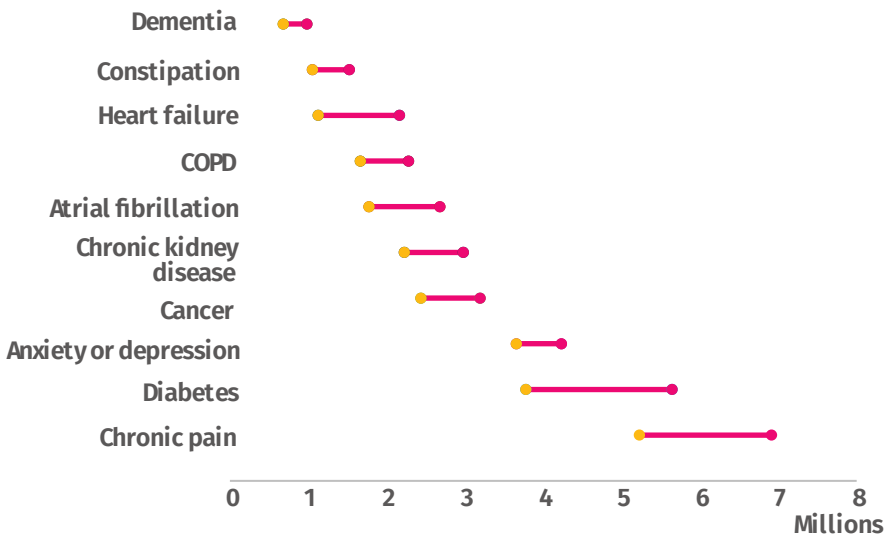
At the heart of these five themes is the role of better health in achieving growth – the central priority of the new government, and at the heart of its plans to deliver investment in public services and higher living standards across Britain.

THE STATE OF HEALTH IN BRITAIN

People in Britain are getting sicker. The most clear-cut evidence is that, despite the population growing, the number of people (particularly aged between 30–69) with a chronic condition is rising. Indeed, the number of people living with a range of major health conditions – from dementia to depression and diabetes – is projected to rise sharply in the next 20 years (figure 2.1). This rise in conditions feeds into a rise in the proportion of their lives people can expect to live in poor health, and into stagnating life and healthy life expectancy in this country.

FIGURE 2.1: EVEN AFTER ADJUSTING FOR DEMOGRAPHIC CHANGES, PREVALENCE OF MAJOR CONDITIONS IS EXPECTED TO GROW MASSIVELY IN THE NEXT 20 YEARS.

Projected total number of diagnosed cases for the 10 conditions with the highest impact on health care use and mortality among those aged 30 years and older, including demographic changes, England, 2019 and projected for 2040



Source: Health Foundation 2023a

But Britain's rising sickness is not just about a higher proportion of people living with a single long-term physical health condition. It is also about the rising complexity of our health needs: more people are living with two, three, four or even more diagnoses (NICE 2023, Steventon et al 2018, Stafford et al 2018).

The challenge is not just about a rise in the proportion of our population aged 65 and over, either (although an ageing population is an important factor). Britain's rising sickness can be seen across different age groups. A decade-long trend of improvements in infant mortality stalled in the last 10 years (ONS 2024h). Rates of childhood obesity, asthma and diabetes are up (Asthma + Lung 2024, RCPCH 2024, Moreno et al 2024). The number of people aged 17–19 with a probable mental disorder rose from one in 10 in 2017 to one in six in 2020 (NHS Digital 2024). And

the number of working-age people with a chronic health condition is up four percentage points in a decade (see Thomas et al 2023).

Nor is the challenge caused purely by declining physical health. We face at least an equal mental health crisis. In fact, mental health problems have become nearly ubiquitous, with just 13 per cent of people reporting high levels of 'positive mental health' in one 2017 survey (Mental Health Foundation 2017). Four in 10 of us have experienced depression, and a quarter have experienced panic attacks (Ibid). There has also been a particular rise in psychological distress among children, adolescents and working-age adults (eg Zhang et al 2023)

HOW MUCH HEALTHIER COULD WE REALLY BE?

Given gains in the 19th and 20th century in population health, it might be reasonable to think improvements to the nation's health have simply 'reached their limit'. However, there are good reasons to think Britain still has substantial scope for further health gains.

First, because other countries have achieved better. The UK has delivered relatively disappointing gains in healthy life expectancy since the beginning of the 21st century. By contrast, Japan transitioned from least to most healthy country in the G7 in the second half of the 20th century – and has a healthy life expectancy at birth around four years higher than the UK. South Korea, Ireland and Singapore have all improved healthy life expectancy substantially in the last few years (World Health Organisation 2020).

Second, because of the UK's high levels of health inequality. There is currently a 15-year gap in healthy life expectancy at birth between Wokingham and Blackpool (ONS 2024b). Major improvements in Britain's overall health could be achieved simply by securing the kind of health outcomes everywhere in Britain shown to be possible in the healthiest parts of our country.

Finally, because so much of the UK's disease burden is preventable, treatable or otherwise manageable. Indicatively, evidence suggests that four in 10 cancers, eight in 10 cardiovascular deaths and four in 10 cases of dementia could be prevented through action on known and identifiable risk factors. Many mental health problems can also be prevented, and conditions like Type II Diabetes, chronic kidney disease and alcohol use disorder can be entirely prevented (IHME 2024).

FIVE LINKS BETWEEN HEALTH AND WEALTH

1. THE EARNINGS CHALLENGE

As a country with a 'free at the point of delivery' healthcare service, there is sometimes an assumption that there is no cost to falling sick in Britain (in contrast with the 'catastrophic' hospital costs associated with the USA). But a hospital bill is not the only way in which sickness can come with a cost. This commission's first enquiry was into the relationship between our health and our earnings.

That depressed earnings have been a defining feature of the British economy in the last 20 years underscores the importance of this link. Indeed, the (welcome) 2 per cent real terms growth in pay packets between May 2023 and 2024 was as much growth in earnings as had otherwise been achieved in the preceding 16 years (Resolution Foundation 2024a).[2] Had earnings grown at the pre-2008 crash rate, Resolution Foundation analysis suggests we would expect average annual earnings to be £14,000 a year higher today (Afref-Adib et al 2024).

Higher wages are a good thing. Prosperity means living in a country where people are fairly rewarded for their effort, where people can afford the essentials, and where work does not still mean poverty for many. Beyond that, disposable income can both help ensure people can afford the essentials and have money left over to afford purchases that support economic growth. To explore how the onset of a health condition might impact people's earnings at work, we used Understanding Society data to track 29,000 people over time, and to see what happened after they fell sick.

METHODOLOGY 1: THE IMPACT OF SICKNESS ON INDIVIDUALS

The commission's first objective was to understand the impact on individual prosperity when people fall sick, with a focus on earnings. To do this, we used Understanding Society's UKHLS survey to analyse how the onset of illness impacts people's economic lives, while controlling for other factors: age, gender, region and ethnicity. We used the time variation in this longitudinal dataset to model what happened to people after the onset of chronic physical illness and the onset of mental illness,[3] including changes to their monthly earnings. To account for the unusual circumstances of the Covid-19 pandemic, we tested for an effect both before (2015–19) and after (2020–1) the pandemic began. A fuller account of the results can be found in Thomas et al 2023.

Looking at data between 2015 and 2019, we found that the onset of a long-term condition led to a fall in annual earnings of over £1,800. A new mental illness predicted an even higher average loss of earnings of around £2,200. And we found that a new illness had a similar impact in the period immediately following the

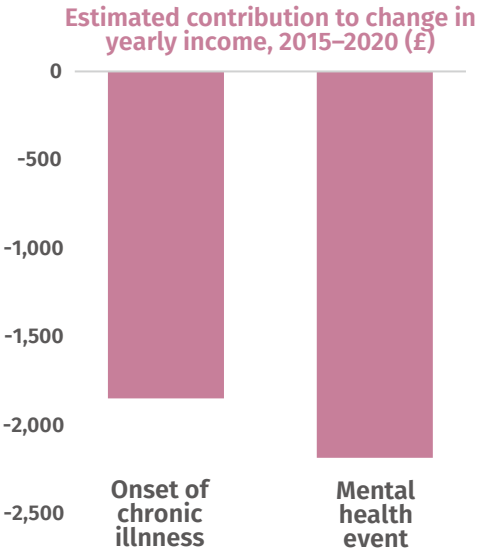
2 With wage growth expected to return to stagnation for at least the next two years.

3 Constructed using GHQ-12 scores as per Bambra 2019.

outbreak of Covid-19 (2020–1), suggesting the relationship between health and earnings is not unique to the period since the outbreak of the pandemic.

FIGURE 2.2: THE ONSET OF SICKNESS HAS A SUBSTANTIAL IMPACT ON ANNUAL EARNED INCOME

Estimated impact of onset of sickness to earnings income, by period sickness begins, 2015–19



Source: Recreated from Thomas et al 2023

The largest costs are borne by people on the lowest incomes. This speaks to the vicious circle that defines the relationship between health and prosperity. People on lower earnings[4] are more likely to fall sick. That experience of sickness impacts their earnings, making further sickness more likely. This means many are trapped by a combination of poor health, deprivation and low opportunity (see Thomas et al 2023).

ON COST AND CAUSALITY

The relationship between health and prosperity is complicated. Someone's economic circumstances have a causal impact on their health through the life course – and events like job loss and low income can have an immediate impact on our health. Our health can also impact our socio-economic position: experiences of poverty, educational outcomes and job progression. This bidirectional relationship can create difficulties in isolating the impact from health through to prosperity, all else being equal.

Recent literature has demonstrated a causal link running from ill health to economic outcomes. Lenhart (2019) and Jones et al (2020) both show a causal relationship between a health event and labour market participation, while Bambra et al (2018) demonstrate a causal relationship between levels of health inequality and regional productivity rates.

4 And people who experienced poor health in childhood through to early adulthood are more likely to be on lower incomes to begin with.

Our longitudinal study design helps further evidence a causal link, but it does not entirely preclude the potential for reverse causality. While our confidence in the direction of the relationship is boosted by the coherence between our results and the literature, we have also carried out sensitivity analysis (dynamic difference-in-differences tests) to find whether illness in a previous period predicts a decline in earnings for a contemporaneous period. We find similar sized coefficients.

Overall, the relationship between health and prosperity is likely to be bidirectional. Over the course of a lifetime, low earnings, low job satisfaction and poor labour market outcomes are likely to worsen health. Poor health, in turn, is likely to worsen economic outcomes. More plainly, the two exist in a vicious circle – likely explaining the geographic clustering of health and economic inequality shown by previous IPPR research.

Informed by the social model of disability, we contend costs are down to the design of society, rather than people's difference. The scale of the costs we show in this chapter are far from innate inevitabilities of a health condition. While that means primary prevention – action to reduce avoidable sickness – is important, it also means striving to eliminate barriers to wellbeing and prosperity for disabled people and those living with long-term health conditions.

2. THE LABOUR CHALLENGE

FIGURE 2.3: GROWTH IN LABOUR SUPPLY RATHER THAN PRODUCTIVITY HAS BEEN BEHIND MOST OF BRITAIN'S POST-2008 GROWTH

Average annual growth rate of GDP (%) and its respective contributions (percentage points) between 1998 and 2019, and the total growth in GDP (%) and its respective contributions (percentage points) between 2000 and 2022, UK

Source: Authors' analysis of ONS 2024c

Since the 2008 financial crash, most of Britain's growth in GDP has been driven by increases in the size of the available labour force (figure 2.3).[5] It is for this reason that Britain's economic institutions (Treasury, OBR, Bank of England and others) have grown increasingly concerned by the rise in economic inactivity due to sickness. In 2020s Britain, fewer workers means less growth – which in turn makes it harder to fund vital public services or other forms of investment.

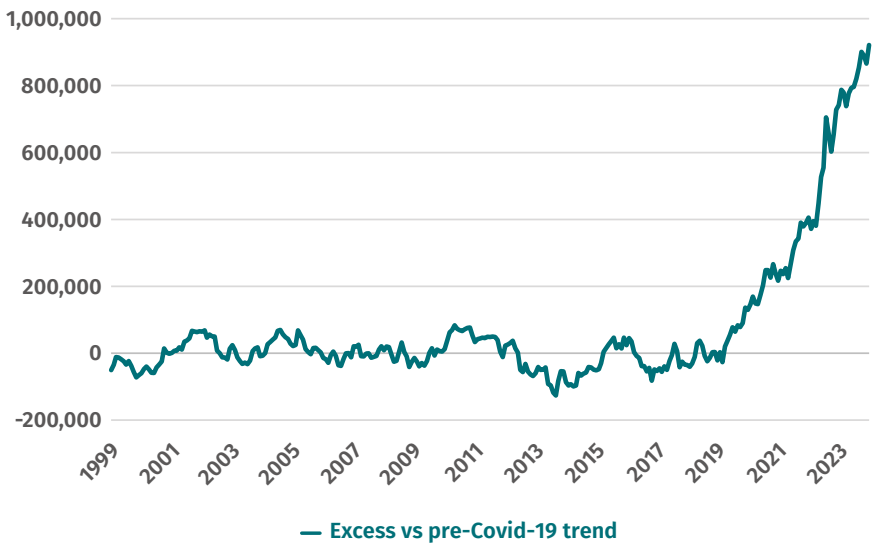
Our research suggests these institutions are right to be concerned. Specifically, we find that by between 2020 and 2023, 900,000 more workers were missing from the labour market due to long-term sickness (compared to what we would have expected to have occurred had pre-2020 trends continued). This figure may yet grow further. While it is hard to predict whether increases in economic inactivity due to sickness will plateau or continue to grow in coming years, should the rate of growth continue at the same pace it has since 2020, we would expect economic inactivity due to sickness to reach 4.3 million[6] by the end of the next parliament (ONS 2024d).

METHODOLOGY 2: HEALTH AND THE LABOUR MARKET

To better understand economic inactivity due to sickness, we use Labour Force Survey data to understand overall trends. Figure 2.4 bases the cumulative increase in missing workers on trends in previous time periods (controlling for demographic change). Figure 2.5. uses international employment and participation data, as per the ONS. Subsequent figures explore the impact of education and occupation control for demographic factors.

FIGURE 2.4: THE CHANGE IN ECONOMIC INACTIVITY DUE TO SICKNESS FROM 2020 CREATED 900,000 'MISSING WORKERS' BY THE BEGINNING OF 2024

Excess economic inactivity due to sickness versus pre-Covid trend



Source: Authors' analysis of ONS 2024d

5 Before 2008, most growth was driven by productivity increases. Ultimately, we do not think high growth is sustainable in the absence of productivity gains – and we do not conclude that labour market growth is an adequate substitution. Nonetheless, this finding does mean that short-term growth is likely to be dependent on increasing the size of the labour market, and particularly on reducing the number involuntarily unable to participate in work due to (often complicated) health needs.

6 Compared to 2.8 million currently – already the highest since records began.

After the 2008 financial crash, the extent and duration of the UK's fall in productivity was termed the 'productivity puzzle'. There are some indications that the Covid-19 pandemic may have created a 'participation puzzle' – driven by economic inactivity due to sickness. Indeed, comparison of trends in employment since 2020 suggests the UK economic participation fell further and is recovering more slowly than in other peer countries.

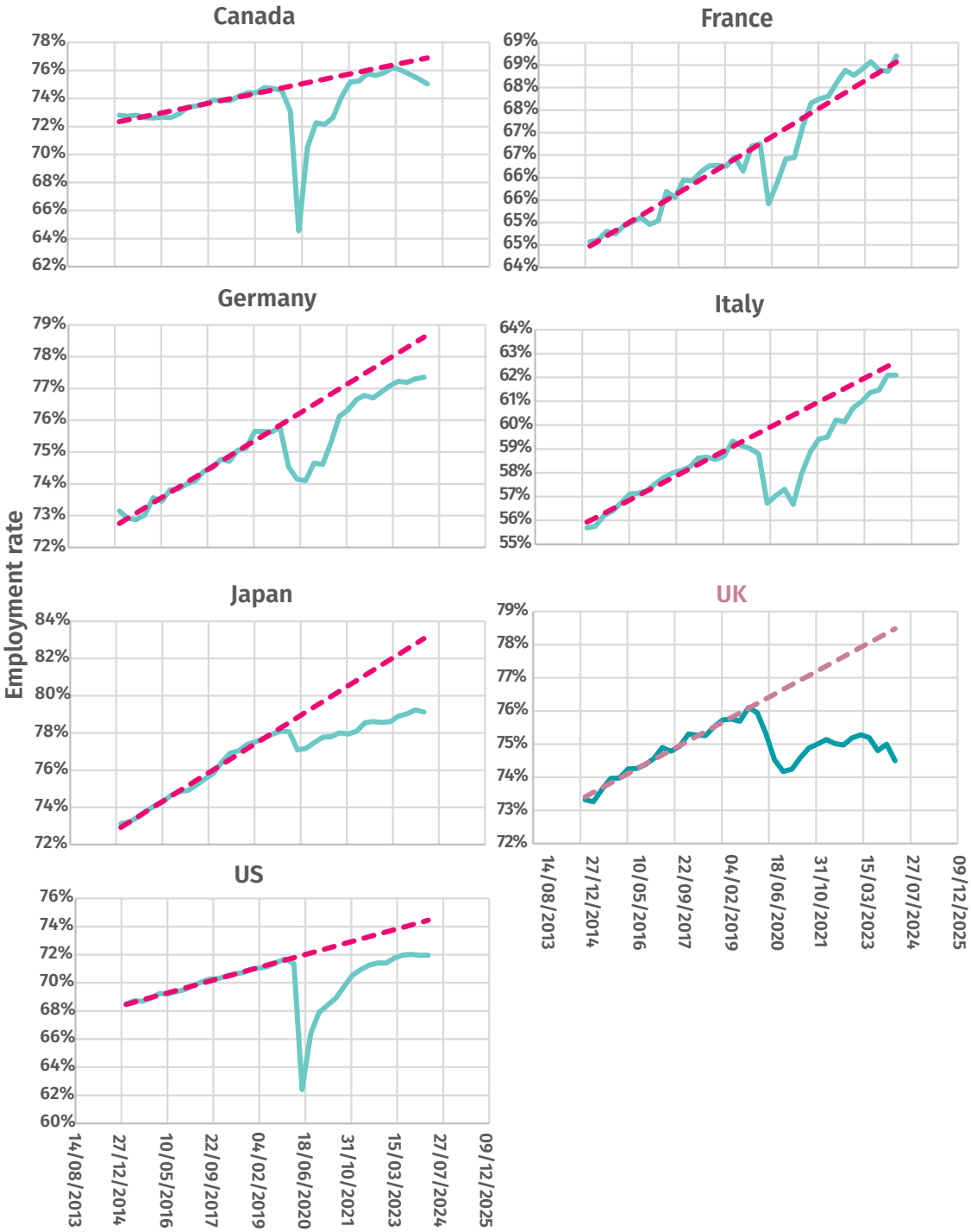
FIGURE 2.5: THE PANDEMIC INCREASED INACTIVITY RATES ACROSS THE G7, BUT FAR MORE SHARPLY AND STUBBORNLY IN THE UK

Seasonally adjusted economic inactivity rate across G7 countries. Dashed line shows pre-pandemic trend.

Source: Authors' analysis of ONS 2024i

FIGURE 2.6: THE UK'S EMPLOYMENT RATE HAS FALLEN FAR MORE SHARPLY THAN IN OTHER G7 COUNTRIES SINCE 2020

Seasonally adjusted employment rate across G7 countries. Dashed line shows pre-pandemic trend.

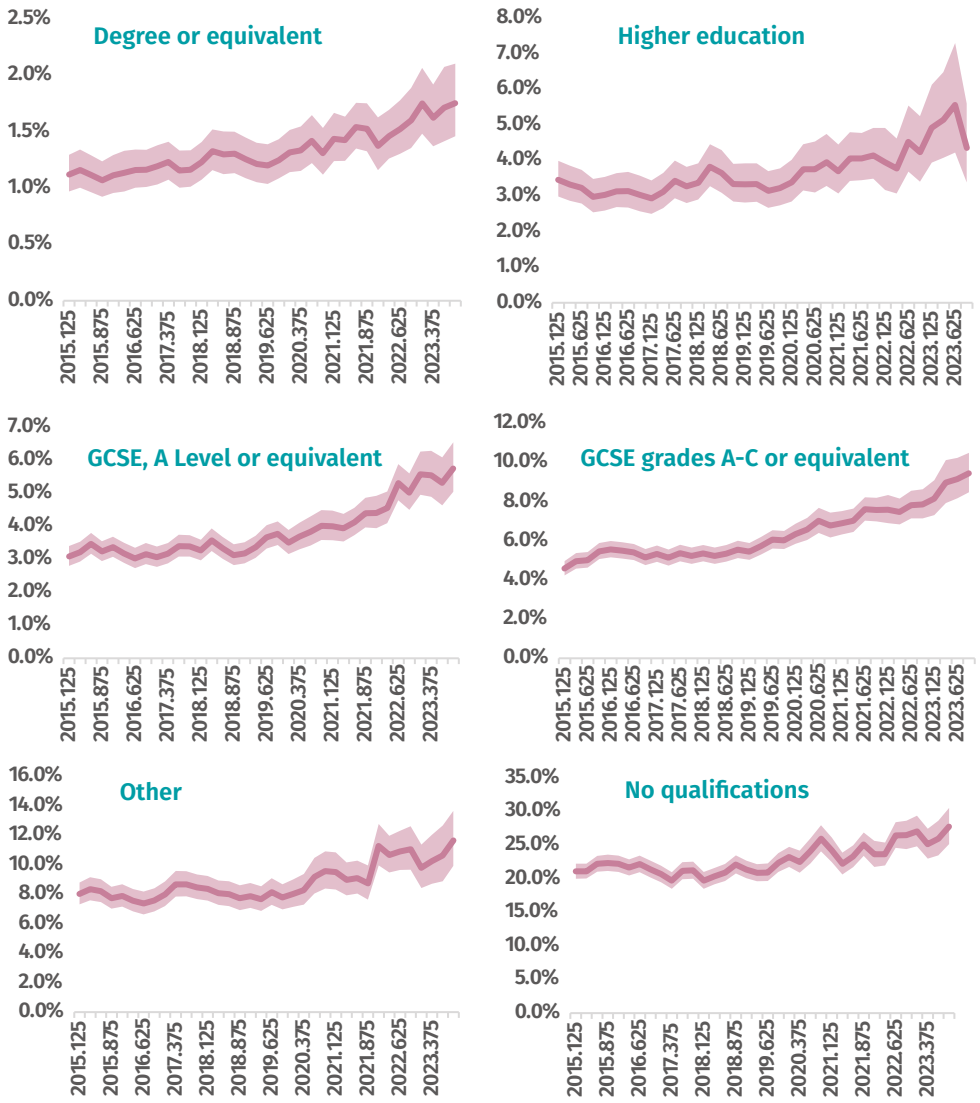


Source: Ibid

We also find that the cost of sickness is higher for those with higher economic vulnerability. The below figures show that economic inactivity due to sickness is both higher – and has risen faster – among people with lower qualifications and among those in less protected professions such as care and elementary occupations.

FIGURE 2.7: ECONOMIC INACTIVITY DUE TO SICKNESS IS HIGHER – AND HAS RISEN FASTER – AMONG PEOPLE WITH NO QUALIFICATIONS

Comparison of economic inactivity due to sickness (working age, SA) by education level – outrun and 1999–2019 trends

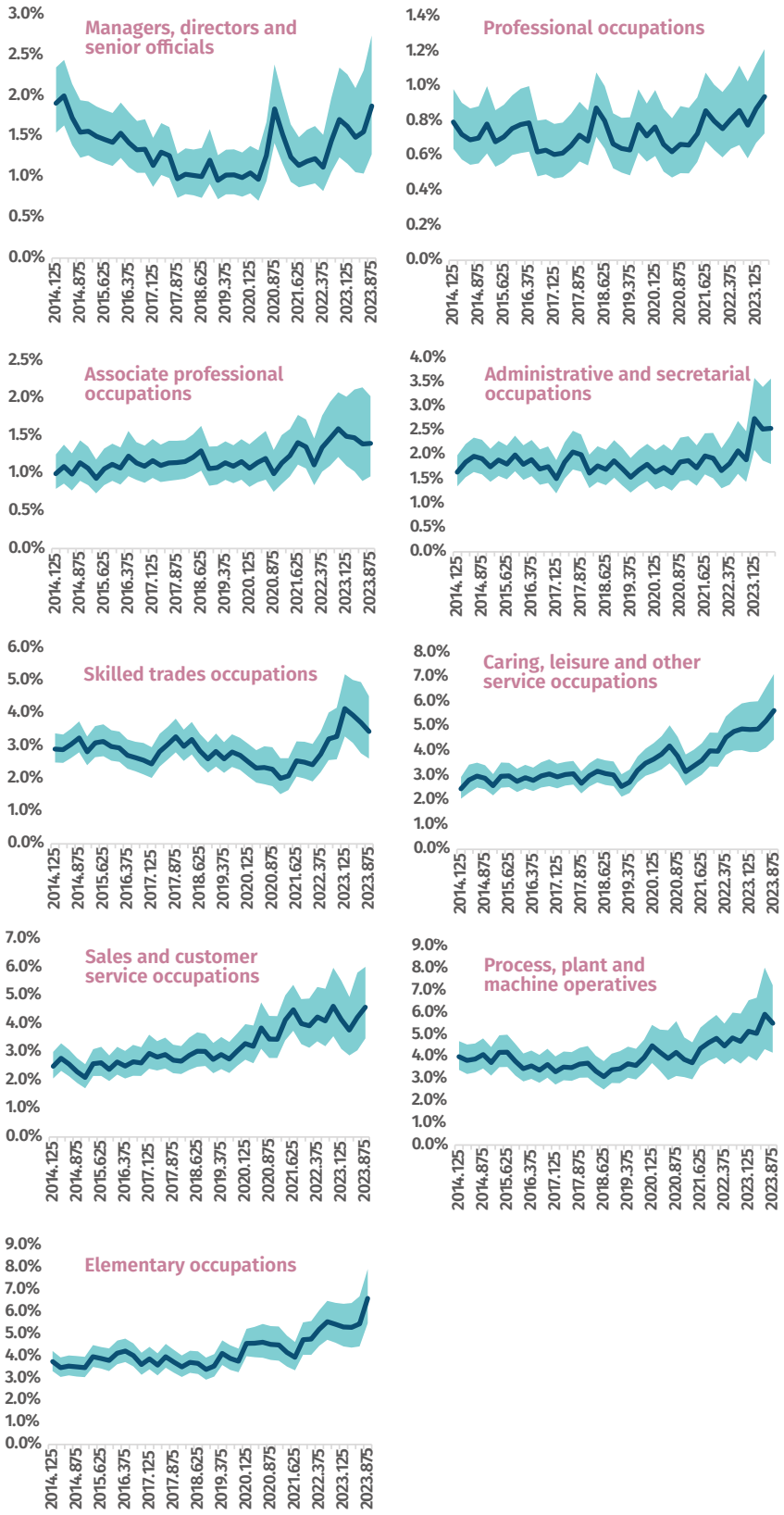


Source: Authors' analysis of ONS 2024d

Note: Note: shaded area represents 95 per cent confidence interval

FIGURE 2.8: ECONOMIC INACTIVITY DUE TO SICKNESS IS HIGHER – AND HAS RISEN FASTER – AMONG PEOPLE IN OCCUPATIONS LIKE CARING, LEISURE AND ELEMENTARY OCCUPATIONS

Comparison of economic inactivity due to sickness (working age, SA) by occupation – outrun and 1999–2019 trends



Source: Authors' analysis of ONS 2024d

Note: Note: shaded area represents 95 per cent confidence interval.

A LIFESTYLE CHOICE?

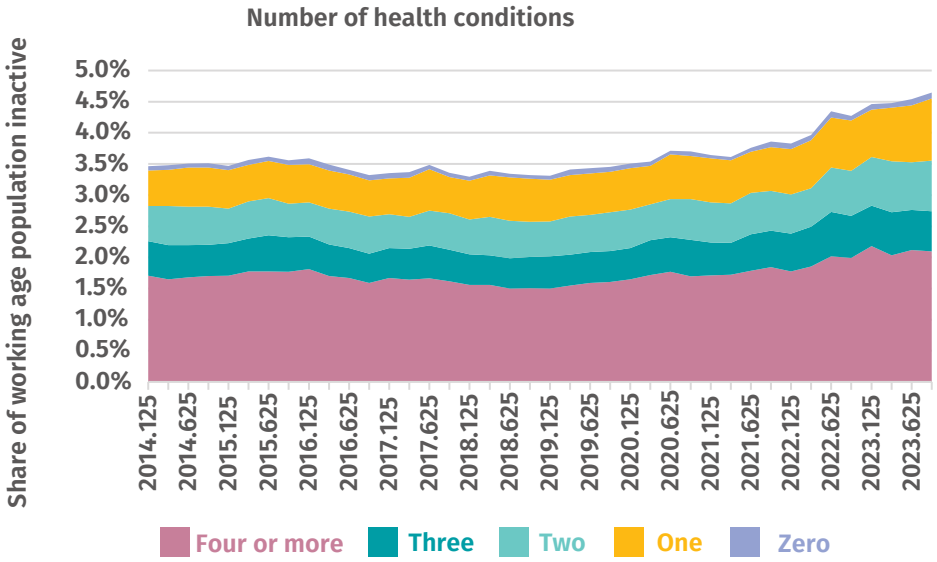
Ahead of the 2024 general election, there were some attempts to explain record levels of economic inactivity due to sickness as a 'sick note culture' – or as a 'lifestyle choice' for a life on benefits, instead of in work. Our findings challenge this interpretation.

Most pertinently, we find that those experiencing economic inactivity due to sickness have far greater health needs than the general population or those inactive for other reasons. Among the whole population of the Labour Force Survey, an average of 35 per cent of people have at least one health condition (and about half of those with a condition have more than one or multiple conditions). Naturally, all those inactive due to sickness have one condition – while around 75 per cent have two or more conditions, and half have four or more conditions (ONS 2024d).

The health profile of those who are inactive due to sickness has not changed substantially in the last few years. As this group has grown, the proportion with 'basic' (two conditions) or 'complex' (three-plus conditions) multimorbidity has remained broadly stable. Were it true that people were leaving (or not looking for) work more easily in 2024 than in 2019, we would expect the opposite.

