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Fit for the Future: How a Healthy Population Will Unlock a Stronger Britain

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Our Future of Britain project seeks to reinvigorate progressive politics to meet the challenges the country faces in the decades ahead. Our experts and thought leaders are setting out a bold, optimistic policy agenda.

Executive Summary

In our paper *A New National Purpose: Innovation Can Power the Future of Britain*, [1] we set out the need to both harness the power of new technologies and to create a streamlined, strategic state to revolutionise the delivery of public services.

Nowhere is this approach more urgently needed than on the country's health. By moving at speed to create a new public-service model, with the right enabling policy infrastructure, it will be possible to increase population health, unlock long-term economic growth and make Britain fit for the future.

While detailed evidence on the drivers of population ill health is still emerging, it is clear that individual factors including lifestyle, the environments in which we live and the genetic material we inherit account for between 70 per cent and 90 per cent of what constitutes health. In contrast, treating sickness accounts for as little as 10 per cent, but consumes more than 90 per cent of available resources.

Health-care demands continue to increase while costs are spiralling as health takes up an ever-higher proportion of public spending. At the same time, outcomes are deteriorating, with UK life expectancy stagnating and health inequalities on the rise. So, we're all paying more and more to achieve less and less.

These problems are being driven by our current approach, which is almost entirely focused on treating sickness. As a result, the National Health Service (NHS) is overwhelmed by rising demand, with more than 7 million people waiting for treatment. This was brought home during the recent winter crisis, which resulted in thousands of excess deaths and showed the cost of ongoing inaction.

What's more, with more than 2.5 million people out of the labour market due to long-term ill health, any sustainable plan for growth needs to have improving population health and prevention at its heart.

This calls for a paradigm shift: we must begin to treat individual and collective health as a national asset. Government must focus its efforts and resources on creating the conditions in which population and individual health can flourish.

This means much greater political attention and public funding directed towards preventative-health measures alongside support for the drivers of good individual health, including personal, environmental and workplace factors.

And we must accelerate and adopt new advances in technology that can enable health professionals to make earlier and more effective diagnoses, alongside interventions that can empower individuals to take greater personal control of and responsibility for their own health. In addition, we need a tougher regulatory approach to make it easier for people to live healthier lives and a new institutional framework that makes government more accountable for public health.

These efforts often face accusations of "nanny-statism". Instead, they are about providing individuals with meaningful choices and a sense of collective social responsibility – which are critical under a taxpayer-funded health-care system – and are being aided by the advent of new technologies.

To deliver on this vision, we must overcome several long-standing barriers, including: 1) outdated delivery models that remain overly focused on the NHS and central government; 2) tensions between fiscal and economic priorities, which have hampered investment in prevention, new technologies and population-health measures that take time to bear fruit; and 3) political short-termism, which undermines health reforms that require sustained policy interventions.

The NHS will always be a priority for constituents and the politicians who represent them, but creating a healthy population must also be a priority. [2] Only by helping people better understand their individual risks and supporting them to have meaningful choices will we help them to live longer and healthier lives. Only by improving population health and prevention will we begin to alleviate unsustainable burdens on the NHS and ensure people can still get access to treatment when they do get sick. And only by investing in our health as a national asset will we create the long-term sustainable economic growth and prosperity that will benefit us all.

Poor Health Is a Major Structural Weakness

The National Health Service (NHS) is simultaneously suffering from two illnesses: one acute, one chronic. In the short term, acute pressures and the continuing consequences of Covid-19 have culminated in the collapse of urgent care and a seemingly insurmountable backlog of elective treatment. [3] Patients are paying the price and we are still seeing more than 800 excess deaths a week, compared to the five-year average. [4]

But this is just the latest and most severe expression of a much deeper problem. Chronic challenges and systemic issues have left the UK exposed to a perpetual cycle of winter crises and pose an existential threat to the future of our health and social-care system. Consistent underinvestment, an outdated and inefficient service model, and stalling productivity have constrained capacity over the past decade. But it is the country's failure to manage *demand* that is by far the greater driving force behind the increasingly overwhelmed and unsustainable health service.

The United Kingdom (UK) has become one of the unhealthiest populations in the Organisation for Economic Co-operation and Development (OECD). After steadily rising through the course of the 20th century, UK life expectancy has stalled in the past decade and for the male population even begun to decline since the pandemic. The country now sits at number 29 in a global comparison of life expectancy, down from a ranking of seven in 1952. [5] Worse still, healthy life expectancy (the proportion of our life spent free of disability or disease) has risen less quickly than life expectancy in recent decades. In absolute years, we now spend more of our life in poor health than someone living in the 1800s.