FIGURE 2.9: THE HEALTH PROFILE OF PEOPLE WHO ARE ECONOMICALLY INACTIVE DUE TO SICKNESS HAS NOT CHANGED SINCE THE PANDEMIC – THEIR HEALTH NEEDS REMAIN HIGHLY COMPLEX

Number of health conditions among people inactive due to sickness start of 2014–end of 2013, as a share of the total working age population



Source: Authors' analysis of ONS 2024d

3. THE PRODUCTIVITY CHALLENGE

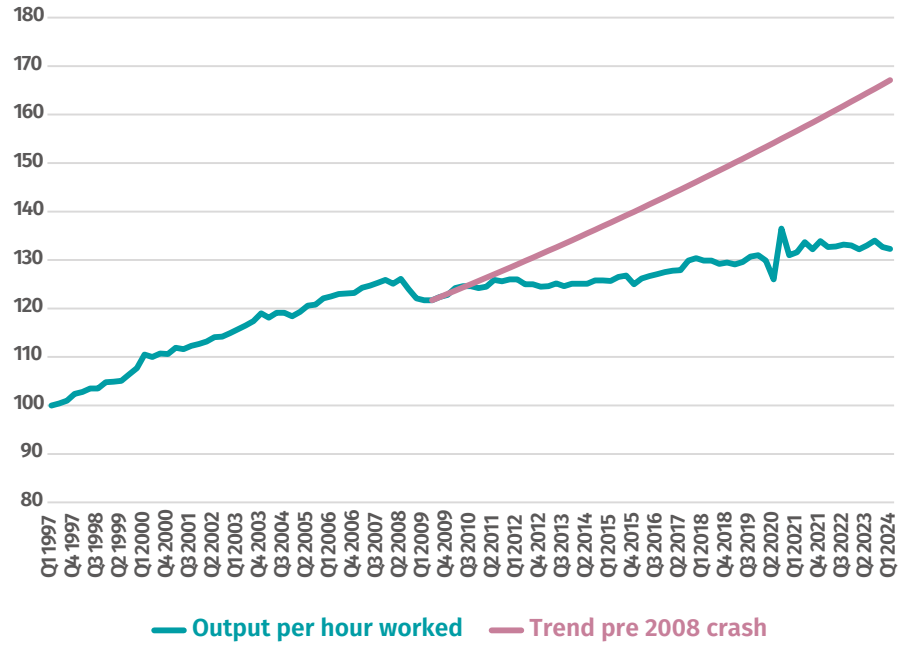
Neither long-term growth in real wages nor GDP are sustainable without increasing productivity. But since the 2008 financial crash, Britain's annual productivity growth has been roughly half what it was prior to the downturn (figure 2.10).[7] As testament to the scale of this fall, we find that if productivity trends had maintained their

7 See also figure 2.3, which shows the reduction in productivity growth's contribution to overall growth.

pre-2008 levels, we would have expected to be 39 per cent more productive today. However, we have only actually achieved a 9 per cent increase in productivity.

FIGURE 2.10: PRODUCTIVITY GROWTH HAS BEEN FAR WEAKER SINCE THE 2008 FINANCIAL CRASH

Quarterly Output per hour with trend pre-2008 crash and trend post-2008 crash



Source: Authors' analysis of ONS 2024e

During the same period, the in-work population has got sicker. Specifically, 36 per cent of working-age adults in the UK have a long-term health condition of some kind (up from 31 per cent in 2013) – and 20 per cent have a 'work-limiting' condition (up from 15 per cent in 2013). And there are now as many people with work-limiting health conditions in work (3.7 million, up from 2.3 million in 2013) as outside it (3.9 million) (Atwell et al 2023).

That sickness might impact productivity is an intuitive deduction – whether because it makes it harder to get as much done or because it makes some kinds of work impossible. This is not to ascribe blame to those with long-term health conditions. As the social model of disability suggests, the origin of these costs lies in the way society and workplaces are designed rather than in any health impairment. Nonetheless, the link between health and productivity is useful to quantify, and this commission's research has explored whether being in poor physical or mental health impacts how much people feel they achieve at work (presenteeism), and their likelihood of taking sick days (absenteeism).

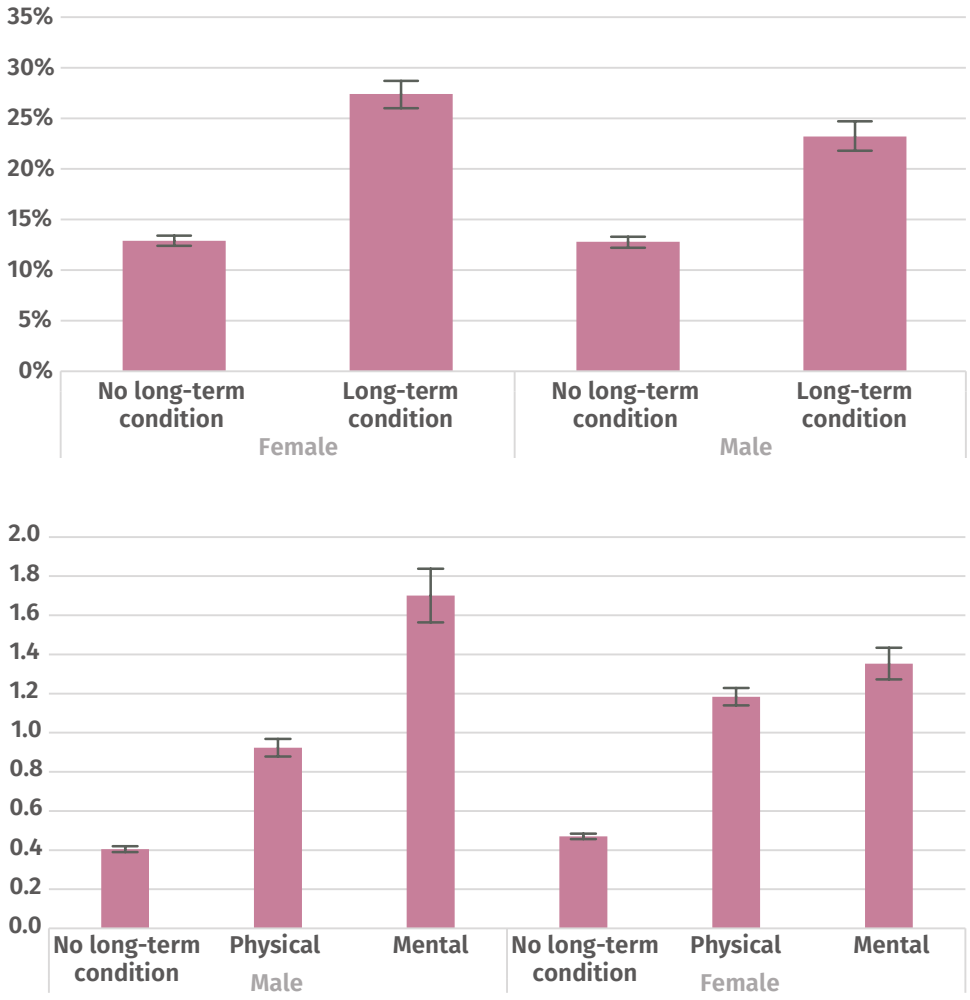
METHODOLOGY 3: HEALTH, PRODUCTIVITY AND WORK

To explore the interaction of presenteeism and sick days with long-term conditions, job quality and demographics, we used data from the Understanding Society study. We define situations where an individual's ill health impacts their work as presenteeism, following the definition in Bryan et al (2022). Logistic regression analysis was used to measure the association between job quality characteristics, personal characteristics, and the likelihood of exhibiting presenteeism controlling for various factors identified in previous research.

To estimate the number of sick days, we used the Labour Force Survey. We used hurdle regression analysis to explore the association between ill health and sick-days taken while controlling for personal characteristics that might influence the likelihood of taking sick-days, based on previous studies. For a more detailed account of the methodology see O'Halloran & Thomas (2024).

FIGURE 2.11: LONG-TERM CONDITIONS IMPACT PRODUCTIVITY

Predicted hours of sick leave taken per week by sex and type of long-term condition



Source: Recreated from O'Halloran and Thomas 2024

That analysis shows that in any given four-week period, women with a long-term condition were twice as likely to exhibit presenteeism compared to women with no conditions, while men were 10 percentage points more likely (25 to 15 per cent). We found similar patterns for sick days taken per week – with mental health conditions having a particularly high impact. Wider literature shows that job quality, financial security, access to sick pay and a range of other factors are important determinants of both sick leave and likelihood of working through sickness.[8]

8 That is, that the costs emerge from society – they are not implicit or inevitable consequences of a health condition diagnosis.

These findings are in line with other studies demonstrating the importance of sickness in productivity. Notably, Bambra et al (2018) have shown that 30 per cent of the productivity gap between the 'Northern Powerhouse' region of England and the rest of England is explained by ill health. At the time of the analysis, reducing this gap was projected to generate an additional £13.2 billion – a figure that, given widening productivity gaps across Britain, has likely increased since.

4. THE PUBLIC FINANCE CHALLENGE

Britain's public services and finances are both under severe strain. While very few public services– from the NHS to education, courts and prisons, and employment support – are performing well, the new government has inherited spending plans that imply substantial spending cuts until the end of the next parliament.

This makes the relationship between health and public finances particularly important. There are three main channels through which sickness might increase public service expenditure: avoidable health and care service spending, avoidable benefit spending, and reduced tax take due to fewer people working. In each case, these costs may emerge either because of a failure in primary prevention (avoiding conditions), or failures in secondary prevention (reducing harm/reduced wellbeing associated with a diagnosis).

Looking at data between 2020 and 2023, the OBR has previously estimated that the reduction in income tax when someone moves from employment to health-based inactivity is £5,000 per person, per year (2023). Applied to our finding that economic inactivity due to sickness has risen 900,000 since 2020, compared to the counterfactual, this suggests a loss of tax revenue of £4.5 billion in 2023.[9]

Elsewhere, the commission partnered with Lane Clarke and Peacock (LCP) to explore the extent to which NHS expenditure changes, depending on population health. We find that by 2034, continued stagnation in the nation's health – as compared to moderate improvement – will mean £18 billion extra annual NHS expenditure (see Patel et al 2023). While we do not suggest this is money that could be 'extracted' from the NHS, it is certainly money that could otherwise be invested elsewhere (eg innovation, technology, capital, staff count, unmet need).

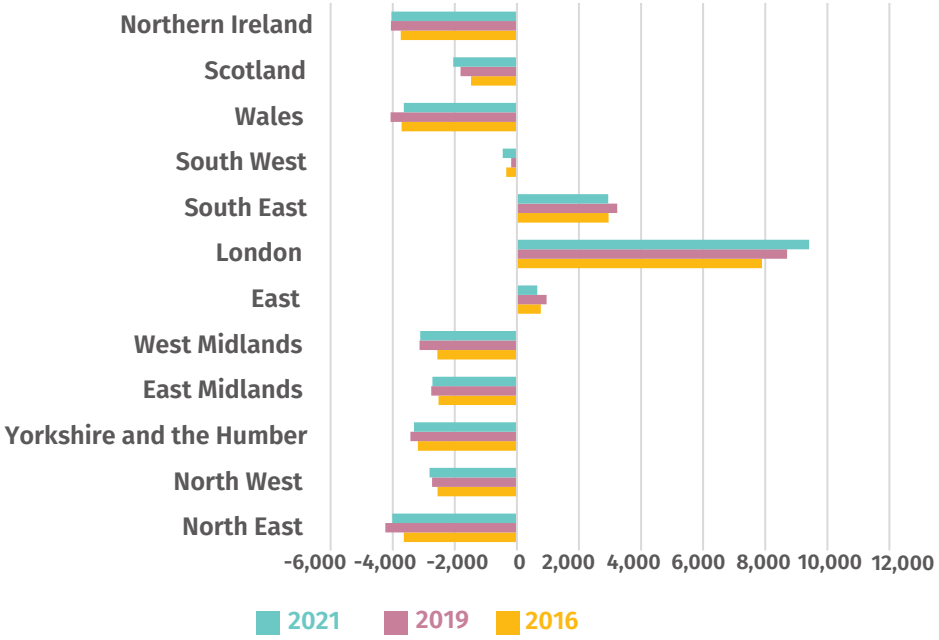
In addition, the Institute for Fiscal Studies has shown a substantial rise in spending on incapacity and disability benefits, concurrent with the rise in economic inactivity due to sickness in the last three years. Its work shows that there were one million more working-age individuals in receipt of at least one health-related benefit in 2024, compared to 2019. This rise is due to the increase in number of people starting a new benefit claim: by November 2022, there were 94,000 new claims for incapacity and disability benefits each month, compared to 20,000 new claims each month before the pandemic (Ray-Chaudhuri & Waters 2024).

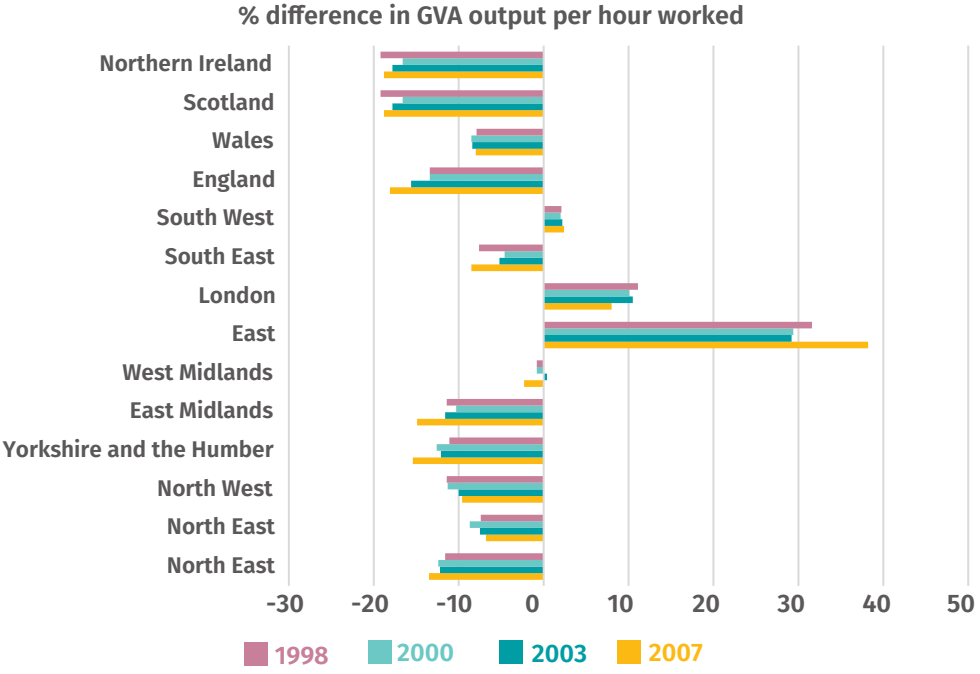
We contend that when sickness or disability limit labour market participation, it is important that disability and incapacity benefits support a good standard of living. But it does not challenge that point to suggest that our success in preventing, treating and managing long-term conditions, in embedding the social model of disability, and in supporting people to access appropriate work, might in turn reduce DWP expenditure.

9 This figure does not account for the tax costs of rising in-work sickness among the working population, which the OBR estimated to be £3 billion in mid-2023. It also does not account for the indirect effect of sickness on other taxes, which the OBR estimated to be £3.7 billion per year in mid-2023. Combined, this suggests a loss to the exchequer of at least £11.2 billion, but likely more.

FIGURE 2.12: DISPOSABLE INCOME AND PRODUCTIVITY ARE LOWER OUTSIDE LONDON – AND THE GAP IS WIDENING

Disposable income per household and productivity (GVA per hour worked) differences between English regions/devolved nations, compared to UK average, 2021, 2019 and 2016





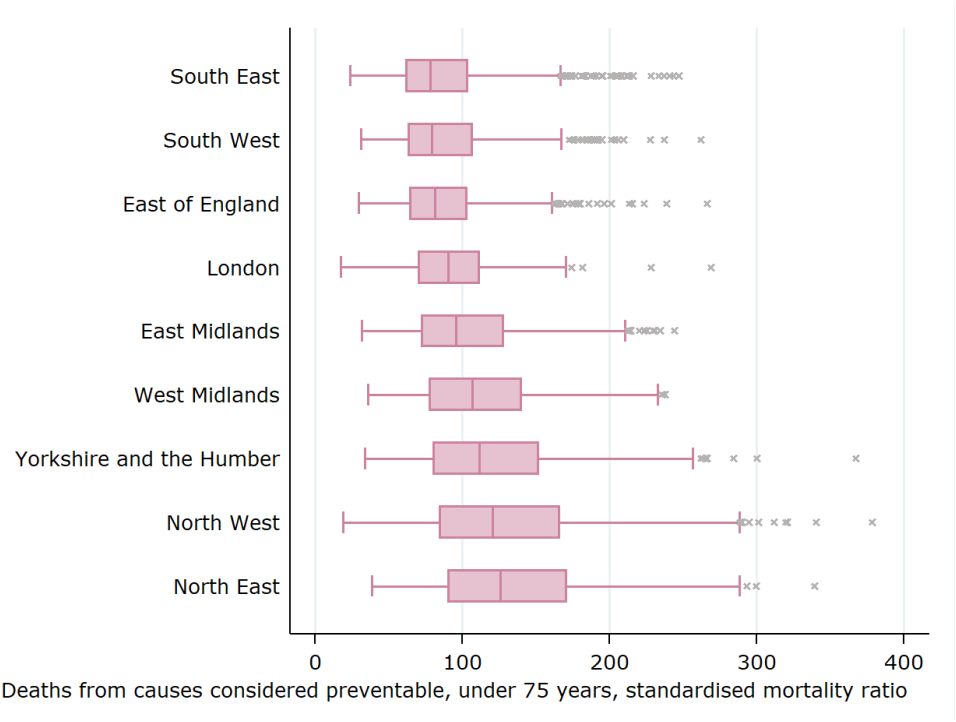
Source: Authors' analysis of ONS 2024f, ONS 2024g

Compared to London,[10] the English regions and devolved nations have significantly less disposable income, lower productivity and lower growth. Compared to similar nations, the UK disproportionately relies on one city for its wealth. That this means others are not enabled to reach their potential likely means lower wealth overall.

As well as inequalities in wealth and prosperity, the UK has profound levels of health inequalities – with some studies suggesting worse inequality than in other European countries (see Cavallero et al 2023). The figure below shows preventable mortality by region – and variation of levels of preventable mortality at Middle layer Super Output Areas (MSOA)[11] level within each region.

FIGURE 2.13: PREVENTABLE MORTALITY IS HIGHER IN THE NORTH OF ENGLAND

MSOA average preventable mortality (death before age 75) of MSOA within regions, England, 2016–20



Source: Authors' Analysis of OHID 2024

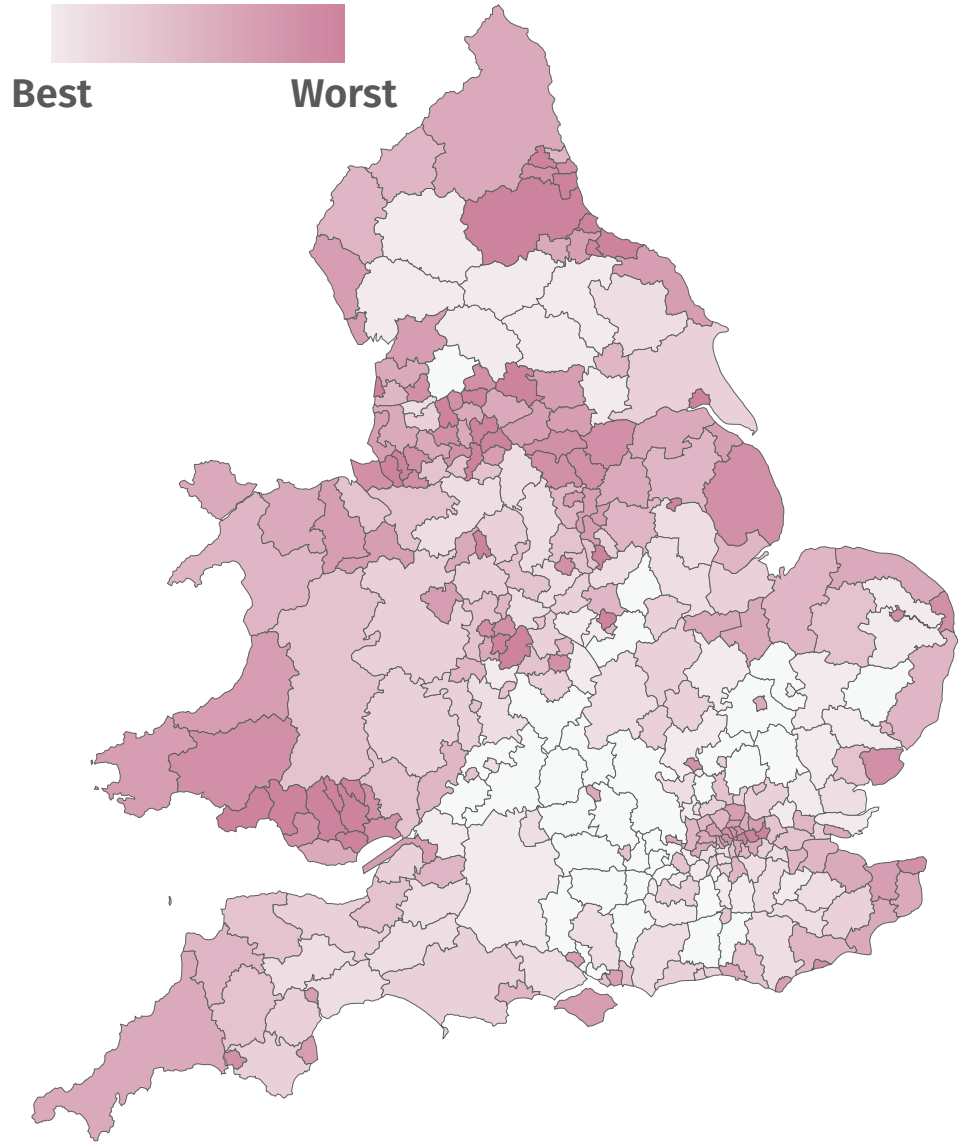
This commission's contribution to the evidence base has been that health and wealth inequalities cluster in much the same places. For instance, we have repeatedly shown that sickness has a higher economic impact on some regions over others. In our first interim report we tested the average impact on earnings if health need reduced 10 percentage points across each region. We found that this reduction would lead to a 1 per cent increase in earnings/person in London, but a 1.5 per cent increase in earnings/person in the West Midlands, the North East and in Wales (see Thomas et al 2023). New analysis for this report shows that the economic inactivity due to sickness rate is far higher in the north of England and Wales than in the south of England.

10 Albeit, we recognise that London's higher average wealth hides inequalities within the city, with sizable inequality between boroughs.

11 Typically, areas of 2,000–6,000 households.

FIGURE 2.14: ECONOMIC INACTIVITY DUE TO SICKNESS IS HIGHER IN WALES AND THE NORTH OF ENGLAND

Index of levels of economic inactivity and sickness by local authority



Source: Author's analysis of ONS 2024d

THE OPPORTUNITY AHEAD

Both the state of the nation's health and the national economy pose major challenges for Britain. On the flip side, the results presented here – the fruits of three years of research – also suggest a major opportunity: that better health could be exactly the medicine our economy needs to deliver more prosperous lives and a wealthier country. In other words, that good health for all is our greatest, untapped route to prosperity, fairness and happiness. This should be the premise at the heart of the government's health mission (as well as its growth and opportunity missions).

There is no better time to strive to deliver on the link between health and prosperity. At a time living standards are falling, growth is low, and people feel worse off than they did a decade or two ago, we can ill afford to miss such opportunities to improve individual lives.

As importantly, better health can also help Britain achieve the national economic growth that the new government has put at the heart of its plans to ensure sustainable investment in public services. The gains could be short-term, through boosts to economic participation that would unlock fiscal headroom for the new Chancellor within, say, a five-year forecast period. And they could be long-term, in restoring the productivity and earnings growth that Britain has struggled to achieve since the 2008 financial crisis.

Whether or not we can achieve better health – and build a brighter future for Britain – comes down to whether we can fully understand the distinctly 21st century health challenges we face, and why our health policy status quo is failing to answer them. We need to understand our rising tide of sickness, and how we can act to arrest it and restore progress. Next, this report turns to defining what is going wrong, to putting forward a new vision for a healthy Britain, and to setting out a practical policy programme for the next parliament.

PART 2:
REIMAGINING HEALTH POLICY

SUMMARY

If we want a healthier, more prosperous future – one where our health enables flourishing lives, where disabled people and those living with long-term conditions do not face societal barriers to wellbeing, and where good population health supports growth and public service investment – then we will need to reimagine our approach to population health.

Today, Britain clings to a distinctly 20th century model of health policy – a sickness model that stresses individual responsibility for our health, and generally only intervenes at moments of acute need. Under this approach, we are getting sicker, even as NHS expenditure and headcount grow. And we are getting poorer, as the costs of avoidable illness to the economy rise.

This approach does not work for NHS sustainability, for people or for Britain's economy. In its place, we propose a new health creation system – a whole society approach to health in which everyone pulls all the available levers to create health in the places people actually spend their lives. Not just in hospitals, but through families, in workplaces, via businesses and within communities.

This would constitute a once-in-a-century leap forward on health – a recalibration as bold as the Victorians' public health programmes, the 1911 National Insurance Act or the 1948 creation of the NHS.

One of Britain's proudest legacies is a historic record of decisive action at a time of health crisis. In Victorian England, infectious disease outbreaks catalysed major public health interventions: from sewers and sanitation to clean water and worker protections (for factory workers and children). In 1911, the increasingly clear insufficiency of the Poor Law saw the introduction of National Insurance – extending health protections to some working people for the first time. And rising acute need from non-communicable diseases in the 1940s led to the creation of the National Health Service in 1948.

The similarities between these moments and 2020s Britain are striking. As then, the nation has intolerable levels of unmet health need. And as then, the impact this is having on the economy – and notably, economic participation and the labour market – is massive. Once again, the time has come for change.

The answers will come from looking forward, not backward. As in other periods when Britain has pioneered new approaches to public health, we need to engage with the way our health challenges are changing. Today, the problem we face is the rise of long-term illness, of multi-morbidity, and of longer stretches of our lives spent in poor health. In response, we need a health policy that thinks not only about people surviving, but people thriving – through genuine support from cradle to grave.[12] That is the vision this part of the report seeks to set out.

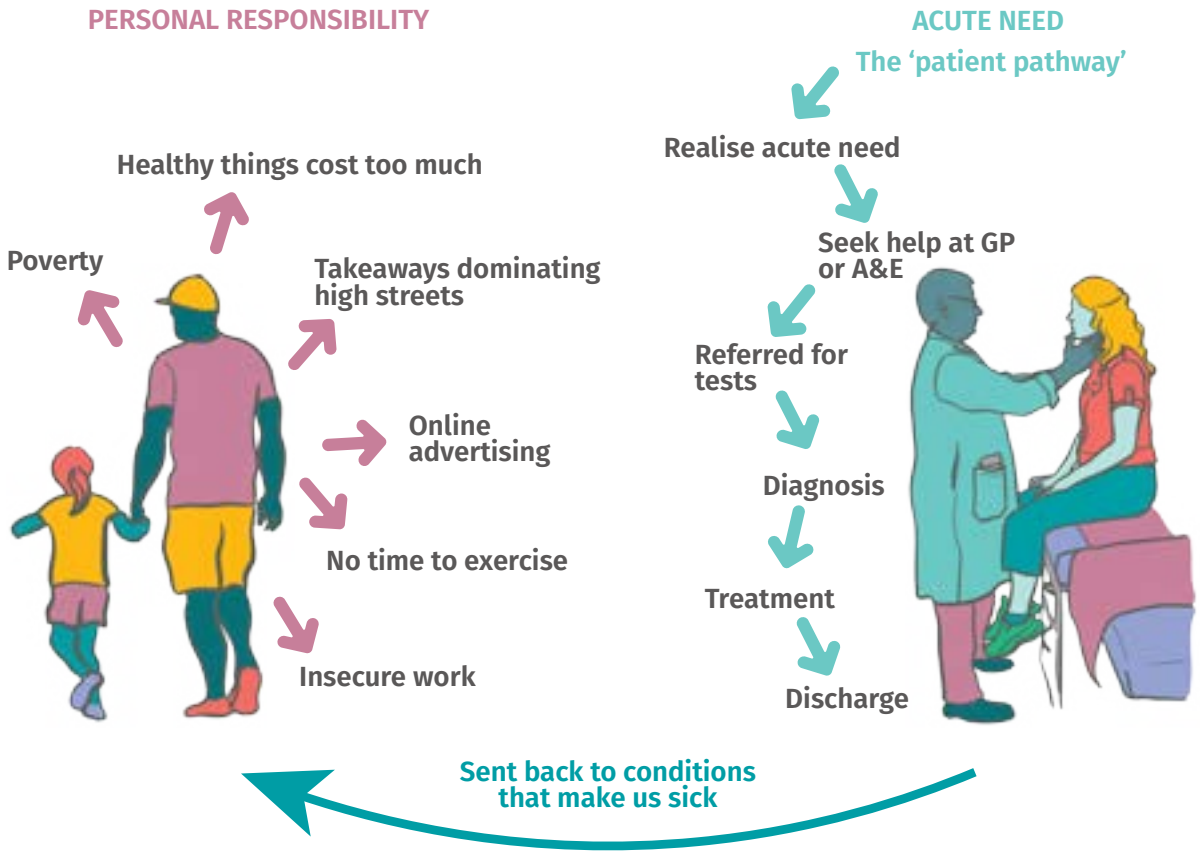
12 Rather than, as too often in our current approach, 'at cradle' and 'at grave'.

THE LIMITS OF THE SICKNESS MODEL: PERSONAL RESPONSIBILITY AND AN OVERWHELMED NHS

To reimagine our health policy should be the goal of the new government's health mission. Doing so successfully demands a diagnosis of what is going wrong. Ours is this: British health policy continues to cling onto a distinctly 20th century model of health policy: 'the sickness model'.

Under it, health is defined first and foremost as a matter of personal responsibility. People are accountable, and often blamed, for 'individual choices': what they eat, whether they exercise, whether they smoke, what work they do, how much they drink, whether they go to the doctor. Intervention is predominantly available only at moments of severe need – and almost exclusively via state-delivered services in hospitals, A&Es and clinics.

FIGURE 3.1: THE SICKNESS MODEL



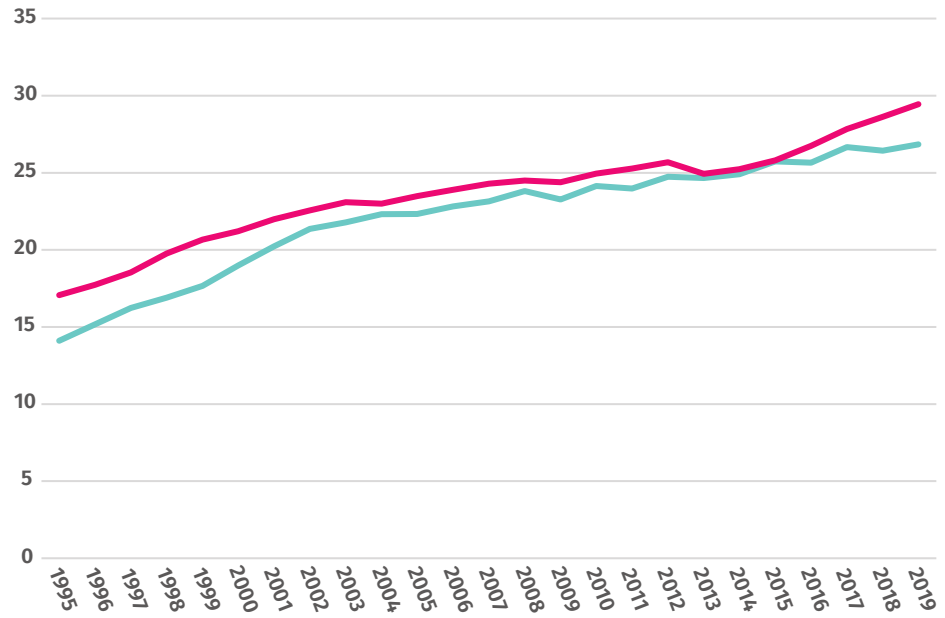
Source: Authors' analysis

Obesity and nutrition – among the UK's biggest public health threats – provide one of the best case studies in the failures of a focus on personal responsibility as the route to improve health. Studies have linked poor diet alone to nearly 14 per cent of UK mortality, equivalent to 100,000 deaths each year (GBD Collaborators 2019).

Reacting to this challenge, the government has introduced 689 different obesity policies over 14 different strategies since 1992. However, with some notable exceptions (eg the soft drinks industry levy), reviews of these policies have noted that the majority make extensive demands on individual agency, with only limited demands of other institutions responsible for poor diet (eg supermarkets, food producers, advertisers) or provision of meaningful support (Theis & White 2021). Since 1995, the obesity rate has risen from 14 to 27 per cent of men and 17 to 29 per cent of women.

FIGURE 3.2: BRITAIN HAS A HIGH AND RISING ADULT OBESITY RATE

Obese population (three-year average), % of population aged 15+, measured



Source: OECD 2023

The spectre of 'personal responsibility' is not always explicitly signposted. But it can also be diagnosed in instances where government policy makes explicit demands and references to individual agency, and in cases where it simply fails to protect them from new health threats:[13] when government resists implementation of well-evidenced policies like minimum unit pricing, at a time alcohol deaths have reached record levels, for example; when it fails to intervene on non-decent housing in the private rented sector, despite the high prevalence of housing stock with the highest category of public health risks; or when it actively liberalises UK gambling laws[14] at a time the internet threatens to magnify the gambling harm (as in the 2005 Gambling Act). And alongside inaction, there is slow action. It took over a decade from evidence conclusively demonstrating severe harm for government to begin regulating tobacco – and it has also been slow to act on e-cigarettes as youth vaping numbers rise.

13 Or in the worst instances, where government policy actively liberalises and promotes health harms.

14 As in the 2005 Gambling Act.

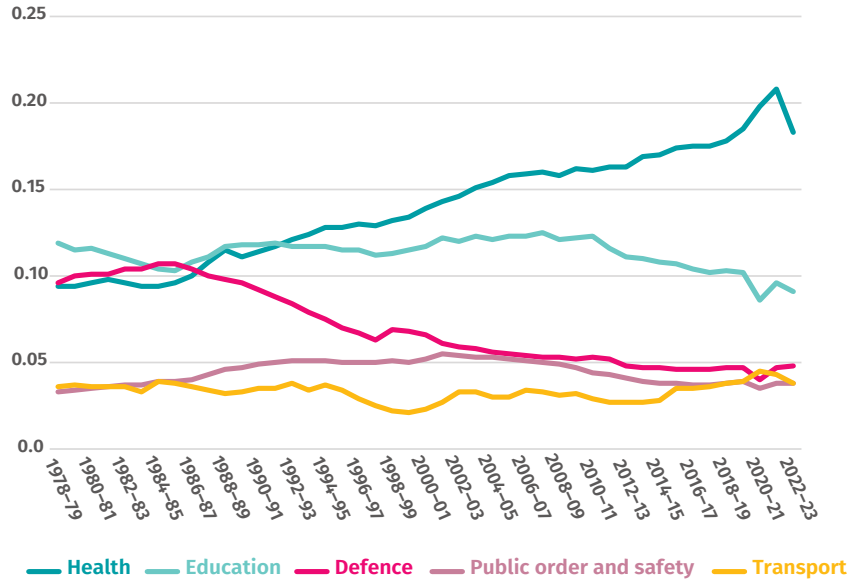
It can also be diagnosed in the support available for people with long-term conditions and for disabled people. They have been particularly impacted by the cuts to services, welfare and fit for purpose infrastructure during austerity, which have created a country where increasingly, people are 'on their own' when living with a condition or impairment. As IPPR has put it elsewhere, the risks of ill health or having a disability 'have been increasingly borne by individuals' rather than institutions: personal responsibility, in another form (Quilter-Pinner et al 2020).

The idea that our health, from our lifestyle to how we manage a health condition, is an individual responsibility fails to account for how difficult healthy lives have become. For someone balancing low paid work with financial insecurity and caring responsibilities, there is no easy way to go out for a run or afford a gym membership. For someone living on increasingly inadequate universal credit rates, the extra cost of healthy food puts good nutrition out of reach. For people in the most deprived parts of the country, a barrage of advertising sways their choices, while a lack of 'healthy infrastructure' like local authority-owned libraries, leisure centres and parks leaves no real alternative. Someone renting a property somewhat near their workplace cannot control the fact private rented housing is often overcrowded or prone to hazards like black mould, or that the road they live on has toxic levels of air pollution.

The implicit irony of the focus on personal responsibility in limiting society's scope for intervention is the pressure it puts on the government-funded NHS. Without a viable strategy to manage 'demand' through primary or secondary prevention, it is the NHS that is left to go it alone in facing rising health need.

FIGURE 3.3: THE NHS HAS AN INCREASINGLY HIGH SHARE OF TOTAL GOVERNMENT EXPENDITURE

Total government expenditure 1955–2022 – NHS, education, transport, social care, housing as a proportion of total spending



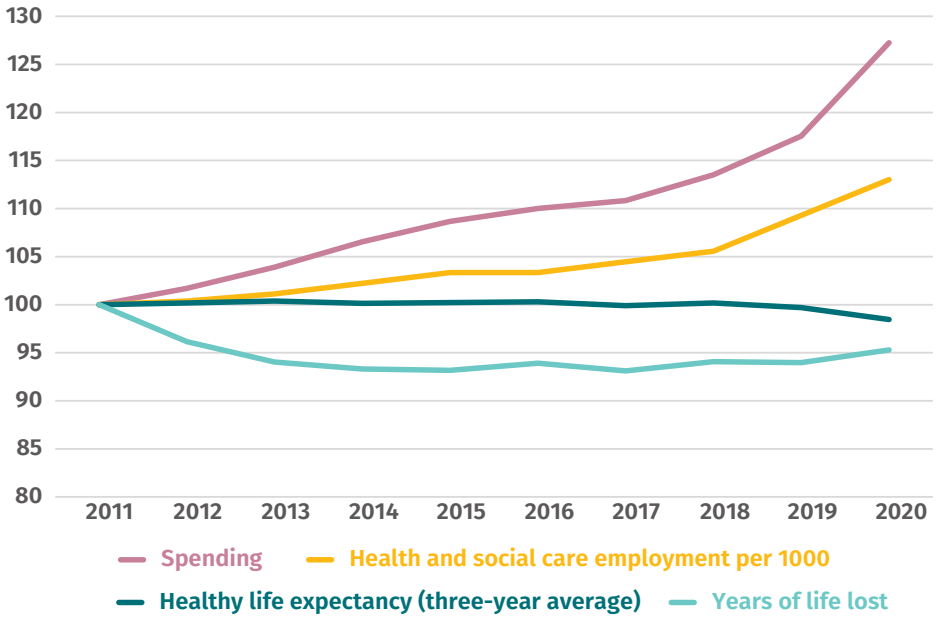
Source: Authors' analysis of IFS 2023b
Note: To label lines in order: NHS, education, transport, social care, housing

As a result, an increasing share of government expenditure has been allocated to it (figure 3.3). Since its formation in 1948, the NHS budget has increased twelvefold in

real terms in England alone.[15] And since the turn of the millennium specifically, the correlation between NHS funding or doctor numbers and overall national health outcomes has been weak at best (figure 3.4).

FIGURE 3.4: IN THE LAST DECADE, NHS CAPACITY AND POPULATION HEALTH OUTCOMES HAVE LOOKED INCREASING DETACHED

Index of NHS spending in England, active physicians, healthy life expectancy and total years of life lost



Source: Authors' analysis
Note: Years of Life Lost is an indicator that accounts for age distribution within premature mortality figures

Even then, the NHS is struggling on almost every indicator – from cancer performance to patient experience and GP access.[16] Leaving the NHS to go it alone on rising health need – as our only means for health intervention – has stretched capacity, reduced headspace for modernisation, and undermined the uptake of innovation and new medicines.

To put it simply, we will not treat our way out of our health crisis. Attempting to do so could mean more unmet need and more NHS expenditure, squeezing funding for other public services. Higher costs for greater inadequacy are self-evidently an unacceptable result.

That is not to say we do not need the NHS – universal access to the best healthcare will remain a vital part of our health policy. Instead, our proposal is that we now need a parallel system that focusses on prevention, with the explicit goal of managing demand in a way that allows our 'sickness service' to thrive: to modernise, provide excellent access, focus on quality, and deliver innovative treatments. That is how we'll deliver the preventative capacity to create space for the NHS to work, once again, for public health and public finances. The rest of this report focusses on that core policy proposal.

15 During which time the population size has only increased 35 per cent – indicating the extent of this increase in spending on a per capita basis.

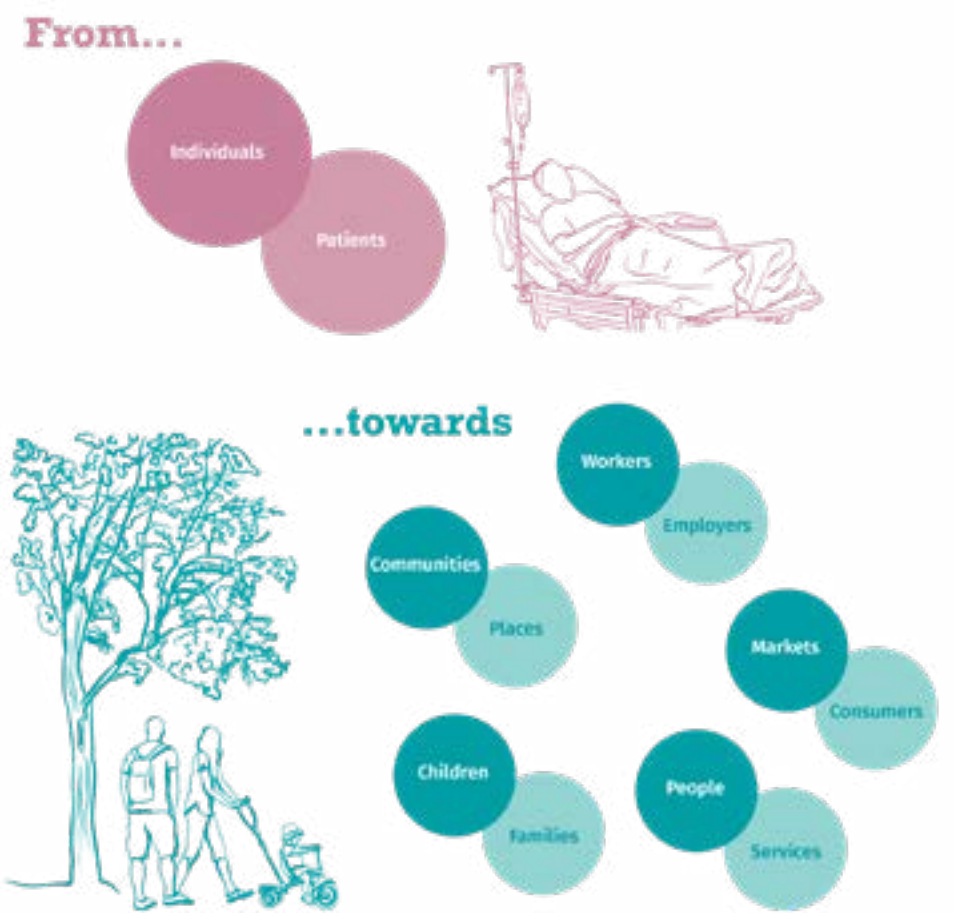
16 For a full audit of healthcare indicators see Patel et al 2023.

DEFINING AN ALTERNATIVE: A HEALTH CREATION SYSTEM

We need to move from a sickness model of health policy to a health creation one. We define this alternative as a whole society approach – where all our institutions pull all the levers available to them to create good health: **the health creation system.**[17]

A health creation system would develop new ways to intervene in the places people spend their time, and through a far greater range of settings and institutions than just hospitals. Indeed, reflecting on where people actually spend their time is one of the best ways to show the limits of a sickness model and the merits of a health creation one.

FIGURE 3.5: A SICKNESS VS A HEALTH CREATION MODEL OF HEALTH POLICY



Source: Authors' analysis

17 To compliment, support and work with the NHS as a specialised sickness service – not to replace it.

Over the course of our life, we might spend half an hour with our GP or dentist a few times a year, and a few days in hospital a few times (on average). But hospital is far from playing a dominant part of most of our lives. Even people in their final year of life only spend an average of 23 days there during that time (Luta et al 2022). But we will spend 90,000 hours at work over a lifetime, and around 14,000 hours at school. We'll spend four hours a day on leisure (ONS 2023b), and 71 per cent of that leisure time is spent with other people (ONS 2018). Most of us spend most of our lives in our homes and in the neighbourhoods where we live, except when travelling or on holiday. There is little space in our current health policy for how and where we live, learn, play, work and grow (despite the extensive body of evidence that exactly these aspects of our life are critical to our health prospects). Our status quo is too often about 'at cradle' and 'at grave', rather than the moments in between.

Britain's health creation system would recognise that our health is not just about the healthcare we receive in moments of greatest acute need, but also about the work we do, the types of businesses that drive forward our economy, the communities and homes we live in, and the families we grow up in. It would incorporate these settings and institutions into our approach. It would help us realise a broader definition of health – one that has parity between physical, mental and social health outcomes. And it would incorporate both primary prevention, avoiding illness before it occurs, and secondary prevention through a significant increase in support for disabled people and those living with long-term conditions, to ensure flourishing lives.

A health creation system does not exist as an either/or with the NHS. Our proposal is **not to replace the NHS – which should continue to strive to be both world class and a pillar within the health creation system itself.** Rather, the health creation system would incorporate the NHS. It would recognise that brilliance in the NHS is dependent on our ability to manage demand, that the NHS has its own huge potential to deliver prevention, and that whatever health policy approach we take in the 21st century, brilliant, innovative care for those who do experience acute health need will remain incredibly important.

We suggest **five founding principles** in its formation**.** Each speaks to the biggest opportunities to deliver health and prosperity, and to make health the business of a far broader coalition within society. We recognise these are not necessarily exhaustive. Over time, a health creation system might evolve, much as the scale and scope of today's NHS is an order of magnitude bigger than that which was founded in 1948. We propose it here to indicate bold first steps – looking at what might be achieved over the course of the coming parliament.

1. **Work that creates health (workplaces)**: Work is key to the relationship between health and prosperity. Yet the nature of work and composition of jobs have not received enough focus in British health policy. Currently, work and health exist in a vicious circle: our work makes us sicker; our sickness makes work less accessible.
2. **An industrial strategy for health (shops and services)**: Policymakers have neither optimised the potential of health for prosperity nor fully reflected how the structure of our economy, from the products on our shop shelves to the shops on our high street or the apps on our smartphone, impacts health.
3. **Health creation at the start of life (children and families)**: Health policy only intervenes 'at the point of service delivery' rather than taking opportunities to create the foundations of good health throughout our lives, particularly in childhood.
4. **Foundations of health in every neighbourhood (places we live)**: The importance of place in health is demonstrated by the 20-year gap in healthy life expectancy between Blackpool at one end of the spectrum

and Wokingham at the other. Some places in Britain enable good health but others undermine it.

5. **Proactive healthcare, in the places we need it (public services)**: The NHS is a sickness service, treating people in moments of need through a reactive care model. It has done less to embed proactivity and struggled to modernise around prevention and long-term condition management.

These are the shifts that should be at the heart of a truly transformative new approach to health – the kind the most successful version of the new government's health mission might aim to give rise to. From here, we delve further into each of these themes to provide a clearer picture of the limits of a sickness approach, and to give a more concrete account of the scale of the opportunity that a health creation approach has to boost health and prosperity.

1. FROM WORK THAT HARMS HEALTH TO WORK THAT CREATES IT

"Work-life balance, that's very important."

IPPR deliberative research participant

It is widely believed that some people deserve to be paid more than others because of the job they do. But do those who earn less deserve to fall sick sooner, live in worse health or die younger? That is the reality of the relationship between our health and our work today – with over a million workers injured or made ill by their work in Britain each year (Health and Safety Executive 2023).

When health policy has focussed on work, it has often looked at the health benefits of being in work, contrasted against the health costs of being unemployed. Studies have consistently shown employment improves physical and mental health outcomes (eg Wadell & Burton 2006).[18] But increasingly, it is also clear that the relationship between health and work is not straightforward: some jobs are as bad for your health, if not worse than, no work at all.

That is not to diminish the continued impact worklessness has on health in Britain in 2024 – an important consideration in the context of a rise in those inactive due to sickness. Bartley (1994) outlines four mechanisms by which worklessness might affect health:

- poverty (financial strain of being out of work)
- stress (which can have physiological effects – studies have found that unemployment can act as a stressor independent of its financial impact)
- unhealthy behaviours (although the evidence base on this is more mixed, with both positive and negative associations reported)
- implications for future employment (unemployment increases the risk of future unemployment).

As much as we should be concerned about the role of sickness in creating new barriers to the labour market, we should also remember it is a vicious circle: unemployment can make us sicker, sickness can make it harder to find or stay in work.

But it also remains true that the relationship between the composition of jobs and health remains under-represented in British policy. Where health policy has focussed on the kinds of work we do, it has often been through the lens of workplace safety. We have made significant progress on hazards in the workplace,

18 While often thought of as a bidirectional relationship – poor health can also limit employment prospects, as shown in other parts of this report – there is strong evidence of a causal relationship between unemployment and worse health outcomes.

with the rate of fatal injuries falling from 2.1 per 100,000 workers in the early 1960s to 0.41 per 100,000 workers today (Health and Safety Executive 2023b).

However, safety is not the only driver of health outcomes in work. Job quality is important too. One route through which low quality work can impact our health is low pay (although ambitious growth in the UK's minimum wage over the last decade has dramatically reduced rates of low pay). Another is insecurity (eg zero-hour contracts). But beyond these more frequently highlighted factors, other evidenced links between physical/mental health outcomes and the composition of work include:

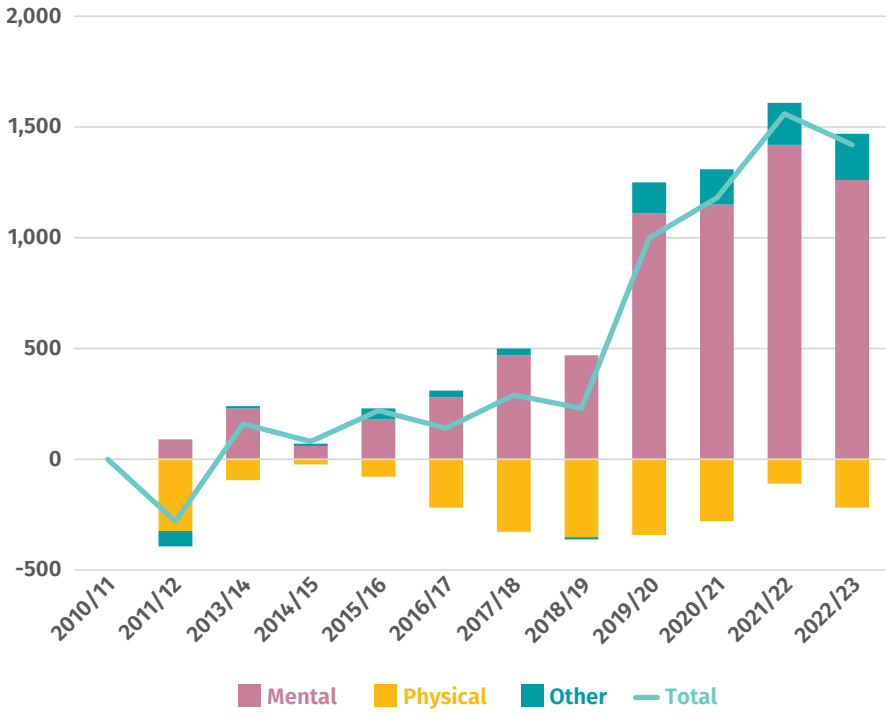
- low satisfaction – where employees are dissatisfied with their job
- low job autonomy
- high levels of stress, overworking and poor work-life balance
- poor line management, workplace culture and job wellbeing.

It should cause some worry that the UK has seen a sharp increase in exactly this kind of work. There have been large rises in precarious, low paid and low autonomy jobs in the last 20 years. New estimates for this report suggest that as many as 25 per cent of all jobs in the UK have at least one aspect that can be considered low quality.

In parallel, there has been a rise in the number of health conditions linked to the work we do. While the number of work-related health conditions declined in 2011–12, it has since increased substantially. New analysis for this report shows that 1.8 million people report work has caused or worsened their health condition (2021/2), a 600,000 increase on 2010/11 (figure 3.7). This trend is overwhelmingly driven by work leading to poor mental health outcomes.

FIGURE 3.6: HEALTH CONDITIONS CAUSED OR WORSENED BY WORK HAVE BEEN RISING IN THE LAST DECADE – DRIVEN BY THE IMPACT OF WORK ON MENTAL HEALTH

Change in health conditions caused by work 2010–11 to 2022–23



Source: Authors' analysis of ONS 2024d

A new approach to health and work is vital in delivering a healthy, more prosperous future. A healthy future of work – where people have access to appropriate work, and the work we do is conducive to good lifetime health – can boost population health and the labour market in tandem. **Our first proposed shift is towards a future of work that supports our health, rather than one that harms it.**

2. FROM TOLERATING HEALTH HARMS TO AN INDUSTRIAL STRATEGY FOR HEALTH

> ***"It's all very good saying eat healthy, but it comes at a cost. Salford has always been known as a deprived area, so it's alright saying to Salford residents 'Eat this or go to such and such market'. But I'd say 75 per cent of people can't afford it."***
>
> ***"Every shop is a takeaway."***
> IPPR deliberative research participants

This report has demonstrated that good health is the foundation of a strong and fair economy. But the structure and composition of the economy can also drive health, for better or worse. We face a choice between **friction**, where the sickness of people creates a sickness in our economy, and **lockstep,** where the health of people provides a basis for broad prosperity. That is, our choice is between a vicious circle, where our economic model is dependent on the things that make us sick, or a virtuous one, where good health is the basis of renewed national prosperity.

The mechanisms through which the economy can undermine health are intuitive. If people's shop shelves are stocked with products that harm health and are advertised aggressively at bus stops and on TV, if the manufacturing process for creating those products pollutes the air, if smart phones are portals to 24/7 gambling and other online harms, then it is unsurprising that there are health consequences.

In lieu of more strategic policy, Britain has developed an economic dependency on exactly these kinds of products and services. Indicatively, recent years have seen increases in the dominance of unhealthy food, gambling, alcohol and smoking. Six in 10 calories consumed by adolescents come from ultra-processed food (Chang et al 2021). Gambling revenues have risen markedly, even though the majority of these revenues continue to come from a small minority of high-risk gamblers (APPG Gambling Related Harm 2020). Alcohol mortality has reached its highest level since records began, rising 30 per cent since 2019 (ONS 2022). And 6.4 million adults still smoke in the UK (ONS 2023c).

More tangibly, one in every three deaths and a full third of the UK's disease burden are down to the combined impact of tobacco, unhealthy food and alcohol.[19] The industries behind those products, in turn, are estimated to make over £52 billion of revenue from sales that are beyond what health guidance in the UK would recommend as safe levels of consumption.

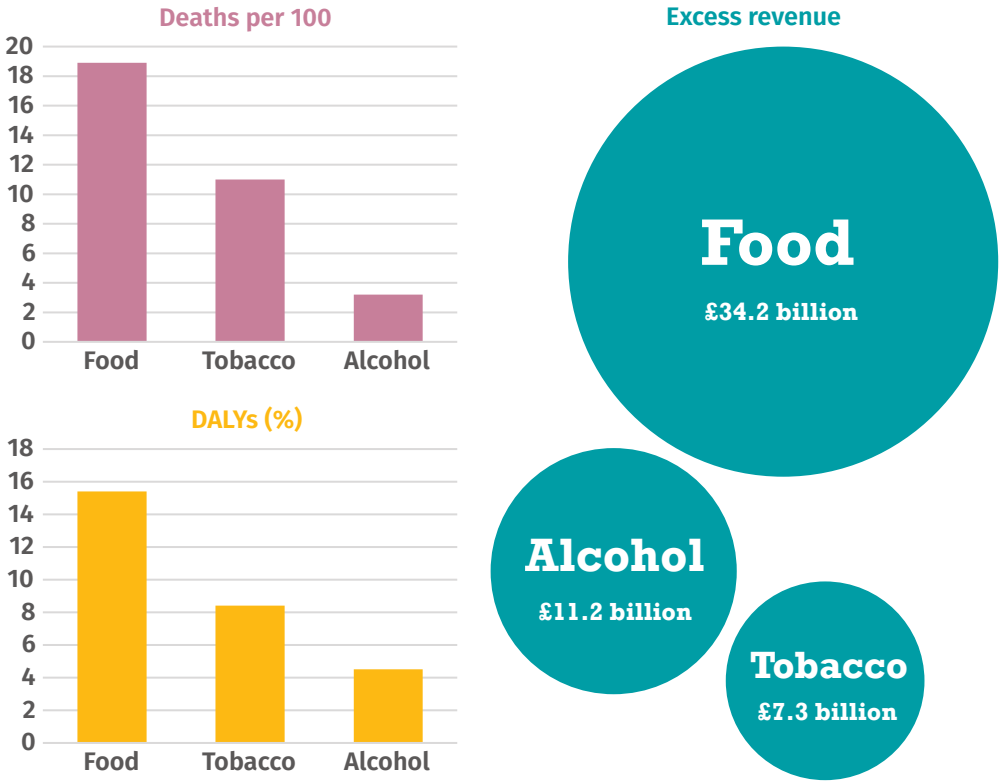
The problem is simple: that the health costs of producing harmful products do not fall (fully) on the businesses that create them. At least in part, they are picked up by a mix of individuals (in the cost of avoidable sickness), the NHS (avoidable treatment costs), and other businesses (via productivity costs or higher staff turnover). This means unhealthy products are artificially cheap and profitable, skewing markets towards them. And as we have already

19 Not the only industries that harm health, but those where causality is best established and therefore reliable data on harm is readily available.

argued in this report, a government health policy bound to an idea of personal responsibility undermines effective intervention or regulation.

FIGURE 3.7: A SMALL NUMBER OF INDUSTRIES ARE LINKED TO A HIGH BURDEN OF DISEASE, AND MAKE SIGNIFICANT 'EXCESS REVENUE'

Deaths per 100, proportion of disease burden and excess revenue linked to food, tobacco and alcohol industries



Source: Authors' analysis of IHME 2024, ASH/OHA/AHA 2023

If this is a picture of unhealthy products and services being subtly enabled, we are comparatively bad at realising the potential of industries that offer both health and economic returns. The UK has relatively low overall investment levels compared to other G7 countries (see Dibb & Jung 2024). More specifically, UK performance in attracting global life science investment has fallen over the last decade; UK public research funding for food reformulation dropped 33 per cent in the last decade; and a range of research shows challenges with access to patient capital outside London (see O'Halloran & Thomas 2024).

Put simply, in lieu of strategy, our economy has too much that harms health and too little that creates it. In similar contexts, other agendas have turned to modern industrial policy. For example, many governments have set out substantial green industrial policies, to accelerate the development of green industries and technologies, and to transition away from dependence on fossil fuels. Such an approach eschews the idea that government's role is to get out the way of free markets. Instead, it views government as an enabler, an investor, a partner and an innovator in its own right.

This might not be a free-market approach but that does not make it an anti-business one. Indeed, green industrial strategies are not being brought forward

by the US and by European governments despite business, but rather because industry is asking for them. They want governments that shape and create markets with a purpose.

Our second proposed shift is towards a healthy industrial strategy. Applied to health, industrial strategy would have space for disincentivising harm and encouraging transformation in 'health polluting' sectors. But it would also go further in utilising the government's role in strategically supporting health positive products, businesses and industries, in spaces like the life sciences, food and drink, active leisure, transport and housing. It would move beyond public health's traditional focus on restricting the things it does not like, towards an articulation of what healthy industry and a healthy economy look like. In the interest of health creation, it would go beyond the usual limits of Health in All Policies and towards a vision for Health in All Industries, as part of a plan to go for growth.

3. FROM WAITING FOR SICKNESS TO INVESTING IN A HEALTHY START

"Eight years ago, there was a community centre, where children could go and play."

"My kids are 11 and 14... there's not really anything for them."

"Nowadays you see a gym on every corner and that's good for the youth, but all the green spaces have been taken away."

IPPR deliberative research participants

Currently, health policy performs poorly on investment in healthy childhoods. Evidence shows that the first 1,000 days from conception is the single most crucial period for development, and that intervention here can support children's health, development and life chances (Institute for Health Equity 2010).

A focus on the start of life is particularly important for a policy agenda interested in both health and prosperity. Few would question that investing in education is vital to the long-term prospects of the UK. Most recognise that without good education and the right skills, the UK economy is unlikely to thrive, and people are less likely to realise their potential and prosperity.

The same is true of childhood health. Among others, work by Anne Case has documented the lasting impact of childhood health on adult health and earnings (Case et al 2003). Using data from a cohort followed from birth into middle age, her work shows that children who experience poor health do worse at school and have poorer health and lower earnings as adults. The immediate impact of poor childhood physical or mental health on immediate educational attainment, and health status in early adulthood, are identified as the key causal factors.

Indeed, health and educational outcomes cannot be neatly separated. Worse health can lead to lower educational attainment – for example, because of the impact of asthma on school attendance, of tooth decay on concentration, or of poor mental health on capacity to learn (eg Hsu et al 2016). And lower educational attainment can lead to worse health, including worse physical, mental and social health outcomes. This relationship is made only more important by the finding, reported earlier in this paper, that the risk of economic inactivity due to sickness is as much as five times more likely among those with no qualifications, compared to the general population.

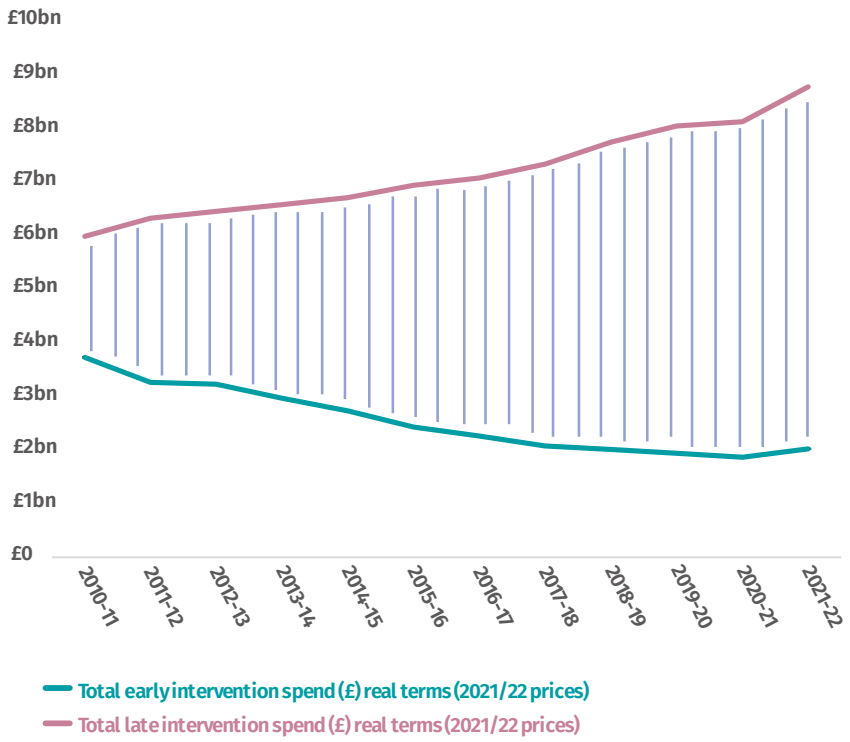
It is worrying in this context that the current generation of children is facing a range of health problems. Most notably, the extent to which they can expect

substantially better health outcomes than their parents is declining. Elsewhere, children and young people are experiencing rises in everything from infant mortality[20] to asthma, diabetes, obesity, myopia, allergies and common mental health conditions (Asthma + Lung 2023, Ochoa-Moreno et al 2024, RCPCH 2024, ONS 2024h).

Concurrently, the UK's infrastructure to support children's health – including through families – has been eroded. Perhaps the clearest example has been a move away from Sure Start, a government initiative to provide support to families with young children in England through a network of 'one-stop shops'. Between 2010 and 2022, funding for Sure Start decreased by over two thirds, leading to 1340 centre closures (Carneiro et al 2024). Yet evaluation of Sure Start has shown that access to a centre had direct (as well as broader) health benefits: it reduced hospital admissions, reduced infectious illness and poisonings, and improved mental health (Cattan et al 2021). Other examples of declining health infrastructure for children include pressures on nursing and midwifery, declining health visitor numbers, and reductions in financial support during pregnancy.

FIGURE 3.8: SPEND ON PREVENTION HAS DECLINED FOR CHILDREN, WHILE SPEND ON REACTIVE INTERVENTION HAS INCREASED

Early and late intervention spending 2010/11 to 2021/22, 2021/22 prices



Source: Recreated from Franklin et al 2023

This speaks to a broader trend in children's services, where early intervention spend has been cut but reactive spend increased. One study exploring spend on early versus late intervention for children between 2015–16 and 2022–3 found that

20 Where there had been significant progress to 2014, but more recently a stagnation and the first indications of a reversal of progress.

preventative spend per head fell from around £3 to around £2, while reactive/later intervention spend rose from £8 per head to over £10 per head (figure 3.9).

Compounding this picture are a range of novel public health threats that pose a particular risk to children and young people. In defining these new threats, the World Health Organisation (2020) highlights:

- the rise in pollution and the direct consequences of climate change
- a rising prevalence of commercial marketing – including personalised advertising online
- an increase in the rate of long-term conditions among children, from asthma to myopia
- unhealthy lifestyles and diets.

Ensuring an inheritance of better health from one generation to the next – as an investment in wellbeing and prosperity – will require solutions to challenges old and new.

Our third proposed shift is from waiting for sickness to occur and focussing our interventions on acute need, often towards the end of people's lives, to creating good health through their childhoods.

4. FROM PLACES THAT MAKE US SICK, TO PLACES THAT ENABLE HEALTH

> ***"Environment, education, housing, healthcare, jobs and benefits. Those are the things that people need."***
>
> ***"The street lighting in Streatham is bad. It's just very bad. And there's hardly any zebra crossing."***
> IPPR deliberative research participants

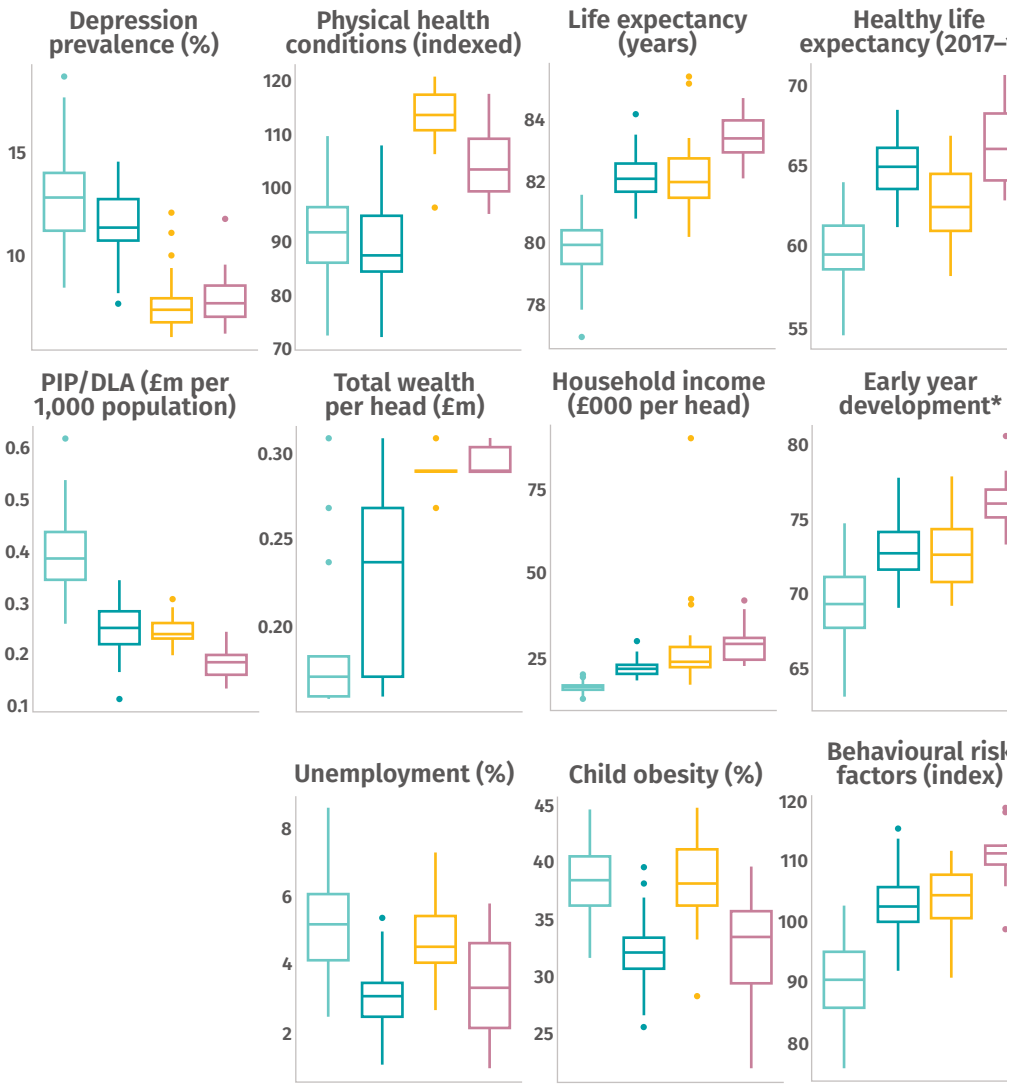
The UK is a deeply divided country. We are divided by health: the UK has among the largest health inequalities of any advanced economy (in both physical and mental health). And we are divided by wealth: we have large and rising inequalities in disposable income, employment prospects, opportunity and growth.

These inequalities cluster in much the same places. Research for this commission has shown that poor health and poor economic outcomes cluster in the same parts of the country. As figure 3.9 shows below, poor health, lower educational attainment, unemployment, low income and limited wealth tend to coexist in more deprived and urban parts of the country – particularly in the north of England.

As this might indicate, the characteristics of the places we live have a profound impact on our health, and therefore our prosperity. In the table below, we outline how the place and environment we live in might impact our health – as well as evidence of variation across the country.

FIGURE 3.9: POOR HEALTH, SOCIAL AND ECONOMIC OUTCOMES CLUSTER IN THE SAME PLACES

Selected health, economic and social outcomes by type of area



Source: Recreated from Thomas 2022

Note: Cluster 1, Northern and Midlands urban areas; Cluster 2 rural and coastal rural; Cluster 3: inner-city London boroughs, Bristol, Brighton; Cluster 4: home counties and wealthier London boroughs

In the face of these highly localised challenges, our ability to design and deliver bespoke, targeted intervention is undermined by the UK's centralisation of resource and power. A large body of research now shows that spending, power and tax are concentrated in Westminster, to a larger extent than in similar countries (Johns et al 2024, Raikes et al 2019). As well as undermining our means to provide bespoke solutions to local challenges, this can lead to a sense of fatalism and powerlessness in places themselves.

FIGURE 3.10: THE HEALTH IMPACTS OF PLACES AND INEQUALITY

	Evidence of harm	Evidence of variation
Housing	Nearly 4 million homes were classed as non-decent in England in 2022 – with non-decent homes more prevalent in the Private Rented Sector (PRS) (Department for Levelling Up, Housing & Communities 2023).	Analysis of government data by the People's Health Trust shows tenants living in Yorkshire and the Humber and the north west of England are most likely to live in a non-decent home. 37.7 (North West) and 33 per cent (Yorkshire and the Humber) of private rented homes failed to meet basic decency standards, compared to 21 per cent in England on average (2024).
Access to healthy food	Nearly 3 million households faced food insecurity in 2022/3, up 1 million from 2021/2.	The North East and north west of England had double the rate of food insecurity compared to the best performing part of the UK, the east of England (House of Commons Library 2024).
Air quality	Human-made toxic air kills between 28,000 and 36,000 people every year (OHID 2022).	OHID data shows the worst hotspots for toxic air are in London (2024), despite improvements following the introduction of ULEZ and low traffic neighbourhoods.
Work security	6.8 million people in the UK are estimated to be in 'severely insecure' work, while 1.8 million have a health condition caused by the work they do (Work Foundation 2024).	IPPR analysis of Institute for the Future of Work data has shown that deprived parts of the country tend to score lower on job quality than the least deprived parts of the country (see Poku-Amanfo et al 2024).
Relationships and community connection	Nearly half of people in the UK report feeling lonely at least sometimes, while 3.83 million people experience chronic loneliness (Campaign to End Loneliness 2023). Loneliness is estimated to have the same impact on health as smoking 15 cigarettes a day.	The number who report feeling often or always lonely varies from 18.52 per cent in Wycombe and 17.9 per cent in Blackburn with Darwin, to under 2 per cent in Fylde, North Kesteven and Wyre (IPPR analysis of ONS 2021).
Addiction	Deaths attributable to alcohol are up 7.4 per cent on 2019 (ONS 2022), while drug deaths rose every year between 2012 and 2021 (ONS 2023d).	Alcohol mortality is highest in the North East and lowest in the east of England. Blackpool has the highest alcohol mortality (33.7 per 100,000), and Barnet the lowest (4.6 per 100,000) (OHID 2023).
First 1,000 days	Between 2019 and 2022, LGA analysis shows the number of children achieving a 'good' level of early years development declined 6.6 percentage points (71.8 to 65.2 per cent) (LGA 2023).	A Health Select Committee Enquiry into the first 1,000 days found 'significant variation in the way local areas prioritise and support families in the first 1000 days' (Health and Social Care Committee 2019).

Source: Authors' analysis

That some parts of the country have brilliant health shows that inequality and its costs are neither inevitable nor a biological reality. Indeed, if every part of the country was as healthy as Wokingham, the healthiest local authority in Britain (and among the most prosperous), we would already have delivered the mission proposed by this report in full. Elsewhere, many other similar countries have created and benefited from far more economically balanced nations, and broader-based growth (Thomas et al 2023). We need a plan to extend health and opportunity across the country, targeted where that is currently furthest from reality.

We need to recognise that the national economic challenges posed by sickness have local origins – and are driven, above all else, by inequality. Solutions to a challenge that affects Nottingham, Manchester and South London significantly – but affects West Oxfordshire and Wokingham less – requires place-based solutions. **Our fourth proposed shift is towards empowerment of communities and their local representatives to take more control over their health and prosperity, based on their distinct needs and priorities.**

5. FROM SERVICES THAT REACT TO SICKNESS, TO PREVENTION LED HEALTH AND CARE

> ***"I live in Streatham Vale and I have no problem getting a [GP] appointment, but my friend who lives 15/20 minutes away from me in Lambeth, she never gets an appointment. How does that work?"***
>
> ***"[In Leith] there's a lot of housing, but there's not a lot of GPs."***
> IPPR Deliberative research participants

Healthcare is not the sum of a health creation system, which must be more than the existing NHS plus extra primary care. But that is not to say that healthcare is not vitally important within it. As this report has already argued, the sheer amount of demand the NHS is trying to manage – on its own, in lieu of others pulling more preventative levers – is unsustainable. The level of pressure it creates leaves the NHS neither able to do its 'core' role of treating sickness well nor able to transform into a more modern, preventative service.

Managing the demand on the NHS through prevention is not just down to the NHS itself. It will rely on the rest of the health creation system working. But equally, we should not be fatalistic about the role in health creation of a public service with a budget of around £200 billion. There is much that is within the NHS's control.

We suggest two key reform priorities in bringing the NHS within a health creation system: a focus on prevention, and a focus on productivity. It remains important in a health creation system that people can get the care they need at times of acute need. The NHS's ability to fulfil that will require it to reach a position where it works for both public health and public finances. To which end, productivity is key.

On the first priority, the NHS holds much promise – particularly through its community, primary care and screening services. Yet it is not doing nearly enough to invest in or achieve that promise.

- There is an increasingly strong evidence base to support bringing a broader array of interventions into community and primary healthcare settings, ranging from social prescriptions to diagnostic equipment.
- Variation in rates of early detection of cancer have been implicated in survival difference between countries – and specifically, the UK's lower rates of five-year cancer survival compared to those in similar nations (Arnold et al 2019).
- Only 53 per cent of people aged 40–70 years old in England took up their offer of a health check between 2012 and 2017, with variation between local authorities ranging from 25.1 to 84.7 per cent (Patel R 2019). The health check is an effective way to identify cardiovascular disease, type II diabetes, chronic kidney disease and other conditions earlier.
- Despite the ambition to shift more care and healthcare resources into community settings, funding for these sorts of NHS services grew in real terms by less than 0.5 per cent between 2016/17 and 2022/23. By contrast, acute and ambulatory care funding grew by over 20 per cent (Gainsbury & Julian 2024). Moreover, UK Health Accounts show that hospital budgets hit record levels in 2022, while both general practice and preventative service budgets fell compared to 2021 levels (ONS 2024k).

This lack of investment in preventative, primary and community parts of the NHS is despite them being the most important services in the link between health and prosperity. In one study of the impact of NHS spending on economic growth, it was shown that £1 spent on the NHS corresponds to an approximate economic benefit of £4. By contrast, £1 spent on primary care or community care had a return on investment of £14 (Carnall Farrar 2023).

On the second of our reform priorities, the NHS performed well on productivity between 2010 and 2019. While the public sector achieved productivity gains of 0.7 per cent per year during the period, the NHS did even better, recording an annual average increase in productivity of 1.2 per cent. This would usually be a success (Patel et al 2023). And yet few would argue that public services were performing better and delivering more effectively in 2019 than they did in 2010.

This exposes a problem around how we measure and go about improving public sector productivity. It is generally defined as the number of outputs produced for a given number of inputs. This definition has led policy makers to constrain 'inputs' (funding), in an attempt to deliver at least the same for less. Unsurprisingly, this has proved to be short sighted. There is a limit to which pushing the NHS's workforce, equipment and estate to its limit – 'running it hot' – works before productivity falls off a cliff. It is this that explains why more money and more staff in recent years have delivered very little extra activity.

To ensure the NHS works for public health and public finances – that is, to ensure it is both a high quality and sustainable sickness service – demands a new approach to productivity. We propose a strategy of ensuring the foundations of more and better outputs are in place, as opposed to simply constraining resource. This would mean:

- investing in the workforce, to reboot staff motivation after the pandemic
- boosting NHS investment in capital and the estate
- ensuring better use of digital, technology and innovation.

If we do not get prevention and productivity right and if we do not achieve on the other health creation shifts proposed by this report, the future of the NHS looks very uncertain. It would:

- grow increasingly expensive –our modelling of NHS expenditure, with no gains in healthy life expectancy or productivity, project it will cost the equivalent of 2 per cent of GDP more by 2034 than 2023
- fail more patients as its approach falls further behind what international best practice looks like, and as access grows more difficult
- become more two-tier –those who can afford to will opt for private healthcare, and those who cannot will be left behind.

A health creation system depends on a sustainable NHS that can both contribute to prevention and do its core job of treating sickness, brilliantly. **Our fifth shift is an NHS that works for public health and public finances, maximises its contribution to health creation, and in that way creates space to improve the quality of acute care.**

PART 3: OUR PLAN FOR HEALTH AND PROSPERITY

1. HARDWIRE HEALTH CREATION ACROSS GOVERNMENT

SUMMARY

If government wants a more whole society approach to health, it will need to shift its role from 'command centre' to 'enabler'. This change should be at the heart of the new government's mission-orientated approach.

We suggest government specifies a goal to add 10 years to healthy life expectancy by 2055 – and to halve health inequality between places – within its existing health missions. But missions should be models of delivery, not just signals of intent.

In addition to broad membership of the health mission delivery board, we propose further additions to the health mission infrastructure, including a new health equivalent of the Climate Change Committee, and through (published) assessments of the health mission impacts of every fiscal event.

Expanding the scope of health policy depends on a rethink of the role of central government. Currently, it is defined by an extensive NHS command and control architecture based on targets, guidance, planning and regulation. In its 2022/3 planning guidance, the NHS was set over 100 targets (DHSC 2022). Significant effort and investment, time and headspace are then channelled into servicing these targets, from A&E waiting times to early diagnosis and the length of elective waiting lists. In other words, health policy's proliferation of targets embeds a focus on the parts of the system that target sickness rather than health creation.

This approach is not compatible with a shift in health policy that aims to be relevant to far more aspects of people's lives, and which 'crowds-in' a much broader array of 'delivery agents' into a whole society health creation effort. The government is unlikely to have much success with a command-and-control approach with non-government actors – whether businesses, families, communities or employers. Nor is it likely to shift the focus towards prevention while the vast majority of health targets – which inevitably define what gets done, what gets prioritised and what attracts investment – focus on, and funnel time, headspace and money, into acute healthcare settings.

Founding a health creation system requires the state to shift from 'command centre' to 'enabling state'. An enabling state is neither about top-down diktat nor about 'letting 1,000 flowers bloom' without direction or strategy. Instead, it is about the state taking a more strategic role: signalling priorities, creating the basis for partnership, crowding-in other actors with the means to contribute to shared goals, and pulling its own levers in achieving progress as an innovator and risk-taker in its own right.

We suggest the first role of an enabling centre is to define a common aspiration: a mission. As argued by Mazzucato and Dibb (2019), the best missions have five features:

1. they are bold, inspirational and have wide societal relevance
2. they set clear direction, and are targeted, measurable and time-bound
3. they are ambitious but achievable
4. they encourage cross-disciplinary, cross-sectoral and cross-actor innovation
5. they involve multiple, bottom-up solutions.

Based on those principles - and through consultation with businesses, charities, the public, industry bodies and sector experts during the commission's last three years of work - we suggest the best focus for the health mission is healthy life expectancy. It is an outcome that genuinely matters to people, sets clear direction for progress and will crowd-in many others beyond parts of government explicitly focussed on healthcare, from communities to the private sector. And more than pure longevity, it is healthy life expectancy that matters most to the relationship between health and prosperity.

Beneficially, the new government has existing commitments to significantly progress healthy life expectancy. In its initial health mission, Labour stated:

> ***"Living well is best captured by the concept of 'healthy life expectancy'...[we will] improve healthy life expectancy for all and halve the gap in healthy life expectancy between different regions of England."***[21]

The next step is specificity. As with all good missions, this should sit at the edge of what is aspirational and what is achievable. To that end, we suggest looking towards how international precedent has shown what is possible. Between 2000 and 2019, the UK added just over 0.1 years of healthy life expectancy at birth per year, on average. In contrast, the worldwide average was 0.3 extra years in healthy life expectancy at birth per year. More pointedly, South Korea, Portugal, Singapore and Ireland – advanced economies, like the UK – each achieved over 0.2 added years per year, on average (figure 4.1). **Based on the improvements this shows to be possible, we recommend the central mission of a health creation system is to add 10 years to healthy life expectancy by 2055.** Given the fastest gains (and the greatest extra prosperity) will almost certainly come from tackling inequality, we suggest this is combined with a goal to halve health inequality between places.

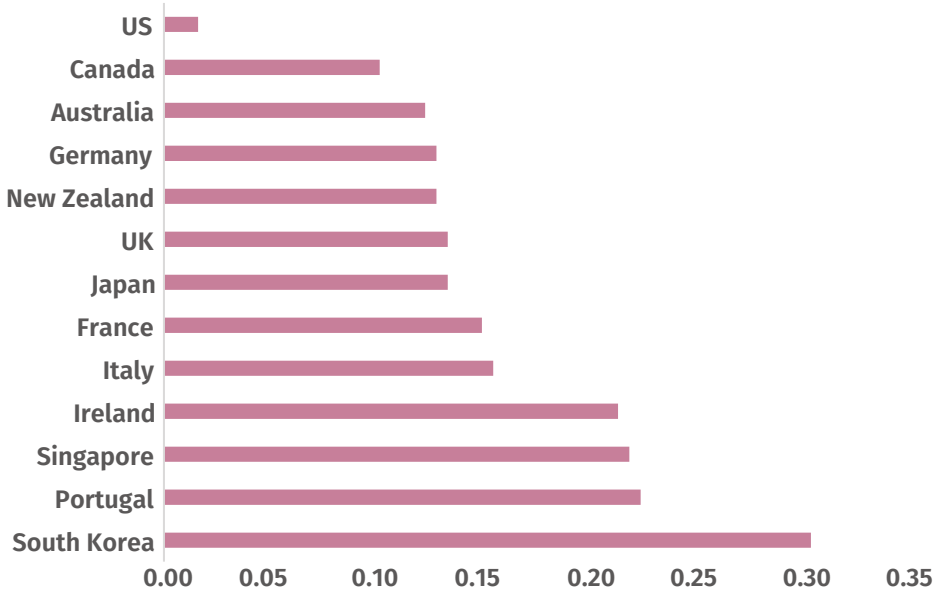
A key benefit of a healthy life expectancy mission is its ability to speak to a range of bottom-up solutions – that is, there can be flexibility on the means through which we meet the end. It can be improved by primary prevention and public health. It can be improved by better support for disabled people and by embedding the social model of disability in built environments and workplaces. It can be achieved through secondary prevention.[22] And it can be achieved by tackling inequality across the UK. Put another way, it is a mission we can all take a role in, and one we can all benefit from.

21 p15 Labour Party 2023

22 Where secondary prevention is defined to encapsulate all efforts to ensure conditions do not get worse, through medicine, technology, early diagnosis or other means.

FIGURE 4.1: SIGNIFICANT IMPROVEMENTS IN HEALTHY LIFE EXPECTANCY ARE POSSIBLE

Healthy Life Expectancy annual average growth (2000-19 averages), select advanced economies



Source: Authors' analysis of WHO 2020

A well-considered aspiration is a start, but it is not enough to deliver real change on its own. Recent UK history is littered with examples of bold aspirations which, devoid of real consideration of delivery, led to little lasting change. New Labour's Child Poverty Mission and – to some extent – the English health inequalities strategy led to only limited, and quickly reversed, progress. The previous government's levelling-up missions (including an aspiration to add five years to healthy life expectancy by 2035) were even more unsuccessful.

The difference between missions that succeed and those that fail is the extent to which they are a model of delivery, not just well worded aspiration. The Child Poverty mission of the late 1990s and early 2000s is an example of the latter: without an infrastructure to marshal collaboration, support delivery and drive accountability, progress was limited to the tenure of the Prime Minister who announced it. Net zero is an example of the former: the combination of a legislative mission with bodies like the Climate Change Committee, approaches like Carbon Budgets, and investment vehicles like the UK Infrastructure Bank, has supported the longevity of the approach and the UK's steady performance against its aims (so far). In designing a health mission, we should be guided by an aspiration to approach health in the systematic way we approach climate and net zero.

This is in-keeping with the latest work on missions by Mariana Mazzucato, Dani Rodrik and many others, which suggests that they should be a theory and a practice of government, not just a signal of intent (Mazzucato et al 2024).

The new government has shown an understanding of this – and has taken positive initial steps. Most notably, the prime minister has announced he will chair new mission delivery boards. This is likely to be beneficial: direct prime ministerial oversight will support tangible action and things getting done. In setting up the health mission board, the government should next ensure membership represents

all the constituencies that matter in health, not just major hospital trusts and NHS officials. We propose that while the healthy lives target is owned as an objective by the Department of Health and Social Care, the mission delivery board should draw its members from mayors, the public, economists and economic institutions, ministers covering education, work, science, children and business, and industry, including major UK employers.

The government should also continue to evolve the architecture that sits around missions. Learning from what has worked historically, we suggest four steps. **First**, it should draw lessons from the success of the Climate Change Committee (CCC) support on net zero. The structure and mandate of the bodies that hold government to account have a strong bearing on what decisions get made and how priorities are managed. The National Audit Office has had some success at embedding a focus on value for money across government; the OBR has strengthened the focus on government's fiscal rules; and the CCC has been independently evaluated as highly beneficial in supporting progress towards net zero (Grantham Institute 2018). This genuinely independent advice, long-term advocacy for the mission, and external accountability are unlikely to be provided by a government-chaired and led mission delivery body.

Evaluations have pointed out that the CCC's successes have come down to four key factors: its statutory footing – it has a clear, well understood mandate; the profile and reputation of its chair – the CCC is well led; its ability to reach across Whitehall rather than one department; and its independence – it cannot be muted at the whim or political convenience of a minister. A CCC equivalent for the health mission – a health and prosperity committee – would perform a function not easily led by non-independent bodies like the Office for Health Improvement and Disparities, and would protect long-term progress even after ministers and leaders change.

Second, the health mission should be combined with an equivalent of carbon budgeting. One of the most important functions of the CCC is the publication of five-year carbon budgets. In essence, these provide an opportunity to break down a 30-year mission into manageable five-year chunks – with priorities signalled across industry and government well in advance. They provide an opportunity to marshal what we know works into a strategy, but also for the CCC to proactively identify where we don't have answers – and therefore need new technology, new ideas and innovation.

Inevitably, shorter-term goals for a healthy lives mission would look different to carbon budgets. They would not intend to limit an activity (emissions), but rather to support an outcome (healthier lives). But the logic would remain the same: health budgets would explore what progress we need to see from different public services and industries to stay on course – and would make policy, including stimulus for innovation, based on those findings.

Third, we propose that a health mission is combined with a mission-driven approach to spending. As things stand, key spending decisions are currently made via business cases submitted to Treasury – often around budgets or spending reviews. These are then assessed by cost-benefit analysis, informed by the Green Book, and provide the basis for ministerial decisions.

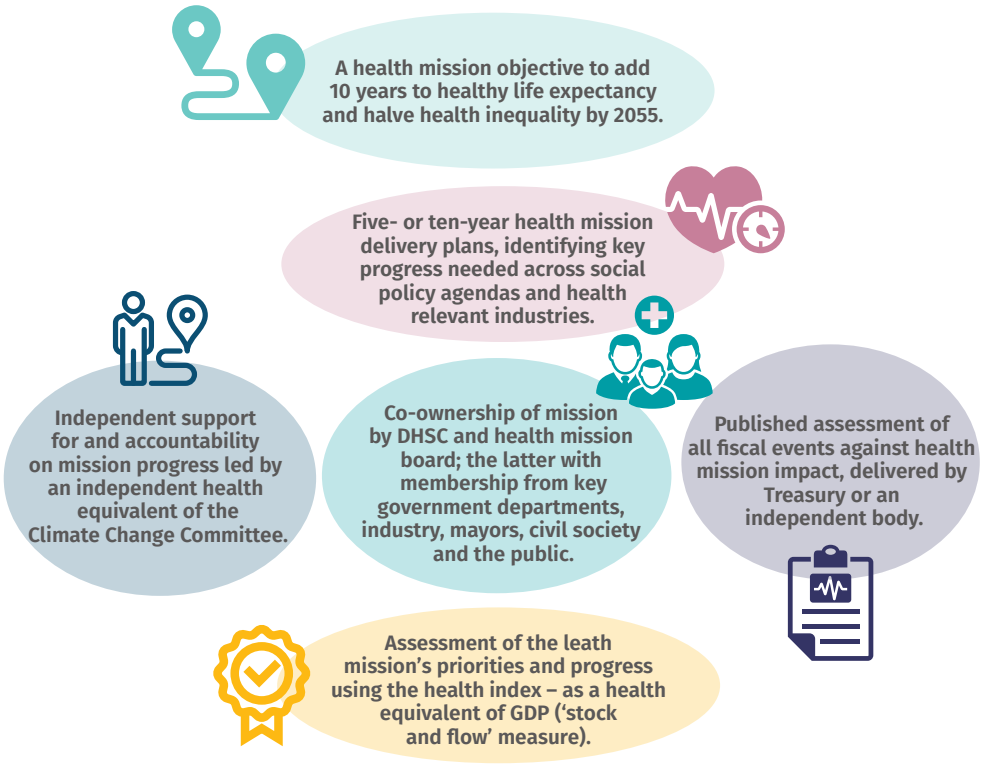
In theory, the Green Book allows for policy makers to evaluate decisions against a holistic set of metrics rather than cost and GDP alone. In practice, these wider benefits are rarely fully considered and, given their lack of relevance to what the government is held to account on around its budgets (eg OBR forecasts, fiscal rules), they lack parity. This can limit long-term investment and government ability to account for the full benefit of investment in health in decision making.

Reforms to the budgeting and spending review process could address this barrier to investment in a health mission. Specifically, learning from the benefit

of publishing independent forecasts – against set statements of intent (eg fiscal rules) – we recommend that either the CCC (or HMT)[23] publish an evaluation of every fiscal event on the mission to improve healthy life expectancy. This would help ensure transparency, accountability and a more deliberate approach to investing for the long term.

Fourth and finally, we propose that the government designates the Health Index a national statistic, and makes it a key measure for mission delivery. The Health Index is a stock and flow measure like GDP, which allows government to track progress over time, and to monitor what is going well and what is going less well. Not only would this help government prioritise health mission investment and policy in the areas most likely to make a difference, it would also provide an excellent basis for evaluations of fiscal events on their potential health mission impacts, and an invaluable tool for the 'health budgeting' process we have already discussed.[24] As part of this process, the government should commission an expansion of the health index to cover the UK, where it currently only covers England.

FIGURE 4.2: PROPOSED EVOLUTION OF A HEALTH MISSION INFRASTRUCTURE



Source: Authors' analysis

Recommendation 1: The government should commit to a specific healthy life expectancy mission – to add 10 years of healthy life expectancy to life by 2055, and to halve inequality between places. It should continue to build infrastructure to ensure this mission is a basis for delivery, not just a signal of intent – including creation of a health equivalent of the Climate Change Committee and much greater use of the ONS health index.

23 Both institutions have advantages. Tasking an independent body to publish forecasts could ensure greater trust in projections, while tasking HMT to publish forecasts could better institutionalise a focus on health within Treasury.

24 Where healthy life expectancy, as a much slower moving metric, may prove more unwieldy for these purposes.

CASE STUDIES: DELIVERING ON HEALTHY LIVES

JAPAN

Japan has the highest healthy life expectancy in the world. This has been supported by the National Health Promotion Movement, known as Health Japan 2021. It reorientated Japan towards a focus on prevention and control of non-communicable disease, with separate plans published in 2000 and 2013. The latest plan set out 53 targets over five domains, covering higher healthy life expectancy, lower health inequalities, prevention, social health and lifestyle improvements (Oh 2021). The plan included a requirement for local government to write and implement health promotion plans for their local population. Evaluation of the scheme has shown improvement on most targets (Oura 2021).

SOUTH KOREA

After success in the 21st century in advancing healthy life expectancy, South Korea launched 'Health Plan 2030' with a stated plan to increase healthy life expectancy by three years over a decade. The plan is backed by a budget of 2.5 trillion Korean won (c.£1.5 billion) and focusses on 28 topic areas over six domains. Priorities include suicide prevention, reduced alcohol consumption, reduced tobacco use, prevention of disease related to climate change, and better mental health provision (Oh 2021).

NORWAY

Norway formally adopted the World Health Organisation social inequalities in health targets in *Health for All* (2000). This reorientated health policy across all government departments and sectors. It was supported by the Directorate for Health and Social Affairs, a national expert group (leading strategy development) and a centre of competence on social inequalities in health (Fosse 2021). Evaluation has suggested this structure helped change the policy problem definition of health inequalities from one focussed on individualisation to a focus on social injustice (Dahl & Lie 2009).

ENGLAND

Between 1997 and 2010, England pursued the English Health Inequalities Strategy. This included a commitment to reduce health inequalities by 2009. Early studies were pessimistic on progress, but later studies, predominantly carried out after the strategy was abandoned, have been far more encouraging (Bambra 2024, Barr et al 2017). This suggests ambition is useful – but that health progress takes time, patience and a long-time horizon.

NORTH KARELIA, FINLAND

Reacting to high cardiovascular mortality in North Karelia, Finland, the Karelia project (1972) focussed more specifically on the preventable causes of cardiovascular disease (rather than healthy life expectancy or health inequalities more broadly). Interventions included mass media public health campaigns, significant improvements in food standards, workplace food improvements, a focus on community and primary health settings (including bespoke hypertension clinics) and smoking reduction efforts. All interventions were designed with communities, and success was marked (Puska & Jani 2020). National roll-out followed five years after the programme began, and the scheme was brought to an end in the late 1980s. (Vertiainen 2018).

2. A HEALTHY FUTURE OF WORK

SUMMARY

Our health is a key determinant of our ability to participate in work. But work is also important to our health. This link extends beyond whether we have work or not – which is important – to whether we have good work and fair terms or not.

While the UK employment rate remained high following the 2008 financial crash, that was partly due to a rise in low quality and insecure work. Evidence now suggests this kind of work is harming our health, particularly our mental health.

We need to create a new wave of healthy jobs. We suggest a new health standard, with incentives for its adoption as well as a Right to Disconnect. For those already outside the labour market, we suggest the NHS is challenged to increase employment of people who are outside the labour market due to sickness, and a new 'right to try' to enable people on incapacity or disability benefits to explore work with less risk. And we propose a new deal for unpaid carers, through fair care agreements.

Good jobs and fair work standards support healthy lives – through decent pay and job security, which act as a foundation of financial security, and through good working conditions that enable people to thrive. Good work can offer us purpose and fulfilment, build strong social networks, and support learning and progression - all of which have a positive role to play in supporting wellbeing.

The protective effect of employment on health is well-established. For every 10 points higher the employment rate climbs, healthy life expectancy improves by around five years (Health Foundation 2024b), while people who are unemployed or economically inactive report higher levels of psychological distress than those who are employed or retired (Pierce et al 2020).

But a rising tide of sickness lies beneath the high headline employment rates of the past decade. The number of people out of work due to disability and poor health now stands at 2.8 million – a record high (ONS 2024d). Spending on disability and incapacity benefits has risen since 2010, with a sharp increase since 2019 (DWP 2024). The question we must ask is this: is work now making us sick?

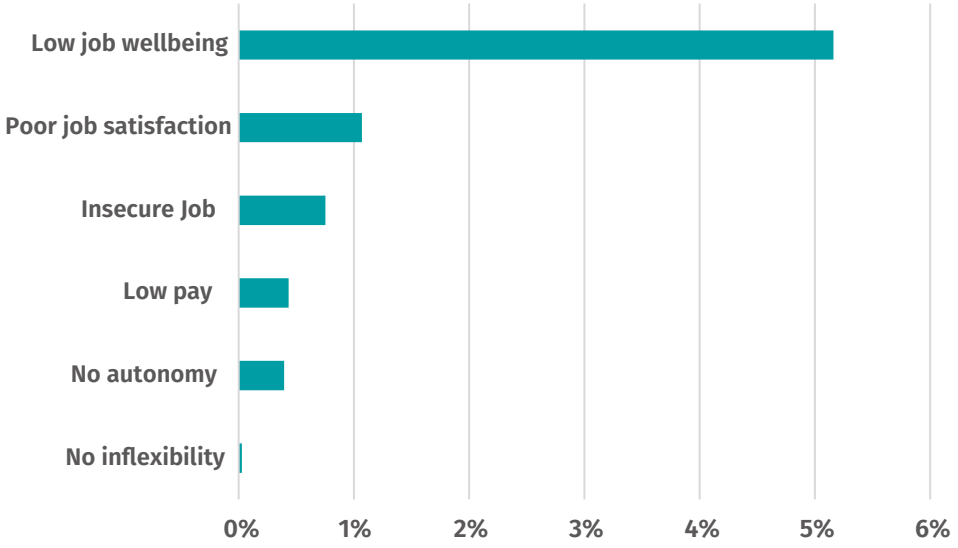
Rates of self-reported, work-related ill health fell steadily from the 1990s and flattened through the 2010s but have begun to climb since the Covid-19 pandemic (Health and Safety Executive 2024). Work-related stress, anxiety and depression now constitute almost half (49 per cent) of work-related illness in the UK labour market, eclipsing muscular-skeletal conditions (27 per cent) as the next largest category of sickness (Health and Safety Executive/LFS). While people face far lower risk of serious industrial injury in 2024 as compared to the 1980s (Health and Safety Executive 2023b), thanks to rising health and safety standards, a new set of work-related health harms are emerging in the form of rising work-related stress and mental distress.

The relationship between work and health is mediated by job quality: good work can be health-enhancing, while poor quality work can harm health. Alongside physical hazards, the workplace – where health policy has historically focussed – working conditions and employment security are important determinants of mental health (Belloni et al 2022). Levels of support from colleagues, stress or pressure to deliver, and the repetitiveness of job tasks all contribute towards healthy or unhealthy working conditions. As a foundation of good work, contractual security also contributes to better health outcomes: fear of job loss, involuntary transfers (job changes that aren't driven by the employee) and worries about re-employment prospects can all affect mental wellbeing (ibid).

We find a strong association between job quality and health –including on measures like pay, contractual security, flexibility, autonomy at work, job satisfaction and wellbeing at work (Figure 4.3).

FIGURE 4.3: THOSE IN POORER QUALITY JOBS ARE MORE LIKELY TO BE IN ILL-HEALTH

Predicted increase in risk of poor health (GHQ > 3) by measures of job quality



Source: Authors' analysis of Understanding Society 2024

Modern health harms are concentrated in high-demand, low-control jobs – those that put workers under pressure to deliver against tight deadlines, but with limited autonomy and control. These 'bad jobs' are related to poor wellbeing, high stress, cardiovascular illness, and sickness absence (Stansfeld and Candy 2006; Haüsser et al 2010; Habibi et al 2015; Mortensen et al 2017). But policy has an important role to play here: improving working conditions over time (increasing levels of worker control and lowering work intensity) can have beneficial health impacts, particularly for workers in high-demand, low-control jobs (Belloni et al 2022).

Good jobs are foundational to good health and prosperity. At the local level, job quality is a determinant of healthy life expectancy across England (Institute for the Future of Work 2024). But the UK's current economic model has driven a proliferation of 'bad jobs' (IPPR 2018). While the last decade has seen significant progress on low pay by raising the national minimum wage, work is no longer a route out of poverty: two thirds of households in poverty are working, while 6.4 per cent of workers are underemployed (wanting more hours than they work) (Health

Foundation 2024c).[25] Insecurity has risen drastically since 2008: 6.8 million people – over a fifth of all people in work - are now estimated to be in insecure work, encompassing temporary contracts, low-paid self-employment, and zero-hours contracts (Lancaster University 2024). There are now more jobs available, but fewer good ones.

It is now possible for an employer to take on a worker with almost no responsibility to them – or for their wellbeing. This flexibility explains concurrent high employment and stagnant wages over the last decade and a half, as the UK economy has fallen into a low-pay, low-productivity equilibrium (see part 2, including analysis of GDP growth related to productivity vs labour market size growth). Little obligation towards workers from employers and low wage bills fail to incentivise much-needed productivity improvements. When workers are cheap, it's much easier to invest in more labour than in productivity-enhancing technology or training.

Recent research has demonstrated the link between good work and improved worker productivity (Carnegie 2023). The inverse is also true: there's a particularly strong relationship between poor job quality and poor productivity (ibid). A growing body of evidence points to improving job quality across the UK labour market as a route not only to improving health outcomes and strengthening labour market participation, but also to solving the UK's productivity puzzle.

ENSURE THE FOUNDATIONS OF HEALTHY WORK THROUGH HIGHER STANDARDS AND SECURITY

Higher standards for healthy work

Several countries have initiatives aimed at helping employers improve the quality of jobs, through better job design and workplace innovation. Scotland has pioneered such work through a Fair Work Convention (2015) – a voluntary partnership between government, business and unions. The Convention's vision is that by 2025, 'people in Scotland will have world-leading working lives, where fair work drives success, wellbeing and prosperity for individuals, businesses, organisations and society'. Similarly, Greater Manchester has a Good Employment Charter.

We see great potential for the diffusion of this idea. In line with previous IPPR recommendations, we propose the UK government establishes a 'good jobs standard' embedded at UK, national, regional and local levels, with a focus on raising the floor on working conditions and encouraging better job design. This would be a set of guidelines for employers – and for employees and trade unions – on the design of high-quality jobs.

This set of standards can be seen as a prevention agenda for economic inactivity due to sickness. Research by the Pathways to Work Commission in Barnsley suggested that as many as half of work exits were avoidable – usually if health adjustments, occupational health and flexible working was available (Milburn 2024). The research also confirmed that people struggled to find supportive employers when risk factors for work exit occurred. The new government has accepted that reducing economic inactivity, including through more supportive employment, and more integrated health and employment support, is important: increasing the number of supportive employments is a key step in delivery.

25 This is higher than the underemployment rate in the early 2000s, when it was 6 per cent.

FIGURE 4.4: FOUNDATIONS OF HEALTHY WORK

	Job quality metrics	Indicator
Fundamentals	Pay	Payment of the real living wage
	Sick pay	Access to sick pay at 80% of previous earnings
	Flexible working	Flexible working offered by default (unless there's a business reason not to) and access to self-rostering for shift workers
Work-life balance	Holiday entitlement	Average number of hours holiday to number of hours worked
	Gap between holiday entitlement and taken	The proportion of days of leave not taken
	Satisfactory hours	Proportion of employees with satisfactory hours
	Unpaid overtime	Proportion of employees reported working unpaid overtime
Employment standards	Job Security	Proportion of staff on zero-hours/fixed-term contracts
	Autonomy	Proportion of staff feeling they have autonomy over tasks, pace, manner, order and hours
	Satisfactory hours	Proportion of staff satisfied with hours
	Health and Safety support offer	Proportion of staff happy with mental and physical health support
Healthcare access	Promotion of, and time to undertake, NHS health check	Whether NHS health check is promoted in the workplace
	Offer of occupational health support	Existence of a voluntary occupational healthcare offer for employees
	Time off for vaccine and health appointments	Whether employees are entitled to take time off for vaccinations and other preventative healthcare appointments

Source: Authors' analysis

Government has the means to support the spread and scale of newly articulated standards. As IPPR has argued elsewhere, the standard could be tied to public procurement, with those having implemented a Fair Work approach preferred in government procurement processes. In sectors with more of a gap to close between current employment practices and fair work standards, government could restrict procurement to compliant providers.

While procurement offers a powerful lever in sectors like social care, much low-quality work is concentrated in sectors that do not rely on government to buy or commission services. To effect change across a wider range of sectors, UK government could adopt the principles and evidence of the trial of a Wellbeing Premium in the West Midlands Combined Authority, undertaken as part of the NHS's Five Year Forward View (2016). This scheme trialled a financial incentive among SME employers (10–250 staff), linked to adopting a 'Thrive at Work' commitment, focussed on employee health and wellbeing.

<list>The University of Warwick and Rand Europe evaluated the approach by testing implementation of the Thrive at Work standard among employers that received a full, partial or no financial incentive for implementation (Rand 2018). Those that received an incentive could choose how to invest it (on training, covering employee time to work on the Thrive at Work programme's

implementation, providing additional health and wellbeing policies, improving workplace infrastructure, buying equipment). The evaluation found:

- monetary incentive did lead to changed employer behaviour, particularly in the groups that received the highest incentive
- workplaces receiving the highest incentive were more likely to engage fully with the premium, for example attending network meetings
- the incentive was well received – and employees reported that employers took positive action on their health and wellbeing.

This suggests that time-limited monetary incentives can support employer behaviour change. To support the expansion of a Fair Work approach, we suggest that the UK government works with local government to enable it to offer business rate discounts to small and medium sized employers that commit to implementing higher employment standards. We propose that this incentive is time-limited for three years, giving employers time to realise a return on investment as the health of their workforce improves. In the first instance, this could be piloted in parts of the country where both health and economic outcomes are poor.[26]

> Recommendation 2: **The government should introduce a new Fair Work Charter, setting out standards for health-creating work. To support implementation, particularly among SMEs, it should combine this with a wellbeing premium – a time-limited discount on business rates (or equivalent taxes) for those that implement those standards. Based on evaluation of uptake among employers, the government should consider whether stronger regulation is needed towards the end of the parliament.**

A focus on job security

Above and beyond this approach, we suggest there is further policy focus on work insecurity. The level of job security is among the most important moderators of whether work is health harming or health protecting. In some studies, insecurity has posed as comparable a risk to health as unemployment (Kim & Knesbeck 2015). Others have confirmed a causal pathway between job insecurity in relation to mental health, headaches, eyestrains and skin problems – while non-causal associations have been found in a range of other studies (Green 2020).

The share of people in insecure work in the UK has grown over the last decade. The Health Foundation estimates that between 2014 and 2023, the number of workers in insecure employment grew slightly: from 3.1 million people to 3.5 million people (Health Foundation 2024). In light of this increase, combined with increasing evidence on the impact of insecure employment on health and wellbeing, we believe there is a strong case for government to act to reduce use of insecure contracts, to rebalance power between employers and workers, and to reduce health harms. In the final report of the Commission on Economic Justice, IPPR proposed the introduction of a new minimum wage where hours are not specified in the contract, set at 20 per cent higher than the standard rate.

This approach would have two benefits. First, it would help ensure compensation for risk. It is patently unfair that zero-hour contracts see employees take on significant risk around their earnings, to the benefit of their employers, and often with no benefit to the worker. Second, it would change incentives. As things stand, it is too easy for employers to defer to insecure contracts, where they have little meaningful justification for using them. Creating a differential in the cost to employers of contracted and uncontracted hours would serve as an incentive

26 See our recommendation on Health and Prosperity Improvement Neighbourhoods later in this report.

to think carefully about whether more insecure contracts are needed – and to improve workforce planning and scheduling practices to avoid the use of such contracts. Doing so would help to rebalance employment practices in favour of a healthier labour market.

> Recommendation 3: **The government should increase the minimum wage for uncontracted hours by 20 per cent – to disincentivise use of insecure contracts where they are not genuinely needed, and to ensure proper compensation for workers who take up this kind of work.**

Support for people outside employment

These recommendations serve as a prevention agenda for economic inactivity due to sickness – by reducing the health consequences of bad work, but also by ensuring people have jobs that do not force them to leave work after onset of a health condition. But with 2.8 million out the labour market due to sickness, direct support for those outside employment is also important.

For disabled people and those living with chronic health conditions, accessing the labour market hinges on available, appropriate work. The UK disability employment gap stands at nearly 30 per cent – above the OECD average (OECD 2024).

Our current system of employment support, delivered through JobCentre Plus, has become a machine for administering benefit conditionality instead of a hub for meaningful employment support. It is designed to push people into any available job, under the presumption that this may support movement into higher-quality or better-paid work in due course. The result is that many people do move quickly into work, but long-term employment outcomes are poor (see Parkes et al 2024).

Since 2021, the UK's disability benefit caseload has risen sharply (OBR 2024). Experts have pointed to a potential link between inadequate core benefit payment levels, a stringent conditionality regime that requires intensive work-search activity from claimants deemed to be 'available for work', and growth in disability benefit claims (Baumberg Geiger 2024; Murphy 2024). Politicians from left and right have pointed to the high-risk route back into employment from out-of-work disability benefits, through which disabled claimants often fear that taking any steps towards the labour market may jeopardise their financial security were it to trigger a reassessment of their capacity for work.

An increasingly stringent conditionality regime for those claimants deemed available for work, combined with inadequate core benefit payment levels, may also be playing a role in driving people towards disability and incapacity benefits. Over recent decades, welfare spending has shifted away from core working-age benefits towards sickness and disability benefit. While some of this is down to rising sickness, another factor is that a) sickness and disability benefits are the most protected part of the welfare system, and b) the risk of moving off them and into work is harder.

Under the last government, this may have been taken as an argument to increase conditionality of health and disability benefits – but such coercive mechanisms rarely work. Instead, we propose that we increase the extent to which people can try work over a period of months without risk of losing their existing award (either their work capability status, their exemption from reassessment or through tapering). This 'try first' approach would give people greater means to not only find work, but to find appropriate work that suits for the long term.

In arguing for this principle, we acknowledge that the social security system is in flux. A previous pause to reassessments of people with limited capability for

work has ended – with uncertainty about when or how government ambitions to end reassessments will be implemented – while a new 'health component' of the welfare system modelled on personal independence payment criteria is due to be implemented. That is, there remain many potential pitfalls that could mean work remains a high-risk prospect (or perceived as a high risk prospect) for disabled people and people with chronic conditions in receipt of social security.

- The risk of reassessment for limited capability for work will mean many prioritise maintaining the security of their current award, rather than seeking or trying work.
- Any new health component of the social security system – even if detached in theory from work capability, as currently proposed - is still likely to make work riskier for recipients, in an otherwise highly conditional and coercive social security system
- There may be contradictions between personal independence payment and work capability that cause people to worry about losing out if they try work. For example, participation in work may increase the perceived risk on scoring highly on the mobility part of an assessment.
- Even if reassessments of capability for work were paused, a lack of public trust in the benefits systems means people might perceive a risk of finding work, even where there is little, without an iron-clad and simply put government guarantee.

As such, our recommendation here is that a period in which anyone with a disability or chronic health condition can try work – with no risk to either their benefits status or the size of their award – is formally and explicitly integrated into our social security strategy, whatever the shape of any other reforms. The benefits of this scheme in making work more viable (including by changing people's perception of the risks) will help reduce rather than increase DWP costs (particularly in the context of costs rising rapidly).

This 'right to try' would be supported by better integration of NHS services and job centres – an idea that the new government has indicated is under consideration. To this end, we support the conclusions of the Pathways to Work Commission, led by Alan Milburn (Milburn 2024). There are already local examples of good practice on this integration – including the Improving the Cancer Journey programme in Glasgow, Lewisham's integrated primary care and employment model, and Greater Manchester's move to Live Well Hubs. Such models help change the mindset of employment services, from policing social security and sanctions to genuine support. National commitment to and investment in these models, alongside greater devolution of employment support. could help scale the approach.

> **Recommendation 4: The Department for Work and Pensions should introduce a 'right to try' for anyone on sickness, disability or incapacity benefits, guaranteeing a return to a previous claimant's benefit award within six months of entering work or training, and introducing a more gradual tapering of means tested disability benefits as a claimant moves from them into work.**

Even with bespoke employment support in place, a supply of 'appropriate work' will be important. In some local labour markets – notably, those most likely to have high sickness and poor economic outcomes – there is simply an under-supply of appropriate work for people with long-term conditions. Indeed, that labour market might be dominated by just a few major employers, making for 'one size fits all' job opportunities. Increased employer flexibility and improved managerial competency will be critical to reducing the disability employment gap over time.

This too is where the NHS should step in. Much has been made of its theoretical power as an anchor institution to support social and economic development. Indeed, this is the fourth purpose of its Integrated Care Systems (ICSs). Yet, as economic inactivity due to sickness has risen, the NHS has been relatively slow in using its own employment opportunities as a lever.

In places where health inequality and economic inequality cluster, the NHS is often among the biggest employers. Few employers could be better placed to ensure inclusive work opportunities for people with complex health needs. We reiterate a previous IPPR proposal that the NHS (with ICSs in the lead), local government and DWP come together to establish **the NHS Pathways to Work Programme –** a scheme to match people who are out of the labour market due to sickness with employment opportunities in the NHS (Thomas et al 2023b). The programme would:

- offer supported employment opportunities and placements in the NHS and adult social care for people out of the labour market due to sickness
- be accessed through local organisations, including referrals through local authority job brokerage schemes, housing associations, third sector service providers, community groups, local job centres and primary care providers
- incorporate an individual placement and support approach.

While this is unlikely to boost the NHS's clinical workforce, it could provide a source of modern roles that the NHS needs badly: social prescribers, link workers, peer support workers, care coordinators, to name just a few.

We recognise that there will still be some for whom work is simply not appropriate. And while the NHS cannot employ everyone, alone, our analysis suggests that a focussed programme – perhaps anchored in a guaranteed offer of a skills placement or job for everyone 16–34 with experience of inactivity due to sickness – could make a substantial difference. Moreover, done well, the programme would act as a preventative health intervention in its own right. While a full redesign of the disability benefit system goes far beyond the remit of this commission, we recognise that ability to work in no way constitutes the sum of a person's value or contribution to society – and that there will always be a need for the social security system to provide an adequate income for those who cannot work due to sickness or disability. The British welfare system should ensure everyone can live a good, flourishing life – with support bespoke to their individual circumstances. IPPR will explore this in more detail in future work programmes.

> Recommendation 5: **As Britain's largest employer, and with reach into every neighbourhood, the NHS is uniquely positioned to experiment and build inclusive routes into employment for disabled people. ICSs should work with local employment support partners and JobCentre Plus to design and trial employment practices that support more disabled people into the NHS workforce – including those who have been out of the labour market due to sickness.**

A legal right to disconnect from work

Time is a foundation of good health. Without it, basic components of a healthy life – time to cook healthy meals, to exercise, and to rest – are unattainable. Yet time, or a lack of it, is often missing from the conversation about the factors driving poor health across our nation. Beyond supporting the spread of general principles of good work, policy makers should also explore ways changes to work caused by the Covid-19 pandemic might lead to worse health outcomes. In particular, the blurring of home and work, as well as increasing work intensity and stress, linked to the shift to remote working may merit further intervention.

Levels of stress and work-life balance are both important moderators in the relationship between our work and our health outcomes, particularly mental health outcomes. Indeed, at least 30 years of research has shown a link between work, stress and poor health outcomes – including as a risk for cardiovascular disease, obesity and a range of wider health problems (Kivimaki & Kawachi 2015, Heraclides et al 2012, Foss et al 2011). Elsewhere, work-related stress has been shown to directly undermine productivity (Torre et al 2018). There are a range of drivers of stress in the workplace, including workload, value and work-life integration (Kelly et al 2020).

There is also evidence of 'work intensification' (Blanco-Donoso 2023). Work intensification is a job stressor with negative impact on health outcomes. Research shows that levels of intensity seem to have been increasing on a number of measures, including proportions of employees reporting in the Skills and Employment Survey that their job demands they work 'very hard', to 'tight deadlines' regularly, and at 'very high speed' (TUC 2023).

The Covid-19 pandemic may have accentuated these trends. Research by the TUC has found that more than half of workers feel work has become more intense and demanding; that three in five working people feel exhausted at the end of the day; and that a third are spending more time outside contracted hours than they did in 2021 (Ibid). Other research has suggested work may have intensified during the pandemic, with the shift to digital transformation, intensification of email use, and the shift towards remote working implicated in this rise (Venz 202, Taylor et al 2021, Eurofound 2021). Other studies suggest a polarisation: that an increase in home working has empowered some workers but blurred the line between work and home negatively for others (Work Foundation 2021).

In response to this increase in intensity, many other countries have introduced a 'right to disconnect'. This was first introduced by France in 2016 – with many other countries adopting the policy in the wake of the pandemic. We summarise international approaches in figure 4.5, below.

FIGURE 4.5: INTERNATIONAL PRECEDENT ON A 'RIGHT TO DISCONNECT'

Argentina	A new law implemented in April 2021 provides a specific right to disconnect for workers.
Belgium	Belgium implemented a right to disconnect for private sector employers (> 20 employees). There are no sanctions for non-compliance associated with the policy.
France	France's right to disconnect was implemented in 2016 and applies to companies with more than 50 workers.
Ireland	Ireland implemented a Code of Practice on the Right to Disconnect. It is not legally binding but can be used against employers in claims for breach of employment rights.
Luxembourg	In June 2023, Luxembourg introduced an obligation for employers to ensure the enforcement of a right to disconnect. Right to disconnect policies need consultation (with staff delegations where fewer than 150 employees, or mutual agreement with staff delegation where at least 150 employees). Failure to comply is punishable by administrative fines.
Portugal	From December 2021, employers have had a general duty to refrain from contacting employees outside working hours. Enforcement is supported by fines.

Source: Authors' analysis

This list is non-exhaustive but indicates some of the choices available in designing the policy: namely around scope (all employers or large employers), consultation (is agreement with staff representatives or unions compulsory), and reporting and enforcement (can staff report non-compliance, and are sanctions available). Drawing from this, we suggest a UK right to disconnect could work as follows.

- **Scope:** Employers with over 50 employees are obliged to have a right to disconnect policy.
- **Consultation:** The policy should be subject to consultation with staff and negotiation with a recognised union.
- **Reporting:** That there should be a process by which staff can report breaches of the right to disconnect policy, with repeated violations investigated by the Health and Safety Executive.
- **Enforcement:** With a new power to issue fines where complaints of non-compliance are upheld.
- **Flexibility:** And with an ability to opt out for sectors where non-standard working practices are genuinely needed (eg care work or sectors like finance that regularly work across time zones).

Recommendation 6: **The government should legislate for a Right to Disconnect. This should specify that employers with a workforce of more than 50 should have a written and agreed Right to Disconnect policy – ideally, introduced through negotiation and agreement with unions or other staff representatives. Repeated breaches of a Right to Disconnect Policy, as reported by workers or their representatives, should be enforced through fines.**

Design and deliver fair care agreements

This commission does not claim to have developed comprehensive solutions on the future of care or adult social care. While a topic IPPR has researched extensively, it deserves bespoke consideration. We will publish a full report on the future of care in the next 12 months.

That said, the interaction between care, wellbeing and work sits very firmly within the scope of this commission. According to the 2021 Census, there are 2.5 million unpaid carers in employment (Census 2021). Moreover, unpaid care is a well-known risk factor for exiting employment. According to Carers UK estimates, 600 people leave work each day due to care commitments, while 75 per cent of carers in employment worry about balancing work and care (Carers UK 2024).

In ensuring better outcomes for paid care workers, the new government has proposed fair pay agreements. Indeed, it plans to begin wider establishment of fair pay agreements in the adult social care sectors. In practice, this would mean negotiation between workers, trade unions and employers on pay, staff benefits, training and other key issues. We propose that a similar model of negotiation would lead to fairer outcomes for unpaid carers.

Fair care agreements could work using a citizen's jury model. A representative group of unpaid carers could be brought together to deliberate on their experiences, the support they need and policy trade-offs. Those deliberations could form the basis for more extensive government consultation – and negotiation on support for unpaid carers on an annual basis. Thematically, the focus of the agreements could be weighted equally between wellbeing and prosperity: what would make care sustainable for people, and what would specifically increase access to work and reduce poverty. For example, a first set of measures might cover a) what support carers need, including through carer's allowance, to afford the essentials and achieve a high quality of life, and b) what support would enable carers to stay in or find employment, including measures from employers, as well as through employment support services.

The main benefit of this approach would be two-fold. First, it would break the paralysis that currently defines care policy. It is clear what would improve wellbeing and prosperity among unpaid carers – but government has been resistant to expanding support. Fair care agreements would make an evolving

support offer the expectation and the norm. Second, it would help ensure that the support available for unpaid carers can be continuously evolved, as the level and type of care they provide changes over coming years and decades.

Recommendation 7: The government should negotiate a fair care deal with carers and their representatives. That deal should provide a pilot and proof of concept ahead of future deals. The process should begin with a citizen jury, before formal consultation and negotiation with carers and their representatives. The deal should cover both wellbeing and prosperity – and include measures to improve quality of life, but also access to work, financial security and poverty levels among unpaid carers.

3. HEALTHY INDUSTRIAL STRATEGY

SUMMARY

The composition of our economy drives our health. Shops and high streets dominated by harmful products will mean worse health. And it is harmful products that our economy has become dependent on.

We propose government uses a far greater array of industrial policy to embed health within our economy as part of its plan for sustainable growth. This should mean action to transform health harming products, businesses and industries, and to support innovation and scale in health-creating, high-growth potential sectors.

We propose health levies are introduced as an incentive for transformation in health harming industries. Revenues should be invested in subsidies to make healthy choices, easier choices. And sectors like healthy agriculture, the life sciences and active transport should be supported through a broad, healthy industrial strategy.

Good health is important to economic and industrial success. It is a determinant of growth and productivity, of economic participation, and of regional balance and strong public finances. Businesses and society alike benefit from these.

But it is equally true that the composition of our economy can influence our health. If our high streets, shop shelves, billboards and smart phones are dominated by products that harm us – and if these products are uniquely appealing, affordable and available – our health will inevitably suffer.

In other words, the economy has both a rate and a direction. And that direction can be shaped. If we want to maximise health and prosperity – and optimise the symbiotic relationship between them – we will need an industrial strategy that shapes both the economy and health. Specifically, that will mean ensuring we have an economy and industries that support rather than harm the nation's health, and that we have the population health outcomes that can support a strong, fair economy.

If the strategy is healthier lives, then delivering this strategy means developing a plan both for what we want our economy to move towards, and what we want it to move away from. Just as green industrial strategy incorporates a positive vision for the role green technology and industries can have in creating jobs and making the UK globally competitive, alongside a vision for a transition from fossil fuels and carbon-intensive industries, so we need the same for health creation strategy. There are many levers in the government's industrial policy toolbox – sticks for laggards and carrots for leaders – that can support this.

In this section, we detail a proposal that the government embeds a new 'play or pay' approach to health across the economy. Where industries are causing avoidable health harms, we suggest that the government uses tax and regulation to change incentives, in a way that catalyses innovation and supports transformation. Where industries and businesses create health and have significant untapped potential for growth, we suggest government uses a

far fuller array of the levers available to support scale. Combined, this can make industry – not just public services – the engine in delivery of our health mission.

MAKE THE POLLUTER PAY

It is clearly unfair that when a product or service causes harm, the business responsible does not pay the full cost. Instead, much of it falls on individuals (who become sick), the NHS (which pays for treatment), and the wider business community (via reduced productivity). In effect, this amounts to a subsidy, particularly for industries associated with high or rising health harms, including gambling, tobacco, ultra-processed food, alcohol and private-rented housing. Or in more classic economic terms, it is a negative externality that British politics and policymaking have grown accustomed to tolerating rather than fixing.

Compounding this is growing evidence that each of these industries have the potential to transform away from their dependence on harmful products, particularly when the government provides the support and incentives to do so. To give one example: following the soft-drinks industry levy, soft drink producers reacted rapidly *en masse* to reduce the sugar content of their drinks – with an average decrease of 35.4 per cent of sugar content between just 2015 and 2019 (Institute for Government 2022). Elsewhere, alcohol companies have increasingly created popular 'no/low' brands as alternatives to alcoholic drinks – while studies have shown that if alcohol reformulation to lower ABV products were achieved, thousands of deaths could be avoided in the UK per year (Rehm et al 2023).

This capacity for change is reassuring. But it is unlikely to happen through voluntary action. For example, in the UK, voluntary reformulation targets have been shown to have little impact on calories, sugar and salt in food. One recent study found that during the period these targets were in effect (2015-18), there was no significant change in the nutritional quality of food[27] (Bandy et al 2021).

There are a variety of reasons why the market might find swift transformation challenging, from the risks associated with being a first mover, to the fact that the benefit of healthier products is often long-term rather than immediate. There is, then, a role for government in changing incentives to help catalyse innovation and transformation.

To help facilitate this transformation (and supported by the logic and success of the soft drinks industry levy), we propose the government introduces a range of new levies on health harming products, to create a powerful new incentive for businesses to price-in health. These levies should have three ambitions:

1. they should increasingly ensure the cost of negative externalities associated with health harming products fall on the producer
2. they should incentivise a shift away from products and practices that harm health and serve as a de facto incentive for healthier products
3. and they should raise revenue to support investment in health creation.

While reformulation is a central aim of our proposal, we do not shy away from the potential revenue raising power of these levies. In the current fiscal context, it is likely the government will need to turn to new tax bases in the future. Just as windfall taxes on fossil fuel companies have proved popular and effective, taxes on products that harm health could be a useful tool. We discuss how we propose using that revenue later in this section, and our tax proposals in more detail at the end of the report.

27 Except in the soft drinks category, where the soft drink industry levy applied.

Unhealthy food and drink

Our first proposal is a new tax on unhealthy food and drink. As this report has already argued, poor nutrition and obesity are among the UK's most pressing and costly public health threats. And as we have also pointed out, the soft drinks industry levy is among the most successful government policies of the last decade. We suggest it is expanded.

This expansion could draw from international precedent. Both Hungary and Mexico have implemented non-essential food taxes. The former introduced an excise tax on packaged products high in fat, salt or sugar – justified by the cost of poor diet to the nation's health service. In Mexico, an 8 per cent tax applies to non-essential, energy-dense food exceeding 275 kcal/100g. Both countries have had positive results in improving diet and increasing government revenue (Illescas-Zarate, Pineda et al 2024).

While further consultation and analysis would be needed to provide more detail on the right product categories to include in the tax, our overall proposal is a 10 per cent tax on non-essential, unhealthy food categories including processed meat, confectionary, cakes and biscuits. We predict this would raise £3.6 billion in 2025/26, rising to £3.9 billion by the end of the parliament. This estimate incorporates projections for behaviour change as a result of the tax.

TABLE 4.1: ESTIMATED REVENUE FROM A NON-ESSENTIAL FOOD LEVY

2025/26	2026/27	2027/28	2028/29	2029/30
£3.6 billion	£3.7 billion	£3.7 billion	£3.8 billion	£3.9 billion

Source: IPPR analysis of ONS 2023d Andreyeva et al 2010

Gambling

The sophistication and accessibility of gambling has increased substantially in the last 20 years – as have gambling companies' profits. This is partly down to technological change: the internet and innovation in online gambling platforms have given every phone, laptop and device the potential to be a 24/7 casino. But it is also down to policy choices. The Gambling Act (2005) chose to treat gambling as akin to any other leisure activity, in contrast to other international approaches.

As a result, gambling harms are increasing. The rise of online casinos has led to a much higher prevalence of gambling across the UK population (eg Gambling Commission 2022). Last year, a new methodology for testing gambling harm found 2.5 per cent of the adult British population may be suffering from problem gambling – far higher than previous estimates of around 0.3 per cent (Gambling Commission 2023a). And the NHS has begun opening (at its own cost) gambling clinics, to increase its own capacity to meet demand caused by gambling harms.

This includes harm to children. The Gambling Commission's 2022 audit found that a fifth of young people had spent their own money on gambling, and 0.7 per cent of those aged 11–16 were already classed as problem gamblers in Britain, with 1.3 per cent 'at risk' (Gambling Commission 2022). The number who are already problem gamblers is a notable increase on 2017 figures, when the rate was 0.4 per cent (Gambling Commission 2017). Technology has made gambling significantly more accessible, but much harder for parents and guardians to monitor.

Given these risks, we propose increasing gambling duties as follows to raise an estimated £2.9billion in 2025/26, rising to £3.4 billion by the end of this parliament. The duties we have left untouched (pools and bingo duties) are

justified on being lower harm and higher value (eg employment numbers) parts of the gambling sector. By contrast, we have proposed higher duties on general betting and remote gaming, as higher harm products. We suggest this is the best application of the polluter pays principle, and it will create incentives for companies to focus on lower harm products.

TABLE 4.2: PROPOSED ADJUSTMENTS TO GAMBLING TAXATION AND ESTIMATED REVENUE

	Rate	2023/24 revenue	Proposed alternative rates
Lottery Duty	12%	£976,717,712	12%
General Betting Duty	15%	£631,154,963	30%
Pool Betting Duty	15%	£7,751,815	15%
Gaming Duty	15-50%	£153,560,649	20-66%
Remote Gaming Duty	21%	£956,133,273	50%
Bingo Duty	10%	£23,357,051	10%
Machine Games Duty	5-20%	£554,380,977	10-40%

2025/26	2026/27	2027/8	2028/29	2029/30
£2.9 billion	£3.0 billion	£3.2 billion	£3.3 billion	£3.4 billion

Source: IPPR analysis of HMRC 2024

Tobacco

Tobacco continues to pose a substantial public health threat to the UK. There are 6.4 million adults who still smoke, despite nearly 80 years of conclusive evidence on the link between smoking and cancer. And despite the severe harm caused by tobacco, tobacco firm profits can still be remarkably high. One study estimated that profit margins can be as high as 70 per cent (Branston 2015). We reiterate the work by Action on Smoking and Health (ASH) on a cap on tobacco wholesale prices, controlling profits at around 10 per cent, and collecting the difference between the capped price and wholesale price as tax. This would work as follows.

- Tobacco manufacturers would be subject to a cap on their wholesale prices, ensuring that their profits are controlled at around 10 per cent.
- To achieve this, government would require tobacco companies to submit detailed Annual Financial Returns (AFRs) audited by independent parties. This would enable DHSC to determine the cost of production for each of these firms.
- The difference between the capped price and the current wholesale price would be collected as a levy or through increases in excise duties. This would ensure that consumer prices remain unaffected.

ASH estimates such a scheme would raise £700 million without changing prices to the consumer (ASH 2023).

We also propose that the vape excise tax – consulted on by government in summer 2024 – goes ahead.[28] While vaping is evidently safer than smoking, the recent rise in youth vaping suggests its use now goes beyond its use as a stop-smoking device. Studies have shown teenagers are relatively sensitive to e-cigarette price changes,

28 Although we suggest caution in any attempt to use this tax to skew the market towards lower nicotine products. Nicotine is not the cause of most of the harm from smoking (or vaping), and higher use of lower nicotine vapes may lead to more frequent vaping, higher exposure to harm and a false sense of security among e-cigarette users.

particularly if they do not already use nicotine (Corrigan et al 2021). Given this, the duty may help support lower adolescent vaping rates without undermining the potential value of vapes as a stop-smoking device.[29]

TABLE 4.3:PROJECTED REVENUE FROM TOBACCO AND VAPE LEVIES

Tobacco levy revenue

2025/26	2026/27	2027/28	2028/29	2029/30
£0.7 billion	£0.7 billion	£0.8 billion	£0.8 billion	£0.8 billion

Vape duty revenue

2025/26	2026/27	2027/28	2028/29	2029/30
£0.0 billion	£0.1 billion	£0.4 billion	£0.4 billion	£0.5 billion

Source: ASH 2023 and 2024

Alcohol

Alcohol mortality has reached historic highs in the UK – and is up 30 per cent on 2019 levels (ONS 2024l). Despite this, alcohol duties have been frozen in recent fiscal events. This is incoherent from a public health (and therefore, a long-term economic) perspective. We recommend that the government undoes the duty freeze which would have occurred in February 2024, which, coupled with the expected increase in February 2025, would see alcohol duty increase by 6.5 per cent.

From there, we suggest the government should reintroduce a duty escalator – a device that has been used historically to increase tax steadily, at times when harm is increasing. We propose this is set at RPI + 3 per cent and left in place until alcohol harms fall to at least pre-2019 levels. This will serve as an incentive to the alcohol industry to take other measures to support public health and reduce tax liability more quickly. We estimate the revenue impacts of these changes as follows.

TABLE 4.4: PROJECTED REVENUE FROM INCREASED ALCOHOL DUTIES

2025/26	2026/27	2027/28	2028/29	2029/30
£0.4 billion	£0.7 billion	£1.0 billion	£1.4 billion	£1.8 billion

Source: IPPR analysis of OBR 2024b and OBR 2024c

Recommendation 8: The government should introduce new levies on health harming products, businesses and industries, beginning with tobacco, gambling, vaping, alcohol and unhealthy food. This could raise as much as £10 billion by 2029/30 (the end of the next parliament). Levies should have the joint goal of incentivising reformulation – by ensuring businesses pay the cost of any harm they cause – and raising revenue. We discuss how that revenue could be invested in health creation and health-creating industries later in this report.

29 Given they will remain significantly cheaper than cigarettes and therefore affordable for most adult users who currently smoke.

Use regulation to make the healthier choice the easier choice

There is much else in the government's industrial policy 'toolkit' that could both support good health and encourage reformulation, including regulation. New regulation would best focus on the extent to which people's decisions are currently skewed by marketing, packaging and poor information – all of which make healthy choices more difficult (Smith et al 2019; Shangguan et al 2020). In identifying ways to change this, there is much the UK can adopt from what clearly works elsewhere.

On food labelling, Chile has had demonstrable success. Spurred by high rates of overweight and obesity in the country (74 per cent of the adult population, the highest in the region), it introduced a new front-of-package warning label. The scheme is simple: packaged foods and beverages that contain added sugar, sodium or saturated fats, or exceed set thresholds for these nutrients or overall calorie density, carry a front-of-package warning label (black octagon(s) declaring what they are high in). Since Chile's implementation, there has been wider adoption of the idea across South and Central America.

The simplicity and prominence of this scheme has had strong impacts. The number of calories purchased have fallen by nearly 24 per cent, sodium has been reduced by 37 per cent and sugar by 27 per cent (Taillie et al 2020). This was in part down to consumer behaviour change but more importantly, the first year of the scheme also saw a reduction in the proportion of products carrying warning labels, suggesting high levels of reformulation. This success sits in stark contrast to the UK's unsuccessful attempts to implement 'traffic light' labelling.

Warning labels have also been successfully deployed on alcohol, including in a trial in Yukon, Canada. Whitehorse undertook one of the world's largest tests of the impact of alcoholic beverages carry warning labels on the risk of cancer, government drinking guidelines and other public health messaging. Following the introduction of the scheme, alcohol sales reduced by 6.6 per cent. South Korea (since 2017) and Ireland (from 2026) have adopted the policy more formally.

There is also precedent for higher standards on gambling advertising. In Italy, a blanket ban was introduced on all gambling advertising – with a similar policy introduced in Belgium. Germany is in the process of implementing a gambling advertising watershed. There is strong evidence behind advertising watersheds as an intervention. A recent literature by McGrane et al (2023) found that advertising exposure directly influences decisions to gamble and to participate in more risky gambling. The authors conclude that gambling advertising restrictions could reduce overall harm and mitigate the impact of advertising on gambling-related inequalities.

In addition, we suggest that the government perseveres with the planned smoking and vapes act, which would make the UK a tobacco-control world leader. Rising childhood vaping rates clearly justify interventions such as point-of-sale restrictions and plain packaging. This was announced as the government's intention in the 2024 King's Speech.

A BETTER PUBLIC HEALTH POLICY MAKING PROCESS

These proposals provide a basis for immediate action that government could take, which would significantly boost public health at relatively low cost. However, there is also a need for reflections on the low agility of public health regulation in the UK. As a country, we are slow to act when new public health threats emerge. Conclusive evidence emerged in the

1950s on the link between smoking and health, but decisive public health action only began in 1965 with the first ban on tobacco advertising – and it took until the 1990s for a first government tobacco strategy. More recently, it has taken a sharp rise in youth vaping rates for the government to act on its appeal to children.

To embed a more proactive approach in government, we suggest that the Health and Prosperity Mission Delivery Committee is empowered to deliver an annual report on major public health threats – novel and existing. Within that report, they should identify key evidence-based regulations that the government can introduce to limit the harm of these threats. While the final decision on implementing these recommendations would remain with the government, the expectation should be that the government follows advice or justifies departure ('comply or justify') – increasing the expectation of intervention by default and accountability when intervention is slow. Such an approach would be akin to that taken by the National Advisory Council for the Misuse of Drugs (and to other expert, advisory policy bodies like the Low Pay Commission).

Recommendation 9: **The government should introduce consumer-friendly regulations to support healthy decision-making. These could include: Chile-style warning labels on pre-packaged, unhealthy food; South Korea-style alcohol warning labels (including cancer warnings); regulation to reduce the appeal to children of vapes and e-cigarettes; and tougher gambling advertising restrictions. The government should consider asking an independent body to report on evidence-based, proportionate public health policies once a year (or regularly), to help ensure more agile public health regulation.**

3. Invest in and enable healthy industry

As much as it would send a transformational signal to markets, disincentivising health harms should not be the limit of our aspiration. The most exciting vision for health and prosperity needs to understand how to make the healthy choice the easy choice – through and with industry.

Much as climate policy has a clear sense of what to do on fossil fuels (reduce economic dependency), and how to create sustainability and growth through investment and technology, so health policy needs the same. In this section, we focus on how to invest in making the healthier choice the easiest choice. In the next, we set out an innovation agenda in the 'health vital industries'.[30]

While this section focusses on an industrial strategy for the industries with the biggest possible contribution to growth and health through innovation, it should not mean health and prosperity are the sole responsibility of these sectors. Indeed, we have argued for 'health in all industries' elsewhere. Other sections of this report – particularly those around employment and work – could also be seen as part of the proposed industrial policies of this commission.

Use health levy revenue to make healthier choices more affordable

Our first proposal is to 'recycle' the revenue from the health levies outlined above into policies that make healthier alternatives more accessible. Disincentivising gambling will work best if other leisure activities become more accessible. Disincentivising unhealthy food demands efforts to make healthy food more accessible (not least, given the regressive potential of food taxes if uncoupled

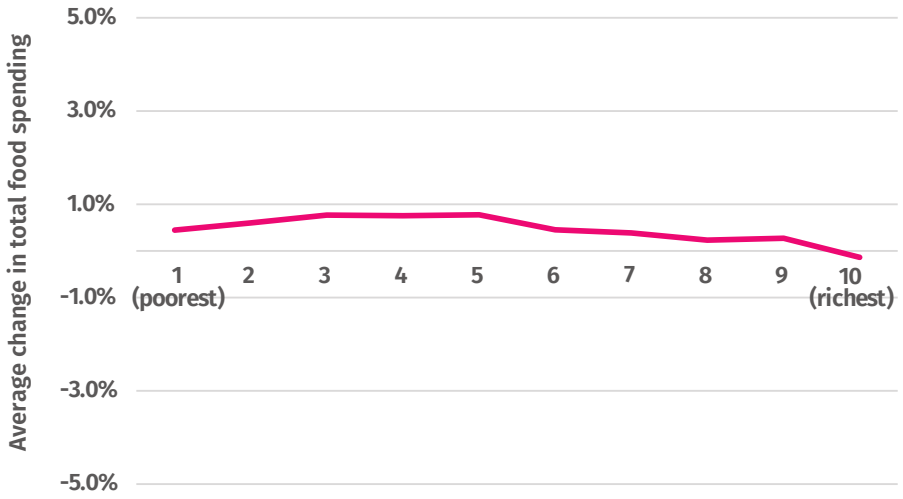
30 Identified as those with potential for health creation **and** growth. To give initial shape, we have approached this as including the life sciences, healthy food and agriculture, and active leisure/transport.

from subsidy). Evidence supports that levies work better when combined with subsidy (Hawkes 2015; Ruopeng 2013).

Our first proposal is for a fresh produce food subsidy. Our modelling shows that an 18 per cent subsidy on healthy products would cost £3.7 billion in the first year (that is, around the same as the revenues raised through our proposed non-essential food tax) and would help mitigate any impact of the non-essential food tax on household finances across the income distribution. Figure 4.6 shows that the combination of the non-essential food levy and an 18 per cent subsidy of fresh fruit and vegetables would have almost no impact on household spending.

FIGURE 4.6: COMBINED DISTRIBUTIONAL IMPACT OF FOOD TAXES AND SUBSIDIES IS BROADLY FLAT

Increase in food and beverage spending by income decile (1 – poorest, 10 – richest) associated with tax and subsidy policies



Source Authors' analysis ONS 2024m
Note: Food and beverage spending represents around 12 per cent of total household spending.

Notably, this is reported before accounting for behaviour change. The combination of the levy and the subsidy would be expected to impact both consumer and business behaviour. We would expect the latter to reformulate products to avoid the non-essential food levy, creating a price differential between more and less unhealthy food. And we would expect the former to increase consumption of cheaper, healthier foods. This would likely mean the impact of the policy in full is progressive for both health and income.

There are a range of options in delivering a subsidy. A universal food subsidy could be delivered through the following measures.

- **Pound-matching:** Replicating the model used to deliver subsidies through Eat Out to Help Out, the government could deliver a fixed subsidy on certain food products – with the discount applied at the till and reclaimed by the retailer.
- **Cards, vouchers or points:** The government already provides a range of food subsidies through vouchers, including healthy start vouchers. It could do similar to administer healthy food subsidies.
- **Through the NHS App:** Many health insurers now use technology to encourage customers to stay healthy, reducing their long-term liability.

For example, Vitality's Healthy Living Rewards provide points that can be exchanged for rewards based on step count. The NHS could adopt the logic of directly incentivising good health by delivering healthy food subsidies through scannable vouchers on its own app.

Beyond food subsidies, similar logic could be used to subsidise other healthy alternatives to the unhealthy foods this report has already outlined. This could include consumer-focussed or producer subsidies. The government might consider the following.

- Active leisure and transport: Despite the fact exercise has significant health benefits (both primary and secondary prevention), physical inactivity is high in Britain. Many struggle to fit exercise into busy work lives. The government already provides some tax exemptions to support active lives, most notably the Cycle to Work scheme. The government could explore further extending these incentives. This could include direct discounts, using the policy design of 'eat out to help out' to offer reimbursement for active leisure equipment universally across the UK. Or it could scale off-peak gym discounts for people outside the labour market – currently delivered by some local authorities, including many in London but not all – as a national entitlement.
- Agriculture and food production: As IPPR has argued previously, farming subsidies are disproportionately skewed to large-scale agriculture – and to producers of meat and dairy rather than fresh plant-based foods. Climate and nature arguments for a change in UK land use are well known and are only strengthened by their public health benefits. Directing a larger share of agriculture subsidies and payments to those producing sustainable, healthy food would help change the UK's food system landscape.
- Occupational health: Occupational health can provide significant benefits for employees. But many employers, particularly smaller ones, struggle to justify initial investment in good occupational health provision. While the government does already incentivise occupational health through a Benefit in Kind exemption, there are opportunities to go further. For example, by allowing employers to reimburse some occupational/community health services in cash rather than just vouchers (the former are currently taxable) or by extending tax relief to a wider range of preventative care (and care designed to support return to work).

REINVESTING HEALTH LEVIES

As well as our proposal for a healthy food subsidy in this chapter, we propose that at least 50 per cent of the revenues secured from health levies are reinvested in community health programmes and infrastructure (leisure centres, libraries, public green space, street lighting). Targeting this investment at communities with demonstrably poor health and economic outcomes would support the progressive impact of the commission's overall recommendations. We discuss this further later in this chapter, in our policy recommendations on **place.**

Recommendation 10: **We propose government considers ways to reinvest revenue from health levies into making the healthy choice the easy choice. Subsidies have particular promise. In the first instance, we propose a major subsidy (18 per cent) on fresh produce – namely, fruit and vegetables.**

Invest in innovation

Alongside using investment to make healthy choices more affordable, the government should consider other tools in its 'industrial policy toolbox'.

There is much exciting health innovation on the horizon in categories as broad as healthy food, health technology, genomics, vaccination and active leisure. These could provide an engine of health *and* growth in the coming decades. To support the UK's ability to lead the world in investment in the ideas, products and brands that support health and growth, we suggest innovation both at the beginning and the end of the innovation pipeline.

Initially, that means investing in Research & Development (R&D). The UK has long recognised that increased investment in health research (and R&D more broadly) is important. And beyond a change in ONS methodology in counting research investment, actual increases in expenditure have been disappointing. As IPPR has argued elsewhere, we continue to lag behind countries like Israel, the USA and Germany on public spending. That is, in backing the ideas that will lead to better health in the years and decades to come.

Reiterating previous calls from this commission, we propose the UK increases public expenditure on health investment to meet US levels[31] by £5 billion by the end of the next parliament. In line with the mission-orientation of the policies in this report, we propose that this extra investment is used in one of three ways.

1. To boost research in areas most relevant to healthy life expectancy – namely, prevention and long-term condition management research.
2. To support research in 'under-researched' areas of health – including cardiovascular disease, Alzheimer's/dementia, neurological conditions and mental health.
3. To deliver multi-disciplinary 'mission-orientated' or 'moonshot' research funding through UK Research and Innovation (UKRI). This could mean a focus on moonshots for pandemic preparedness, healthy childhoods, workplace health and antimicrobial resistance (AMR).

In line with wider research, we would expect this uplift in public R&D investment to have the beneficial effect of crowding-in a near-equivalent amount of private investment.

As well as investment in R&D, we recommend the government makes some investment available to support the scale of later-stage health innovation and infrastructure. This could include provision of long-term or patient capital for small innovators working in health/growth crucial sectors like food, active travel or the life sciences. Or it could include capital investment in the infrastructure needed to ensure a thriving agriculture or life sciences sector.

There are excellent emerging case studies of the benefits of increasing access to capital for health innovators. For example, the Good Food Programme accelerator is a business support and venture fund aimed at scaling businesses and products with the potential to help tackle childhood obesity, run by Mission Ventures and Impact on Urban Health. An initial investment of £1.4 million in a pilot fund was matched by over £6 million of further investment within 12 months. Initial evaluation has shown that the brands participating in the accelerator increased revenue by 63 per cent on average in the first year, with seven achieving supermarket listings.

In lieu of access to this capital, health innovators can often struggle. Sectors like food and drink are dominated by major multinational companies with large advertising budgets, established supermarket relationships and supply chains, and excellent brand awareness. It is reasonable to think that disruptors need additional support to establish themselves. In providing it, Britain could

31 As a proportion of GDP

establish itself as the home of health innovation – giving it competitive edge as other countries look for their own solutions to very similar health challenges.

Practically speaking, this could be delivered through the new government's National Wealth Fund. To achieve meaningful incorporation of health innovation investment in its approach we suggest two measures.

1. The health impact assessment is made a criterion for all investment – meaning prospects that can demonstrate positive UK health impacts are more likely to be supported.
2. A directorate is formed to focus specifically on prospects with the best potential health Return on Investment.

This updates the commission's previous recommendation of a National Health Investment Bank (as in Thomas et al 2023).

> Recommendation 11: **We propose that the government actively supports health innovation, at early and late stages. It should increase public investment in health research to catalyse progress on heart disease and mental health, to create 'mission' style research funds, and to boost prevention research. And it should use existing investment institutions like the National Wealth Fund to help scale and support health innovations.**

Pull all levers to enable innovation

As IPPR has argued elsewhere, industrial strategy is about more than fixing market failures. It is about pulling the full array of levers available to the state to achieve an overarching aim – in the case of green industrial strategy, sustainability; in the case of this report, healthy lives and an optimised relationship between health and prosperity.

FIGURE 4.7: INDUSTRIAL POLICY TOOLKIT

Theme	Lever	Example
Production (supporting products and innovations entering the market)	Costs	Subsidies to incentivise certain goods, outcomes or methods of production – for example, sustainable agriculture subsidies
	Rules	Product standards – for example, on lifecycle emissions
Purchasing (supporting demand for products and innovations in the market)	Costs	Advance commitments to purchase products at a set price to ensure certainty of demand
	Rules	Procurement standards to ensure government purchasing supports its wider goals
Economic conditions	Skills	Apprenticeship and post-16 skills policies
	Infrastructure	Public investment in national and local infrastructure – from roads to digital
	Innovation, research, development and commercialisation	Public research spending or work by the NHS to support clinical trials

Recreated from Dibb et al 2024

That is, healthy industrial policy should look to actively support industries that can best create health and support growth. As a starting point, we define 'Health vital industries of the future' as life sciences, healthy food and agriculture, active leisure and transport, and healthy housing. Indeed, the government already supports and affects these industries in providing healthcare, education, infrastructure and a system of law. More simply, our suggestion is that it provides more deliberate and strategic support.

That should include investment, as covered in the previous section. But the government's industrial policy toolkit is much more extensive than that alone. Previous IPPR work has defined that toolkit as shown in figure 4.7.

While we do not attempt to write a full industrial policy incorporating housing, life sciences, food and agriculture and active transport/leisure here, our central recommendation is that the government develops such a strategy within the first year of the next parliament. Drawing from previous work of the commission, and drawing from the above toolkit, we suggest that this should consider the following:

On the life sciences

- **Maximising the market for innovation:** Life science innovation often has one major customer – the NHS. This means the government has significant control over the demand for innovation. This should be a major industrial policy advantage: the government has unique power to make, co-create and sustain markets for a high priority industry. And yet, despite the transformative potential of many innovations – from personalised medicines to new Alzheimer's treatments – uptake of innovation in the NHS is low and variable. A 'comply or justify' framework for NHS organisations with demonstrably low use of NICE-approved innovative medicines may support uptake. The government could also consider an innovative therapies audit – a data-led approach to identifying and publishing local variation in uptake and use of innovation. To support accountability and oversight, a member of the life sciences council should be involved in the health mission board.
- **Clinical research, innovation adoption and trials:** The NHS could be world leading as a site for clinical research, trials and innovation adoption. But many clinicians simply do not have time for research or to focus on innovation spread. Allocating an average of 5–10 per cent of clinical time to either clinical research or innovation leadership could support demand for innovation and uptake of best practice for patients. The government should also capitalise on current public interest in health – a legacy of Covid-19 but also visible in (as an example) download numbers of health apps like 'Zoe' – to better promote and enable participation in clinical trials. This could include a health advertising campaign for the Be Part of Research functionality of the NHS App. This should be in addition to the new government's existing commitments to increase clinical trials and speed up recruitment. It should be noted that this will rely on uptake of innovations (clinical trials require comparison to existing gold standard treatment).
- **Discount rates:** Many life science innovations have long-term benefits (such as cell and gene therapies). Yet the current discount rate (3.5 per cent) makes it hard for these benefits to be 'priced in'. NICE has already concluded that an evidence base exists to change the reference case discount rate from 3.5 to 1.5 per cent. Implementing this change would ensure the full value of long-term good health is accounted for. The government should also consider reviewing how the Health Technology Assessment accounts for the health *and* prosperity benefits of innovation.

Healthy food and agriculture

- **Production costs of healthy food:** Despite being more expensive (per calorie), healthy foods also have smaller profit margins than unhealthy foods. We have already recommended a subsidy for healthy food in this report (see also recommendations on free school meals later in this chapter). Elsewhere, agricultural subsidies for vegetables, fruits and legumes could help make healthier and more sustainable farming more profitable.
- **Public procurement:** The government spends a significant amount on food, in schools, prisons, the NHS and care homes. Yet the food offer of these services is dominated by ultra-processed food. Shifting food procurement towards healthier products, particularly domestically produced healthy options, could help support demand and profit for healthy food providers, from field to plate. See our recommendation of universal free school meals later in this report.
- **Mentorship schemes:** The Good Food Programme found business support, as well as investment, was a major enabler in supporting the success and scale of healthier food brands. Currently, they are often in competition with established multi-national brand with established supply chains, advertising budgets and supermarket relationships. With this in mind, we could incorporate business support and mentorship as a role within the National Health Investment Bank.

Active leisure and transport

- **The right infrastructure**: Community active leisure infrastructure is in decline, from sports pitches to swimming pools and leisure centres. We discuss policies to rebuild this infrastructure in the **place** section of this report.
- **Support cycling over cars**: Cycling could be a far bigger part of the UK economy. Estimates from 2016 suggest that cycling and mountain biking contribute half a billion to British tourism each year, while a 2023 study estimated the benefits of the cycle industry at over £7 billion. But the country is not set up for bikes. IPPR has previously recommended an expansion in active transport networks, including a phased increase in spending to £50 per head by 2029, a new national cycle lane network, and proper enforcement of highway code rules to protect cyclists.

Recommendation 12: **The government's industrial strategy for health creation should not solely cover what we want to transition away from (tobacco, unhealthy food), but should also support health vital industries of the future. Support means more than just investment. We propose the government delivers a healthy industrial strategy for key industries, using its full industrial policy toolkit to support their national and global success. This should be considered a central plank in Britain going for growth.**

4. A NEW BEGINNING ON CHILDHOOD HEALTH

SUMMARY

Britain's rising sickness is not just a challenge for older people, after retirement. It is impacting children and young people too. Not only are they increasingly likely to face health challenges in their childhood, but our lack of progress on life course health means they are the first in modern history not to be able to expect much longer, better, healthier and more prosperous lives than the generation that came before.

No-one would question that education is important to immediate wellbeing and long-term prosperity. The same is true of childhood health. That's why we need to rebuild the foundations of good childhood and lifetime health in Britain. To do that, we propose restoring Sure Start, delivering free school meals and ending the two-child limit and benefit cap to lift hundreds of thousands out of poverty.

We have grown accustomed to each generation living a longer, healthier, and more prosperous life than their parents. Since the mid-1800s, every generation has left a 'health inheritance' for future ones. But in 21st century Britain this has been eroded.

Children today can still expect to live longer lives than their parents, but only barely. And the trajectory of steadily rising healthy life expectancy – which meant children could predictably expect to live longer in good health than their parents – has recently also stalled.

Children today also face worse outcomes during childhood itself. Childhood asthma, diabetes, myopia and allergies are all on the rise; obesity rates are high; and even infant mortality – already much higher in the UK than other European countries (House of Commons Library 2023) – has begun to rise (NCMD 2023). Among the most pernicious threats faced by children is to their mental health. The NHS's mental health survey of children and young people (aged 7—16) in England showed that 17 per cent have a probable mental health disorder, a 50 per cent rise on 2017 (NHS Digital 2022).

New analysis for this report shows the impact of slowed progress on children. By comparing trends in childhood health, we find the following.

- If obesity rates among children in year 6 plateaued in 2014, 24,100 fewer children of that age would be living with obesity (as of 2022/23).
- If we had maintained improvements in infant mortality seen between 2001–03 and 2014–16, 1,600 fewer infants would have died between 2020 and 2022.
- If we had achieved the same improvement in non-communicable disease prevalence among children as between 2001 and 2014, 450,000 fewer children would have a long-term condition (as of 2021).
- And if we'd achieved the same improvement in healthy life expectancy as between 1990 and 2010, children born in 2021 could expect to live between two (girls) and three (boys) years longer in good health.

This is worrying for long-term health and prosperity, particularly in the context of our proposed 30-year mission. No-one would doubt that education is a vital foundation for lifetime prospects – and that if education outcomes were to get worse, our economy would suffer severely. We should see childhood health in much the same way. Indeed, health and education cannot be neatly separated: poor health in childhood can undermine educational attainment. Indicatively, Resolution Foundation finds that children aged 11—14 experiencing poor mental health are three times more likely not to pass five GCSEs (including Maths and English) compared to healthier peers (McCurdy C & Murphy L 2024).

Our proposals in this chapter have a simple aim: to ensure we have the healthiest generation of children ever, and to reinstate the 'health inheritance' of each generation from the last. To that end, we explore three proposals. First, that families need greater access to a far broader range of support services in their neighbourhoods, the kind made accessible by Sure Start, a scheme that has been diminished over the last decade. Second, we recommend the government introduce universal free school meals – directly addressing hunger and poor nutrition, currently among the biggest public health threats faced by children. And third, that the two-child limit is abolished as a first step towards reducing unacceptably high rates of child poverty.

1. SUPPORT FAMILIES THROUGH A 'SURE START RESTART'

Sure Start (now 'Flying Start' in Wales, 'Best Start' in Scotland) was introduced in 1998 as a network of children's centres and other support for families with children under five. The idea behind the initiative was provision of a 'one stop shop' for the services children might need for the best possible start in life, including health services, parenting support and education, cooking and nutrition classes and support, early education and childcare, and employment support services.

While early results of a national evaluation of Sure Start were mixed, more recent evaluations have given a far more promising account of their impact. A study of the short-and medium-term impact of access to Sure Start centres between birth and five years old by the Institute for Fiscal Studies (ISF) found a significant improvement in educational achievement: children living within 2.5 kilometres of a Sure Start Centre performed nearly a whole grade better in their GCSEs. The same study showed that Sure Start also improved access to specialist support for children with special educational needs and disabilities (SEND) and reduced rates of SEND in adolescence. The educational benefits of Sure Start alone were worth £1.09 for every £1 spent (Carneiro et al 2024).

Further studies have also shown health benefits. Another IFS study showed that access to Sure Start in a child's early years improved children's health at various later stages. It reduced rates of infectious illness, reduced poisonings and improved adolescent mental health outcomes. Access to Sure Start was also shown to have prevented thousands of hospitalisations per year (Cattan et al 2021).

The benefits of Sure Start were greatest for the most disadvantaged children. Improvement in educational attainment (measured by GCSE performance) was three grades higher among children eligible for free school meals living near a Sure Start centre than for poorer children without access to Sure Start (Carneiro et al 2024). Health benefits were also larger for children in disadvantaged areas than in more affluent areas (Cattan et al 2021). Given that our analysis has strongly implicated inequality in the link between health and prosperity, this underlines the potential of Sure Start to deliver on both this commission's aims.

Despite this success, Sure Start has been eroded in the last decade. Research by Action for Children found that the numbers accessing centres in England fell by a fifth between just 2014/15 and 2017/18, despite the numbers of children increasing in that period (Action for Children 2019). Government figures show that over 1300 full children's centres were lost between 2010 and 2021 (UK Parliament 2022).

There have been attempts to reverse this trend. By 2024, the government had invested around £300 million in Family Hubs and a new Start for Life programme, modelled on the principles and successes of Sure Start (Action for Children 2020). But in the context of over 1,000 closures, such limited investment – amounting to fewer than 100 new hubs – does not equate to anything like a restoration of what Sure Start once was.

Government should deliver an ambitious restoration of Sure Start through a programme of **Sure Start Restart.** This should be founded on a commitment to restore Sure Start investment to the point it would have been had its pre-2010 trajectory continued. At its peak in 2010, Sure Start investment was £2.5 billion (2022-3 prices). As it stands, our analysis shows that local government Sure Start expenditure had fallen to just £526 million in 2022-3 (Department for Education 2024).

We propose the government restores Sure Start investment to its 2010 levels by the end of the parliament (see appendices for costing). In the first instance, this should enable significant investment in restoring the number of Sure Start Centres around the country, and ensuring they provide access to a common set of services including parenting classes and support, antenatal services, financial support, support with benefits, employment support, access to early education and childcare, breastfeeding support, and child development (including support with speech and communication). To help ensure money is used for this purpose, we propose that the ringfence on Sure Start funding is reintroduced.

As in the initial implementation of Sure Start, we suggest that the service offer targets places with higher levels of deprivation. Originally, Sure Start provided an enhanced offer for places in the most deprived 30 per cent of the country. In the context of the health and economic inequalities demonstrated by this report – and the capacity of Sure Start to support both health and work prospects – we suggest that an enhanced offer (supported by a funding premium) is put in place in areas where poor health and economic prospects cluster (see our recommendation on HAPI Zones for more on targeted support).

> Recommendation 13: **We recommend a full restart of Sure Start – beginning with restoration of funding to previous peak levels. A first move should be the restoration of Sure Start's infrastructure, including rebuilding over 1,000 centres that have closed in the last 10 years. The government should also ensure funding is available for a diverse set of services to co-locate within Sure Start Centres – particularly in parts of the country where poor health and poor economic outcomes cluster.**

2. DELIVER UNIVERSAL, NUTRITIOUS FREE SCHOOL MEALS

There is little more important in a child's lifetime health than the food they eat. Most obviously, chronic hunger during childhood can lead to poor health outcomes, including higher risk of depression, suicidal ideation, asthma and other chronic conditions (Ke & Ford-Jones 2015). Hunger can also undermine learning among school-age children – reducing educational attainment, and in turn exposing them to a higher lifetime risk of health conditions. But increasingly, food insecurity is about more than not having enough to eat in countries like

Britain. It is also about having enough of the right food to eat. Malnutrition, not starvation, carries a higher cost to this country today.

A recent Imperial College London study found that ultra-processed foods make up more than 40 per cent of children's food intake in grams, and more than 60 per cent of their intake of calories (Chang et al 2021). And research at the University of London has found that factors such as advertising and price increased the dependency of poorer families on ultra-processed options (Gallagher-Squires 2023). A key driver of this is how much cheaper unhealthy diets are. The 2023 *Broken Plate* report showed the following average costs for 1,000 calories of different foods.

- 1,000 calories of fruit and vegetables cost £11.79.
- Meat, fish, eggs, beans and other sources of non-dairy protein cost around £8.00 per 1,000 calories.
- 1,000 calories of unhealthy foods come in at just £5.82 per 1,000 calories.

High rates of inflation have worsened this picture, with 1,000 calories of more healthy foods increasing by £1.76 in the last two years, while 1,000 calories of less healthy food has increased in price by just 76 pence (Food Foundation 2023).

The health impacts of poor diet on children, hunger aside, are concerning. Obesity is associated with a range of chronic conditions, including some forms of cancer, cardiovascular disease and Type II diabetes. One of the most tangible signs of a lack of access to quality food among children is stunting: UK children are seven centimetres shorter at five years old than other five-year-olds across Europe (NCD Risk Factor Collaboration 2020).

We argue that every child should have access to a nutritious diet, including through universal provision of free school meals. In some parts of the country, this is already a reality: recently, London Mayor Sadiq Khan announced all primary school children in the capital would receive funded school meals in the coming academic year. In some boroughs that already provide free primary school meals, the funding will extend further and enable secondary age students to access free school meals. Internationally, free school meal provision is available in Finland (since 1948), India (midday meal scheme introduced in 1930), Brazil (made universal in 2009) and Sweden, among others.

The research base on a broad range of benefits of free school meals is increasingly strong. Analysis by PwC for Impact on Urban Health shows a significant return on investment for universal free school meals (Impact on Urban Health 2022). Evaluation of free school meal provision in Southwark by researchers at the University of Essex found that receipt reduced the prevalence of obesity by 9.3 per cent among reception children, and 5.6 per cent among year 6 children on average. This study also found a £37 reduction in monthly food spending among families with two adults and two primary-aged children – an attractive benefit, given on-going challenges with food prices, cost of living and living standards (Holford & Rabe 2022). Recent systematic review has shown universal free school meals improve educational attainment, student participation and diet quality, and reduce BMI – all factors in long-term good health (Cohen et al 2021). And wider studies have shown that universal free school meals are significantly better at ensuring benefits to all low-income households than targeted approaches (Morelli & Seaman 2005).

This makes a compelling case for provision – and an argument for universal provision as optimal (although some improvements are better than none). However, simply expanding eligibility would miss an important opportunity to improve the nutritional quality of free meals provided in school settings. Today, 64 per cent of calories in school meals come from ultra-processed foods (higher

than their contribution to children's average diets as a whole) (Parnham et al 2022). Given the price differential between healthy and unhealthy foods, this is likely to reflect that the funding rate per meal for free school meals in England has fallen in real terms: had it kept pace with inflation, the rate would stand at £2.87 per meal.

We estimate a universal free school meal offer for all children in state-funded schools (our proposed approach) would cost an additional £3.3 billion in England. This includes the nutritional supplement in budget/meal outlined above, but does not include Barnett consequentials (it should be noted Scotland and Wales have more extensive free school meal provision than England). Only covering primary school children (the approach in Wales) would cost £1.8 billion, although the policy's impact would be more than proportionately lower. In both cases, there would be savings - for example, the £130 million allocated by the Mayor of London to free school meals. As this does not impact the outlay by the Treasury, we do not deduct that saving from our core costings, although it would provide local public money that could be invested in other priorities.

There is more besides this that can then be done within school settings. As well as the case for universal, healthy meals, evidence would also support continuation of the childhood waist measurement programme and expansion of the Daily Mile. University of Stirling research on the latter has shown that fitness of participating children increased 5 per cent, fat levels were reduced 4 per cent and sedentary behaviour fell 5 per cent (Chesham et al 2018).

> Recommendation 14: **As in India, Brazil, Finland, Sweden and some parts of Britain, the government should introduce free school meals. This would provide a direct answer to the biggest public health threat facing children today (hunger, malnutrition and obesity). It would also support families with the cost of living and deliver lifelong health and economic returns.**

3. ABOLISH THE TWO-CHILD LIMIT AND BENEFIT CAP

Introduced in 2017, the two-child benefit cap ('the two-child limit') restricts the number of children for which a household can receive universal credit or child tax credits. Recent analysis from the Child Poverty Action Group indicates that as many as one in 10 children in the UK (1.5 million) are affected by the two-child limit

The two-child limit is now the biggest driver of child poverty in the UK (Reader et al 2022). Resolution Foundation research has shown that the two-child limit results in low-income families losing around £3,200 a year for any third or subsequent child born after April 2017 (Try 2024). The impact on poverty rates of hundreds of thousands of families losing out on thousands of pounds worth of benefits is intuitive. And data shows that while the proportion of families with two children in poverty has remained broadly flat, the poverty rate among larger families has risen, and continues to rise, sharply.

Experiencing poverty during childhood has been linked to a wide array of lifelong health consequences. Children living in poverty in the UK are more likely to die in their first year of life, to be born small, to become overweight, to suffer from asthma, to die in accidents or to suffer tooth decay (Caan 2013). In turn, and in combination with the wider consequences of poverty, this can undermine early year development, educational outcomes and future work prospects – all variables that are linked to worse health in adulthood (Wickman 2016).

Given this, reducing child poverty is likely to be among the most powerful levers in delivering long-term health and prosperity in the UK. To that end, research shows that removing the two-child limit would have immediate, positive and large impacts on child poverty. For example, IPPR research has previously found that removing the two-child limit would reduce child poverty by 300,000, and total poverty by a further 100,000 (Parkes et al 2024). Moreover, analysis by CPAG

finds that it would lift 850,000 children out of deep poverty – which, while not perfect, would nonetheless improve their life chances (Childhood Trust 2023). We project that the costs of removing the two-child limit and benefit cap would be £3.2 billion in the first year – a cost of just £10,000 to the state for every child lifted out of poverty.

Recommendation 15: **The two-child limit is one of the biggest, individual drivers of childhood poverty. And there are few bigger factors in poor childhood and lifelong health than poverty, particularly deep poverty. We recommend the two-child limit is abolished alongside the benefit cap – at an estimated cost of £3.3 billion in 2025/26. We project this would reduce child poverty by 400,000.**

TABLE 4.5: ESTIMATED COST OF ABOLISHING THE TWO CHILD LIMIT AND BENEFIT CAP

2025/26	2026/27	2027/28	2028/29	2029/30
£3.0 billion	£3.2 billion	£3.4 billion	£3.7 billion	£3.9 billion

Source: IPPR tax-benefit model using DWP 2024

NEW AND EMERGING THREATS TO CHILDHOOD HEALTH

Novel public health threats to children are constantly emerging, whether they are extreme content on social media, new and sophisticated forms of targeted advertising, harmful drugs like nitrous oxide, the neurological impacts of smart phone use or new, exploitative corporate tactics. We need greater means to anticipate risks.

There is little scope in UK policy for proactive childhood health protection. As this report has already argued, too much of our policy is reactive. We wait for harms to emerge, spend years researching them, and only then intervene – often with delays to policy change then coming from legal challenge or lobbying efforts.

To give an example of the latter: in 2023, Sustain found that Kentucky Fried Chicken (KFC) had launched a legal challenge against at least 43 councils in England over planning policies to restrict new hot food takeaways near schools. They were successful in more than half of cases – in part, because local authority lacked the resources to defend their policies in court (Sustain 2024).

To support more proactive local health protection, we suggest Director of Public Health roles evolve as follows:

- They are empowered to pilot a defined suite of childhood health protection policies locally, with agreement from the relevant upper-tier local authority – including advertising bans and regulation, and smartphone bans in schools.
- They are given proper budgets to defend their policies in court. More widely, the government should have a policy of always defending public health policies against legal challenge. In and of itself, this would act as a signal to markets.
- Powers to overrule the opening of health harming outlets near schools, or where they pose a provable risk of increasing health or economic inequality.

At its best, this would elevate the DPH role to be more akin to a deputy mayor or the (more influential and powerful) commissioner of health role in cities like New York.

5. BUILDING HEALTHY PLACES

SUMMARY

Britain is divided by health and wealth, and the same places have poor health and economic outcomes. This is a double injustice. Delivering health and prosperity means addressing inequality. Specifically, it means local leaders and communities identifying and solving the particular health and economic challenges they face in a bespoke way, delivered at place level.

To achieve that, we need investment and new local powers, and to rebuild healthy local infrastructure. We propose the creation of a new concept – Health and Prosperity Improvement (HAPI) Zones – a locally-led scheme designed to empower health creation in places that most need it, through targeted devolution, investment and engagement. Within this model, we also propose a programme of restoring health critical infrastructure, from libraries to green spaces and leisure centres – owned locally.

As this report has demonstrated, the cost of illness on prosperity is not felt equally across Britain. Poor health and economic outcomes cluster around much the same places – often more deindustrialised, urban and deprived parts of the country. There, sickness locks people out of opportunity, and a lack of opportunity locks them into sickness. We have previously called this the double injustice.

Solving health inequalities locally therefore represents a key pillar in any strategy to deliver health and prosperity. Decision makers in Whitehall are unlikely to be able to solve distinctly local challenges around health and opportunity, meaning they are less well-placed then local leaders to deal with the specific ways sickness impacts local economies. And many of the key drivers of poor health – from air quality to poor housing, access to green space and loneliness – are best solved locally.

The qualitative work undertaken by this commission consistently found that communities and local leaders want to take a leading role in this change. People want to see their community empowered to deliver better health and stronger economic prosperity, while local leaders actively want the powers and resource to deliver solutions.

Encouragingly, our work has also identified many brilliant, if isolated, examples of local health innovations that are genuinely transforming lives. The approach to work in Greater Manchester, Leeds's obesity programme, the Wigan Deal and the Preston model are all examples of initiatives, designed and delivered in places, that are improving both health and prosperity.

The challenge is not a lack of evidence or local will. It is the extent to which communities have the power, resources, spaces and assets to deliver on the promise of health and prosperity. To that end, we recommend two new approaches.

- **A programme to spread 'what works' to the places that stand to benefit most:** The best local health programmes are transformative – but what works often doesn't spread to those places that most stand to benefit from it. To facilitate the spread of best practice, we propose a new programme of Health and Prosperity Improvement (HAPI) Zones. These should be designed

to enable local leaders to identify the right interventions – ideally, based on what demonstrably works elsewhere – and target places where health and economic inequality are most profound.

- **A programme to rebuild the assets that enable healthy places:** Good health relies on the right community assets. There is no lack of evidence on 'asset-based approaches' to health creation – that is, on using existing social, cultural, human and physical resources to meet health challenges. But we must realise that many places have lost their assets in the last 15 years as meeting places like youth centres, businesses with community heritage or value, and local infrastructure like swimming pools and libraries have faced budget cuts and closures. We need to restore a base level of 'healthy infrastructure' to places across the country in order to restore our health.

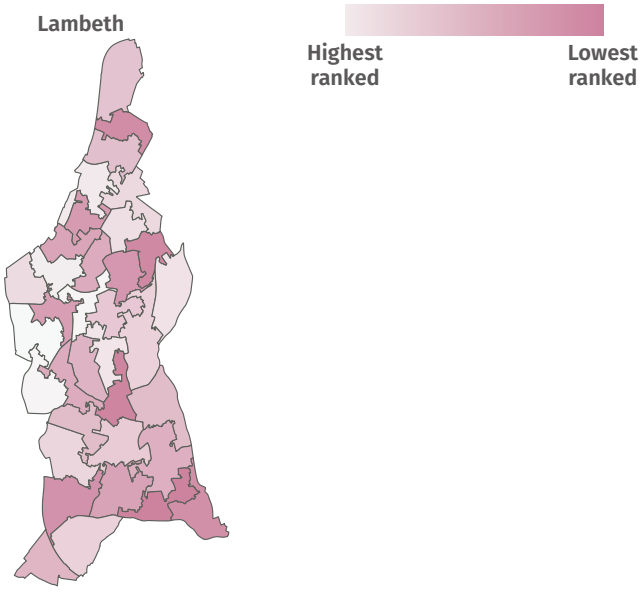
The logic behind these ideas is simple: if everywhere were as healthy as Wokingham, our healthiest local area, Britain would already have achieved the mission proposed by this report of 10 years' extra healthy life expectancy. It is in targeted and bespoke action on health inequality that we will make the biggest leaps towards a healthier and more prosperous future.

1. CREATE 'HEALTH AND PROSPERITY IMPROVEMENT' ZONES

We need a mechanism to spread the best public health initiatives into the places that need them most, bespoke to local needs and delivered locally. We propose a new local power to create **Health and Prosperity Improvement (HAPI) Zones** in the parts of the country where health and economic inequalities cluster. Practically, the ability to create HAPI Zones would be a new power for local leaders – similar to Clean Air Zones.

The biggest strides forward in population health have generally come when national and local intervention is both highly ambitious and well-coordinated. Henry VIII's moves to build the first formal sewers by creating new powers for local leaders, the creation of local Chief Medical Officers (now Directors of Public Health) to answer Victorian Typhoid outbreaks, and the slum clearance of the 1930s are all examples that we continue to benefit from today. HAPI Zones would continue to recognise the crucial role of place-based leadership in health creation.

FIGURE 4.8: HEALTH INEQUALITY HOTSPOTS IN LAMBETH AND SOUTHWARK



Source: Author's analysis ONS 2024d

They would work as follows. Local leaders would work with local people – as well as local businesses, public services, civil society and community groups – to identify and designate new HAPI Zones, covering a defined population where poor health and economic outcomes cluster. While we do not suggest a need to be prescriptive on the population covered, we would expect these areas to be natural communities within a local economy – for example, the parts of North Lambeth and Southwark where our analysis shows poor health and prospects cluster (figure 4.8).

While national government should ultimately retain sign-off on the final designation of HAPI Zones, to ensure consistency in approach and basic alignment with national priorities, the expectation should be that they are designated and given impetus locally. This is consistent with the principle of subsidiarity, also used in relation to Integrated Care Systems.

From there, each HAPI Zone would develop a long-term health creation plan as a joint endeavour between local leaders, public services, communities and other stakeholders (like local businesses or major employers). In line with previous IPPR recommendations, we suggest that all plans include extensive deliberation with communities themselves (see figure 4.10 on possible deliberation/ consultation techniques).

Each plan would be backed in turn by new investment and new powers, made available by the centre. We suggest each is eligible for a share of 50 per cent of the revenues derived from the health levies already recommended by this report .[32] Learning from challenges around the Levelling-Up Fund we suggest this is allocated by formula and based on need, rather than time-consuming and expensive competitive tendering processes.

In turn, HAPI Zones could be prioritised for new health investment or pilots. For example: local collaborations on new patient pathways, vaccine pilot or health technology rollout with life science companies; investment in community or primary care health infrastructure; or trials of schemes like Housing First beginning in HAPI Zones – in the places where people stand to benefit from them most. In that way, the approach could support exciting testbeds for new ways to improve health, in places where our existing approaches are evidently not currently working.

HAPI Zones should be encouraged to deliver lasting change rather than to focus on low hanging fruit. To this end, it is important they learn from some of the difficulties associated with Health Action Zones – a similar, place-based approach to health inequalities introduced by the New Labour government and which delivered mix results. Health Action Zones had little real engagement, limited time horizons, and were more focussed on targets and extensive national guidance than on meaningful local empowerment. These design flaws have been linked to the schemes' failure to deliver real transformation.

32 See our appendices on policy funding and costing for more detail.

FIGURE 4.9: CONSULTATION AND DELIBERATION METHODS THAT COULD BE USED IN HAPI ZONES' HEALTH CREATION PLANS

Method	Description	Pros	Cons
User feedback	Mechanisms for systematically collecting and using the views of citizens such as surveys or consultation	Collects information at scale, allows for representative sampling	No guaranteed findings are used, does not shift power and information can lack nuance
Representation	Representatives are elected (or otherwise appointed) into positions of power	Can ensure citizen voice is in the room where decisions are taken	Can be tokenistic. Power imbalances can mean this form of representation is drowned out or ignored
Advisory	Groups of citizens are selected onto advisory boards	Can enable more nuanced discussion	Can be tokenistic
Citizens' juries	Groups of people are selected to deliberate on specific issues, often with power to make a (binding) decision at the end	Can enable more nuanced discussion; power can be genuinely shifted	Expensive to run, hard to scale, risk that the small group is not representative
Participatory budgeting	People given power to allocate a share of government spending	Hands over real power, and forces consideration of trade-offs	Risk of being skewed by small number of people
Co-design	Groups of citizens work with professionals and experts to co-design services or policies	Hands over real power to people and can enable more nuanced deliberation	Hard to scale, only involves a small share of the population, and more viable for affluent/time rich people

Source: Recreated from Poku-Amanfo et al 2023

To that end, we suggest three further key elements to the design of HAPI Zones. **First,** as in ICSs, the approach should be based on genuine subsidiarity – a principle of solving challenges at the most local level possible, with national and regional bodies in supporting roles. **Second,** that the time horizon is long enough for progress to be seen. We suggest HAPI Zones last at least 10 years before their appropriateness is reassessed. **Third,** that significant capacity for evaluation is baked in, to allow both scope for trial and error, and a continuous process of identifying what works, what doesn't, and why.

CASE STUDY: HAPI ZONES AS AN OPPORTUNITY TO LINK HEALTH AND EMPLOYMENT SERVICES

This report has already argued for closer integration of healthcare and employment services. HAPI Zones could provide an opportunity to pilot and target that integration in places where health and work needs are highest.

There are now excellent examples of place-led, integrated health and employment. Lewisham's mental health services have incorporated employment and social support at the heart of their approach. The Improving the Cancer Journey Programme in Glasgow includes employment services (and financial support) as standard for people who need them following a cancer diagnosis. The Pathway to Work Commission has developed ideas for bespoke health and employment

support in Barnsley. And Northamptonshire NHS Foundation Trust has integrated Individual Placement Support (IPS) as a formal service offer.

Place-based solutions enable targeted support in a way national schemes struggle to do. The barriers to good health and good work will vary from place to place, and from person to person. As the Pathways to Work Commission found, there are different segments of people experiencing economic inactivity, including:

- people in crisis, facing acute barriers to work
- those for whom work is not now possible, but could be with significant support
- those close to employment, for whom significant support is less needed
- those in work, but at significant risk of exit (eg after a new diagnosis).

Understanding the person, the complexity of their needs, and the reality of the job market in the place they live are important in providing the best support.

We suggest HAPI Zones could be a vehicle to spread targeted, locally defined healthcare and employment support offers across the country. They would offer a point of collaboration for ICSs, primary care and local government. They would also provide a basis for community consultation and national investment in developing new approaches. And they would do this in the places where health and work needs are highest, providing a body of best practice and experiment.

Recommendation 16: The government should give local authorities and mayors the power to create HAPI Zones. HAPI Zones would see local leaders and their communities work together to develop bespoke health creation plans in places where poor health and economic outcomes cluster, with the backing of national investment, new powers and other enablers from central government.

2. BUILD BACK BRITAIN'S COMMUNITY INFRASTRUCTURE

Many community-led approaches to health – including our own proposal of HAPI Zones – draw from the idea of 'asset-based' or 'strength-based' approaches. These try to move away from thinking about communities as simply settings for services, and towards using the full strengths of a community to deliver positive health and wellbeing.

Put in more practical terms, an 'asset-based' approach suggests empowering communities to use their pre-existing resources to meet public health challenges – often with a focus on tackling health inequalities. Assets could be physical infrastructure, local businesses, shared histories and senses of identity, voluntary organisations and charities, or natural resources like beaches, rivers or green space.

The logic behind these approaches is sound. If health is about more than just healthcare, then it makes sense to look at the resources a community has, beyond hospitals and healthcare settings, to improve it. However, any proposal that communities simply use their existing strengths to tackle health inequality can risk overlooking the fact that many of their assets have been eroded or lost in the last 15 years – particularly in more deprived communities, where poor health and limited opportunity are bigger problems.

Most obviously, places up and down the country have lost physical assets like libraries, swimming pools, community centres or green spaces. Indicatively, IPPR

North analysis has estimated that 75,000 local authority-owned assets – worth £15 billion – have been sold in the last 15 years (Billingham et al 2023). But many communities have lost less tangible assets too, as voluntary and community groups or events that relied on these physical assets to function have been cut back or lost entirely. Bennett Institute research has shown a decline in shared identities and pride in place (Shaw et al 2023), while evidence on social isolation and loneliness in Britain speaks to a decline in relationships.

Proposals to tackle health inequalities through strength- or asset-based approaches can risk forgetting that austerity stripped away much of the core infrastructure places need to tackle health inequalities – particularly in the most deprived parts of the country. Above and beyond asking places to play to their strengths, we need to ensure every part of Britain has the foundational infrastructure needed to enable healthy lives. We suggest every part of the country should have the spaces and social connections to provide **eight assets every place should have, to build the foundation for healthy lives.33**

FIGURE 4.10: EIGHT FOUNDATIONAL ASSETS FOR HEALTHY PLACES

Foundation	Asset	Health link
Everyone should be able to take part in sports and exercise.	Sports facilities and leisure centres	Sport supports health, through both physical activity and social interaction.
Everyone should be able to use a local library.	Libraries	Library use has been shown to improve health, particularly among children (Arts Council England 2015), while libraries can be helpful health settings[34] (Philbin et al 2019).
Everyone should be able to walk, jog, run or play outside.	Green spaces	Spending time in green spaces improves mental health outcomes (Barton & Rogerson 2017).
Everyone should be able to meet and socialise with friends where they live.	Youth clubs or centres	Youth club attendance is associated with immediate health benefits, including higher school attendance, lower alcohol use and better self-reported health (2024)
Everyone should be able to learn to swim.	Swimming pools	Swimming has widely accepted health benefits. For example, one study found those who participated in any amount of swimming had 28—41 per cent lower risk of cardiovascular disease mortality than those who participated in none (Swimming and Health Commission 2017).
Everyone should be able to get home safely.	Street lighting	Feeling safe outdoors is an important moderator of green space use or exercise, especially among women (Shenassa 2006).
Everyone should have the option to cycle to school or work.	Cycle lanes	Cycling is correlated with cardiorespiratory health and lower all-cause mortality (Oja 2011) .
Everyone should be able to breath clean air.	Public transport	Air pollution is linked to stroke, heart disease, COPD, lung cancer and a range of other conditions (WHO 2024).
Everyone should be able to feel pride in place.	Assets of community value	People living in places with a strong sense of connection are less likely to experience isolation and ill-health (Shaw et al 2023).

Source: Authors' analysis

33 In defining these basics, we focus on where local places and spaces can enable health. While we recognise services like healthcare and education are important and often delivered locally, we focus on assets beyond services – in keeping with the idea of assets, and in recognition that better healthcare and education need a national policy response.

34 For example, in providing internet access to people who would otherwise be digitally excluded from online healthcare.

Evidently, ensuring every place in the UK has the assets it needs to deliver on the promise of good health will need investment. We suggest asset creation is a key priority for the national funding allocated to HAPI Zones. For example, the government could specify that between one third and one half of this funding is used for asset creation.

Yet creating this infrastructure will also demand an approach that goes beyond funding. Without proper consultation with communities and leadership by and through local government, decisions on what to create (or protect) within communities would be insufficiently informed by local priorities and contexts.

Above and beyond the investment we have already recommended is allocated to HAPI Zones, we suggest they are the site for piloting a bolder version of an asset-based approach – what we call a 'strength creation' approach to health development. This could include the following.

- **Using planning requirements to support green space:** IPPR's Commission on Environmental Justice suggested a renewed planning framework, which should include a local planning rule that no home is further than 300 metres from an accessible green or blue space (Murphy et al 2021). This would particularly benefit poorer areas, which have the fewest protected green spaces (CPRE 2022).
- **Building community power to protect assets:** While the Localism Act introduced 'Assets of Community Value', giving local areas the right to bid for a designated asset if and when it is sold, this is only helpful if that asset is put up for sale. Scotland's use of 'common good property' goes further, covering all moveable items (including art), and including duties on transparency about the existence of assets, and public consultation on decisions regarding them. This could be scaled across the UK.
- **Explore participatory budgeting:** Scotland has also demonstrated the potential of participatory budgeting, where a proportion of local government budget is allocated by community groups to meet local people's priorities. The same could give communities a meaningful say in their priorities for investment.
- **Explore hyperlocal governance:** Hyperlocal governance – governance by parish councils, neighbourhood forums, or more informal community bodies – can support democratic engagement among communities. However, its use is extremely patchy. HAPI Zones could explore opportunities to improve and expand hyperlocal representation.

Recommendation 17: **The government should use HAPI Zones to invest in the community assets needed to sustain and enable good health: libraries, leisure centres, youth clubs, street lighting and a sense of pride in place. This infrastructure is critical in supporting healthy places but has been particularly eroded during austerity.**

6. PROACTIVE HEALTHCARE: FOR PUBLIC HEALTH AND PUBLIC FINANCES

SUMMARY

A health creation strategy is not about ignoring the NHS or accepting its current inadequacies. Our NHS is in crisis, and there are few paths to health and prosperity that do not include restoring access, quality and good patient experience.

To some extent, the other policies in this report will provide the NHS with the capacity and headroom to do that. By managing demand, they will free up beds, appointments, and time to innovate and for research. But as a service with a budget equal to a small country's GDP, there is also much the NHS can do itself.

Prevention, the shift of care into community settings, system working and the anchor institution agenda are all well-established reform priorities for the NHS that can deliver health and prosperity. However, none of these are new. The real question is why the NHS is reluctant to change and modernise, meaning the same reform priorities have been discussed for decades but never delivered. It is this puzzle we focus on here.

The NHS is not the sum of what matters in health. But that does not mean it is not vitally important. The NHS can contribute to the health mission outlined in this report in three main ways.

1. It can directly contribute as a good employer, and as a delivery agent of industrial strategy (eg using procurement budgets to support population health), and as an anchor institution.
2. It can contribute to health creation and prevention, particularly through community and primary care functions, including preventative prescriptions, screening programmes, general practice, social prescribing and long-term condition management.
3. And it can deliver excellent care when we do have acute need: no health creation plan would be complete without incorporating a plan for sickness.

The new government has recognised this potential. One of its earliest commitments has been a reorientation of the Department of Health and Social Care (DHSC) around economic growth; it has recognised that the department should not only bid for extra money – it should create it.

In other words, healthcare should contribute to both the health mission and the growth mission. The ways in which it can do so are well-established and evidenced. They include better use of innovation, a shift towards prevention, productivity gains to ensure good use of money (freeing up other investment opportunities), a greater focus on care in the environment, and a realisation of the potential of the anchor institution agenda. The challenge is not that these means to build health and prosperity are unknown, it is that they are inadequately used.

More promisingly, there is now a ready-made vehicle for a new attempt to deliver on these reform priorities: the 10-year health plan under development in DHSC. However, the challenge this new strategy will need to engage with is not only *how* to deliver on prevention, the shift to community, the potential for technology and innovation, or the NHS's potential as a partner and an anchor. It will also need to wrestle with the fact that attempts to realise these reform agendas have repeatedly failed, despite significant political consensus and policy effort, in the NHS's 75-year history. The same reform priorities have been features of strategy for decades, with little real progress. The forthcoming health plan will need not only to explore what kind of changes are needed, but also the root causes of the NHS's lack of capacity for change.

Our diagnosis for this is that the NHS bears sparingly little resemblance to what a mission-orientated public service might look like. Mission theory suggests bold aspirations are best met through decentralised working, partnership, innovation and risk taking, and bottom-up solutions to problems (Dibb & Mazzucato 2019). The status quo of the NHS is significant centralisation, command-and-control oversight, risk adversity and siloed working.

Put another way, the NHS should not just 'contribute' to missions. Rather, missions should become the compass for a fundamentally different way of approaching healthcare, fit for public health and public finances in the 21st century. Our contention is that delivering a mission-orientated approach to healthcare will be the basis for creating the conditions for successful modernisation where so many others have failed.

For that reason, this section of the report will not repeat now well-established ideas on the NHS's need to design preventative care pathways, to invest more in capital or to reform the composition of the workforce. There are many excellent reports that do this (see Friedman and Wolf 2023, Patel 2023). Instead, we look at how the forthcoming 10-year health plan can engage with some of the institutional drags on NHS capacity to reform. Specifically, we cover the following.

- **Who leads health policy –** and how we move more meaningfully away from a command-and-control approach, and build the capacity for strategic risk, system working and partnership.
- **Where healthcare is done –** and how we create the conditions for more healthcare to be done in and designed with neighbourhoods and communities.
- **How healthcare is funded –** including how funding can enable and incentivise fundamental reform over the next 10 years.

These might seem more abstract than questions of how much more capital funding the NHS needs. But it is answers to these questions, rather than any misguided attempt to change the NHS funding model or founding principles, that will be foundational in arresting declining satisfaction, unsatisfactory outcomes and access challenges.

1. WHO LEADS: INCREASING ICS AUTONOMY AND LEADERSHIP

The NHS has implicitly accepted that major reform priorities like prevention, integration, long-term condition management and partnership depend on system working. The vision for Integrated Care Systems (ICSs) was anchored in the idea that systems rather than the centre had the means for partnership, the information on local need, and the capacity for coordinated working to best deliver on population health management.

To that end, the government's inheritance of 42 ICSs (and similar moves towards integrated system working in Scotland and Wales) is a piece of good fortune. The work of reorganising and creating the necessary statutory structures for

integration has already been done. The government need not undertake a major, time-consuming and controversial process of creating new NHS bodies and geographies.

But we must also recognise that the ICS experiment has yet to achieve anything like its stated objectives. As the Hewitt Review concluded, there are some genuinely impressive examples where ICSs have changed the way the NHS works: Wigan's £13 million investment in a Community Investment Fund or the bespoke health inequalities team recruited in Hyde, Greater Manchester. But the review also rightly expressed concern that the transformational promise of ICSs is not being met – that the acute sector remains dominant, that risk aversity and siloed working remain common, and that population health management is still just a nice-to-have (Hewitt 2023).

The diagnosis of this commission is that simply creating ICSs has not been enough to recalibrate the relationship between the centre and systems. If the promise of ICSs is a more preventative, outcomes- and partnership-led approach, led by places with devolved power, then too much of the old, centralised control architecture remains. For all the talk of 'subsidiarity', power and real autonomy have not adequately flowed from the centre out to communities.

The most pertinent example of this is the continued use of top-down national targets, directives and 'guidance'. A proliferation of top-down targets gives systems little capacity or headroom to define their own priorities and partnerships. Worse, it can mean that all available time is used to service (or even 'game') targets at the expense of a meaningful focus on population health management.

A mission-based approach would look different. The centre's role would be to articulate a much smaller number of more aspirational targets. This would include the mission goals stated by this report – 10 years on healthy life expectancy, reductions in inequality – plus perhaps a few other additions if needed. From there, systems would be challenged to work to genuinely understand their population, their health needs and (through consultation) their priorities in setting their own goals on how to meet those national priorities. To that end, as part of making the ICS the *key* vehicle in a health creation, mission-led approach, we reiterate the Hewitt Review's recommendation of significantly curtailing the number of centrally mandated targets.

This process, led by Integrated Care Boards (with Integrated Care Partnerships) would allow for an increasing proportion of the NHS budget to be commissioned for outcomes rather than activity. This has had recent proof of concept through a £200 million ringfenced health inequalities funding allocation. Locally defined priorities based on population need could allow systems to purchase the service best designed to meet a long-term outcome – whether a healthcare service, a voluntary organisation or something different. The more long-term the outcome, the more ambition is enabled: much more innovation is possible in commissioning the services and infrastructure to boost healthy life expectancy in 30 years than in getting the two-week wait for cancer back on track within six months. Achieving it will require significant management capacity and expertise to move from central bodies to systems – and proper trial, development and evaluation of outcome-based commissioning models.

Within this model, the centre's role would change to one based on enabling learning, evaluation and continuous improvement. This is not a purpose that the design of central bodies is currently optimised for. It is a particular challenge to central regulators and inspectors like the Care Quality Commission (CQC). As things stand, the CQC uses inspection to provide single word ratings, which can

lead to regulatory action, enforced change of leadership, fines or legal action. This is a model that can install a blame culture and a risk aversity within systems– anathema to fulfilling the potential of new and innovative ways of working, particularly those that need time to embed and realise their benefits (eg outcome-based approaches).

As IPPR has argued elsewhere, changing this approach does not mean being weak on standards, or letting go and hoping for the best. Instead, it means rebalancing the levers used to drive improvement (Quilter-Pinner & Khan 2023). That would mean reforming the CQC to be a data-led, improvement focussed regulator, with inspectors using qualitative information and smart data to provide more actionable insights. And it would mean building the capability of the CQC to work with systems collaboratively on that process of improvement: fewer clipboards and less judgement, more empathy and actionable insight.

> Recommendation 18: **ICSs are a promising foundation for a more collaborative, strategic and outcomes orientated approach to health policy. But their mere existence is not enough to realise that potential. We propose government does more to genuinely devolve power to ICSs as part of a mission-based approach. And we propose central bodies like the CQC are reformed around continuous improvement instead of blame and judgement.**

2. WHERE HEALTHCARE IS DONE: CREATING THE NEIGHBOURHOOD NHS

The NHS has also long accepted that tackling inequalities, delivering on prevention and managing complex health needs will demand a reorientation of care around primary and community services. But as it stands, the current model of primary and community care is not organised in a way that can deliver this shift.

In some ways this is not surprising. One of the bigger pragmatic compromises Bevan made in winning support for the NHS Bill was an agreement to leave the existing model of general practice broadly in place. GPs continued as private sector providers, delivering for the NHS as independent contracts.

This approach is not without its advantages. Indeed, it served us well for many decades after the formation of the NHS. But in an era of rising sickness and long-term, complex conditions, its limitations are also increasingly visible.

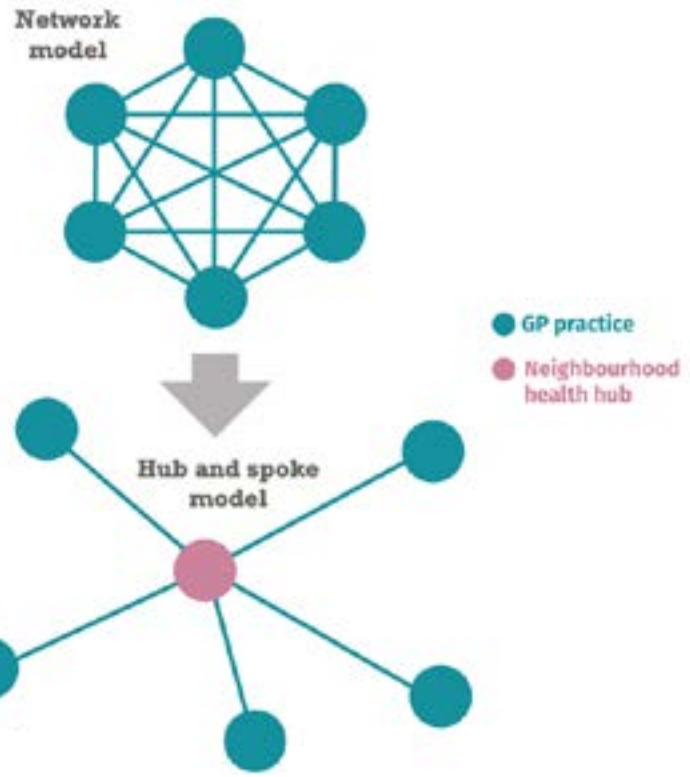
- It leaves GPs on the outside of the service, often meaning that acute providers are prioritised for new capacity, resource or power. The system often gives these things to the parts of the health system it has more levers to direct.
- It encourages small scale providers who, without means to deliver at scale, struggle to provide the broad range of services the population increasingly needs.
- As a unique operating model in the NHS, it allows siloes between providers – notably, but not exclusively, between primary and secondary care.
- It is increasingly shifting risk onto general practice partners – including the risk of not being able to find new partners to take their share in a small business when they want to retire.
- As the business and bureaucratic demands of primary care and general practice have increased, it is a growingly unpopular career choice for junior doctors – many of whom want opportunities for research, clinical work and leadership, rather than to run their own small business.

Any success in bringing more care into the places and communities people live will need a new approach. IPPR has long called for an alternative that we call the 'Neighbourhood NHS' as a foundation for successfully bringing more care into the places we live. The Neighbourhood NHS would have two key objectives.

1. **Delivering on continuity:** Continuity of care can help ensure services are more preventative – including being better at providing the bespoke, long-term condition management that can support secondary prevention. Yet levels of continuity are in decline. While not everyone needs continuity – some patient populations will prefer fast access – it can be particularly helpful for those with on-going and complex health needs.
2. **Delivering on scale:** The rising and increasingly complex health needs of the population demand a wider range of services best located in the community, including diagnostics, mental health services, pharmacies, social prescription and more. This is only feasible if general practice and primary care work at much greater scale. Attempts to achieve this through 'network' approaches (eg Primary Care Networks) have not had huge success.

On the surface, these might seem like contradictory objectives: greater scale is not intuitively compatible with greater continuity and more relational care. But there are models that can bring both together within a 'prevention first' model of healthcare – what we call a 'hub and spoke model'.

FIGURE 4.11: THE HUB AND SPOKE MODEL OF PRIMARY CARE



Source: Authors' analysis

A hub and spoke model would allow for the separation of responsibilities: the hub focusses on delivering scale, while the spokes (individual GP practices, pharmacies) focus on delivering continuity.

Currently, Primary Care Networks (PCNs) can provide a range of 'enhanced' services such as depression counselling, atrial fibrillation screening and smoking cessation, and access pots of funding to support this expansion. But in practice, with GPs

stretched thin, few have been able to dedicate the time and resource needed to make expanded service provision a success.

At a minimum, we suggest new primary care hubs – one for each neighbourhood, possibly piloted in the first instance within HAPI Zones (see above) – which join up primary care, community care, mental healthcare, diagnostics, social care access and some public health services (eg services provided through the ringfenced public health grant). These would come within a single site, where patients can access 'teams without walls' under one roof.

Hubs would not have directly registered patients but would instead act as a second order mega list of all patients covered within a PCN. This will ensure that local relationships between GP practices and communities are not eliminated, but the benefits of scale can be realised. In turn, we suggest all population health management and enhanced service provision responsibilities are shifted to hubs and away from individual GP practices, allowing them to focus on patient-facing care and continuity of care.

At their best, these hubs would be opportunities to genuinely engage communities and strengthen their ownership of their local NHS services. Tangibly, this would mean starting the design of new hubs, *not* with ICSs but with communities themselves. Hilary Cottam, among others, has argued that primary care services should begin by deliberating with people who have a range of needs, including complex needs, about what they would like to change in their life. This can identify both where there are untapped assets in communities that can be brought into a mission, and where resource needs to be shifted, to create new capacity or services. What emerges often blurs the line between healthcare and wider social policy – and between state delivered healthcare and civil society (see Cottam 2022).

This might best be facilitated by a shift from loosely federated partnerships (PCNs) and towards a model of Neighbourhood Care Providers (NCPs), as previously recommended by IPPR (Thomas & Quilter-Pinner 2020). If ICSs provide a vehicle to formalise system work, to begin working together as a single team, to facilitate partnership and to deliver real population health management for large populations, then it is striking that there is little equivalent at the neighbourhood level. Creating one could help align culture, strategy and incentives – but more importantly, it could also provide a vehicle for population health planning. NCPs could either be newly created or formed by existing community trusts, more advanced PCNs or multi-speciality community providers (MCPs). Over time these NCPs should take on the contracts for primary, mental health and community care. They could also deliver social care and public health in order to really fulfil the possibility of population health.

The major expense in delivering on a hub and spoke model would be the capital outlay in constructing and equipping new Neighbourhood Health Centres (the 'hubs'). An authoritative estimate on the investment needed is challenging, as the cost will vary widely across the country. However, based on a sample of previous costs for constructing hubs (£4 million per hub in Wales to £17 million in Havering), we suggest that building one hub per c.30,000—50,000 people in the UK would cost around £12.5 billion (with wide confidence intervals of £5 billion to £20 billion). This could be done over a 10-year period, through an annual uplift in NHS expenditure of around £1.25 billion per year.

CASE STUDY: REGENT PARK COMMUNITY HEALTH CENTRE, CANADA

Founded in 1973 in one of Toronto's poorest neighbourhoods, Regent Park focusses on health promotion and disease prevention through multi-disciplinary teams, with local leadership and a community-based board of directors.

Early services ranged from free dentistry for those in need, to the East Africa Health Program supporting – and largely delivered by – recent immigrants. Social workers offer goal-focussed counselling, while community development invites locals to act together on shared problems.

1. **Keeping well:** 85—90 per cent screening rates for major cancers, well above national average. CHC patients across Ontario go to A&E 21 per cent less than comparators (Dale McMurchy 2023).
2. **Wellbeing and prosperity:** Pathways to Education programme for 'academically at-risk' young people reduced drop-outs by 70 per cent, and improved post-secondary enrolment threefold, with a 24:1 return on every dollar invested. The model has since expanded to CHCs across Canada.

CASE STUDY: COHEALTH MELBOURNE

cohealth is an Australian not-for-profit community health service, with 30 sites across Melbourne. Each centre delivers primary healthcare and community-based support including at least one 'vanguard' regional initiative per service, with management by community boards.

Programmes include community leaders trained as 'health concierges' for screening, housing and financial support, and bicultural mental health liaison workers from the refugee community. Many centres also co-locate GPs on-site, who focus on clinical care and refer to services as needed.

Recommendation 19: **The government should found the Neighbourhood NHS: a new system of 'hub and spoke' general practice. Hubs should lead major preventative service offers at scale, while spokes focus on continuity of care and long-term condition management. Specifically, the government should invest £1.25 billion per year in creating hubs in every neighbourhood over the next decade.**

3. HOW HEALTHCARE IS FUNDED

NHS attempts at reform are often undermined by a 'feast or famine' approach to healthcare funding. By this, we mean the habit of NHS funding oscillating between years where there is more money than it can efficiently absorb, and years where the gap between demand and funding cannot be wholly addressed.

The last five years have seen this cycle play out on fast-forward. In 2019, the NHS seemed to have longer-term funding certainty, from the funding allocated to the NHS Long-Term Plan (2019). It was undermined in 2020 by the Covid-19 pandemic, although this shock quickly prompted then-chancellor Rishi Sunak to promise the NHS a 'blank cheque'. By mid-2022, the government suggested that the NHS would need to roll back funding expectations. Through 2023, the focus had returned to efficiency drives – and a (rare) real terms fall in funding for the 2024/25 financial year.

This poses a problem for reform: to change how the NHS works, to be more preventative, more anchored in community, more personalised or more innovative often requires 'double running' – running the old service during a period of transition to the new. The NHS has little-to-no capacity to pause hospital care today, to free up money to invest in prevention that will reap benefits years or decades in the future. 'Feast or famine' does not allow it to fund a transition for two reasons: a) it creates future uncertainty that undermines investment; and b) it creates a status quo where innovation is cut or shut down during regular famine periods ('efficiency').

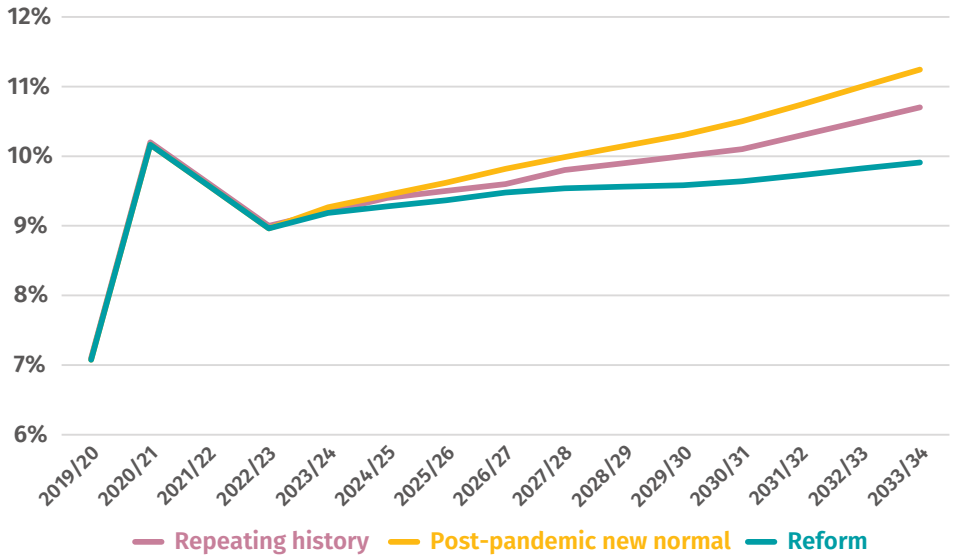
In other words, it embeds risk aversity because worse times are always imminent, it undermines experimentation, and it creates a short-termism incompatible with innovation. Our current approach to funding is anathema to a mission-orientated healthcare approach.

But this commission has strongly articulated that simply providing endless money – permanent 'feast' – cannot be the answer either. We recognise that an unchecked rise in healthcare expenditure may have undesirable consequences: that it might squeeze out investment for other public services, worsen the NHS's ongoing productivity challenges and act as a disincentive for innovation and prevention. The answer needs to be more sophisticated.

Our proposal is that the NHS needs a long-term funding deal that genuinely looks across the next 10 years. In the first five years, money may need to be front-loaded – to provide the basis for transformation. But the very strong expectation should be that over time, the NHS 'bends the curve' towards more sustainable levels of funding (as a proportion of GDP). To further enable long-term investment, the government should take every opportunity to move the NHS away from single-year and towards multi-year budgeting.

FIGURE 4.12: PREVENTION AND PRODUCTIVITY IMPROVEMENTS COULD 'BEND THE CURVE' ON HEALTHCARE COSTS AND IMPROVE QUALITY

Government healthcare spending in England as a share of GDP under three different scenarios



Source: Patel et al 2023

Our analysis has shown that this is possible. Working with LCP, we modelled what would happen to NHS funding if healthy life expectancy were to improve and productivity were to rise (indicating successful reform). We find that the difference between this path and our current trajectory would reach £20 billion by 2033/4 – or the equivalent of the entire defence budget.

To which end, a 10-year funding scenario should come with strings attached. These could include expectations on productivity. But as importantly, they should include an expectation that the composition of the NHS's budget finally changes. In the last decade, the proportion spent on primary/community care, acute/hospital care and preventative interventions has remained broadly flat. 2020 and 2021 were exceptions to this rule, with primary and preventative spend increasing in response to the pandemic. But as of 2022 (latest data), this has more than reversed, with hospital spending reaching its highest level in a decade (50.2 per cent). We propose that the government stipulates that NHS spending for out of hospital care should reach 15 per cent of the total NHS budget, and that spending on preventative services should reach at least 8 per cent (currently 8.9 and 3.9 per cent respectively).

The exact amount the NHS needs over time has not been a focus of this commission, which has been an enquiry on health, not solely an enquiry on the future of the NHS. However, a final point worth making is that the new government is right to say that economic growth makes NHS funding easier. For example, we find that a 1 per cent increase in people's earnings above and beyond current projections would secure an estimated £37.9 billion by 2029/30 – above the level of investment we have previously indicated the NHS might need to deliver higher standards.

FIGURE 4.13: SUSTAINABLE NHS FUNDING IS FAR EASIER IF REAL WAGES GROW FURTHER AND FASTER

Predicted revenue benefits of earnings growth above baseline, with no change to tax, 1 per cent increase in income tax and 2 per cent increase on higher income tax rates (£bn)

2029/30	No change	1% on all income tax rates	2% on higher/ additional income tax rates
With forecasted earnings growth	0.0	10.9	8.7
+0.5% additional earnings growth year on-year	19.1	30.3	28.1
+1% earnings additional earnings growth year-on-year	37.9	49.7	47.4

Source: Authors' analysis

To that end it is important to end by noting the dependency of the NHS in the medium to long term on the success of the broader vision this commission has set out. This has been a report on the role of population health in achieving economic growth and wider prosperity. The success of the proposals in previous chapters will make a long-term funding settlement for the NHS – more generous in the immediate future to enable reform – more plausible. That is, our health service is dependent on our health – an outcome that it only partially controls.

> Recommendation 20: **The government should map out a 10-year funding plan for the NHS based on providing upward investment early, to deliver the reform that enables funding sustainability in the longer term.**

CONCLUSION: A MISSION FOR THE NEXT PARLIAMENT

The Commission on Health and Prosperity set out to explore the relationship between our health and our economy at a time the UK is experiencing decline on both fronts. We have demonstrated not only that health has a profound value, but that its benefits are well matched with the UK's clearest structural economic weaknesses.

From there, we have proposed the formation of a health creation system to work alongside a universal, free at the point of use sickness service. In an era defined by chronic rather than acute health need, the country cannot thrive without both. It is self-evident people will fall sick, and that they will need quick access to fast, effective treatment. But it is also clear that the ability of that system to manage need and exist sustainably is dependent on the UK having a strategy to prevent need. Without that, everything collapses.

The commission has proposed five pillars for a health creation system, orientated around the places people spend their time and on the things that most impact health, and where intervention is most possible: workplaces, markets, families, places and within the NHS's primary and community services.

We propose the formative aim of the health creation system is a new mission to add 10 years to healthy life expectancy by 2055. This is at the edge of what is achievable, and what is aspirational. The best comparable countries to the UK have demonstrated similar improvements, but only with concerted effort and a whole-society approach. It depends on us all pulling all the levers available to us.

Our focus has not been a blueprint for 30 years. Such an exercise would be futile. Instead, we have orientated our policy recommendations around the next parliament. Our core question has been, what would need to be true by the end of the 2030s for the UK to have built the foundations to set off on and begin to achieve such a bold mission?

In this conclusion, we bring our policy recommendations together into a single framework. Throughout this report we have described policies that amount to 10 foundations to add 10 years to healthy life expectancy over the next three decades.

1. Healthy work and workplaces.
2. Support into appropriate work after we fall sick.
3. Protection from products that make us sick.
4. Meaningful access to products that support our health.
5. The services and support we need at the start of life.
6. Financial security and freedom from childhood poverty.
7. Places to live that support our health.
8. Access to community assets, like libraries and leisure centres.
9. Access to a neighbourhood health centre.
10. Access to a brilliant sickness service, when we do need it.

In many ways, these policies are a truer expression of the initial 'cradle to grave' sentiment proposed by the NHS. Except where most of us currently interact with the NHS only at 'cradle' and then near 'grave', this framework brings health into our whole life: our childhood, the place we choose to live, the work we choose to do, the shops we use and the hobbies we enjoy.

While we recognise that implementing this plan is not cheap, we believe the potential return is huge. For all the data on the poor state of our health and economy, this commission has been focussed on an opportunity: that health might just be the clearest untapped route to prosperity. At a time when the UK has perishingly few paths to a fairer, more sustainable and happier future, it is one we must surely now grasp.

APPENDIX

FULLY FUNDED, FULLY COSTED

To support delivery in the next parliament, we have fully costed our plan for health and prosperity. Overall, we suggest our interventions have the following cost implications over the next five years.

TABLE A.1: COSTING OF MAJOR POLICY RECOMMENDATIONS (£BN)

		2025/6	2026/7	2027/8	2028/9	2029/30	Mechanism
Neighbourhood NHS	Current						Borrowing
	Capital	1.3	1.3	1.3	1.3	1.4	
New Food Subsidy	Current	3.7	3.7	3.8	3.9	4.0	Health levies
	Capital						
R&D investment (additional)	Current						Borrowing
	Capital	2.6	3.2	3.8	4.4	5	
HAPI zones	Current	3.7	4.1	4.5	4.9	5.2	Health levies
	Capital						
Free school meals	Current	3.3	3.2	3.2	3.2	3.2	Health levies + wealth tax eg IHT
	Capital						
Restart Sure Start	Current	0.2	0.5	0.9	1.4	2.1	Wealth tax eg IHT
	Capital						
Two-child limit + benefit cap	Current	3.0	3.2	3.4	3.7	3.9	Wealth tax eg IHT
	Capital						
Total	Current	14.0	14.7	15.8	17.1	18.4	
	Capital	3.9	4.5	5.1	5.7	6.4	

Source: Authors' analysis
Note: All figures are in cash terms

Overall, fully implementing the plan proposed by this commission would reflect an £18 billion investment in the future of health and prosperity in Britain. We propose that the return possible through this investment – particularly in the long term – far outweighs this outlay. Successfully delivering healthier lives promises to increase growth, productivity, work and public finances. We propose that the government funds these interventions in a few different ways.

Borrowing

The government has committed not to use borrowing to pay for day-to-day spending. However, there is still an opportunity to use borrowing to invest in

growth-generating infrastructure. We have therefore recommended that increased borrowing is used to cover capital components of our policy recommendations.

Health taxes

Combined, our proposed health taxes, have significant revenue raising potential as part of a healthy industrial strategy. By the end of the next parliament, we estimate levies could raise £10.3 billion of additional revenue:

FIGURE A.2: REVENUE-RAISING POTENTIAL OF OUR PROPOSED HEALTH LEVIES (£BN)

	2025/26	20262/7	2027/28	2028/29	2029/30
Gambling	2.9	3.0	3.2	3.3	3.4
Tobacco	0.7	0.7	0.8	0.8	0.8
Alcohol	0.4	0.7	1.0	1.4	1.8
Food	3.6	3.7	3.7	3.8	3.9
Vapes	0.0	0.1	0.4	0.4	0.5
Total	7.6	8.2	9.1	9.7	10.4

Source: Authors' analysis

We propose this revenue is used to directly support people on lower incomes or more deprived parts of the country – where health and economic outcomes are often concurrently worse. It should cover food subsidies and HAPI Zones (including investment in community infrastructure).

Wealth taxes

We propose remaining policy recommendations are funded through wealth tax. While work is currently overtaxed in the UK, wealth is undertaxed. We see a particular opportunity to increase inheritance tax, particularly to fund policies concerned with restoration of the health inheritance of future generations and restoration of a children's health inheritance.

We estimate that increasing inheritance tax from 40 to 50 per cent would raise up to £1.9 billion per year by the end of the next parliament, while scrapping agricultural and business asset reliefs from IHT would add a further £1.7 billion. This would cover the end of the two-child limit and benefit cap.

An alternative, which would raise a larger amount of revenue, would be to end special treatment for capital gains in the UK. If everyone who makes capital gains paid the same tax rate as earnings from work, previous IPPR research has estimated the UK could generate tens of billions in the coming years (Dibb & Parkes 2022). This would comfortably cover the recommendations linked to wealth tax in figure A.1.

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