Meanwhile, there has been a marked rise in health inequalities. A male in the London borough of Kensington and Chelsea can now expect to live for 95.3 years while in Blackpool, male life expectancy is just 68.3 years – a staggering 27-year difference. [6] Infamously, life expectancy drops by a year for every two stations as you travel east from Westminster on the London underground. [7] As a result of these trends, *The Economist* recently estimated that a quarter of a million more Britons died sooner than expected compared to our European peers between 2012 and 2022. [8] The human cost of inaction is mounting.

Lower Productivity and Greater Inactivity

The economic consequences of the UK's poor health are also beginning to bite, leading to lower productivity and greater economic inactivity, harming our prospects for growth. [9] Almost 2.5 million people in the UK labour force are currently unable to work due to ill health and around 17 per cent are

reporting long-term ill health. [10] The Confederation of British Industry (CBI) estimates that 130 million working days are lost due to illness every year. Supporting workplace health could reduce this by between 10 and 20 per cent to generate £60 billion annually for the UK economy – equivalent to almost 3 per cent of GDP. [11]

Meanwhile, smoking, obesity and mental-health-related issues alone are estimated to cost the UK economy almost £200 billion a year. [12, 13, 14] As shown in Figure 2 in the next chapter, many of the drivers of these costs are down to lifestyle, the environments in which we live and genetics.

Poor health has become one of the most significant structural weaknesses of the UK economy. As Andy Haldane, former chief economist of the Bank of England, put it: "The UK is suffering from a weakened, and weakening, societal immune system… this is constraining both our capacity to grow and our resistance to shocks… [and] explains why the UK has suffered anaemic growth." [15] We, quite literally, cannot afford for this to continue.

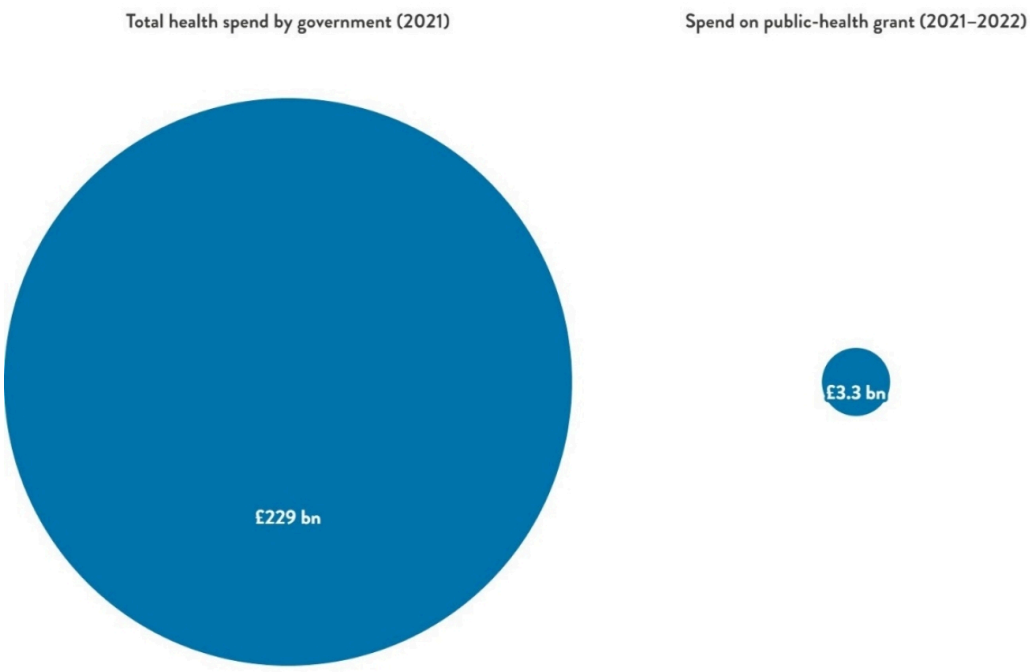
Collectively, this paints a bleak picture of a health-care system on the brink of collapse and a failure of health outcomes at the most fundamental level. Continuing this trajectory will further reduce our life chances, undermine our resilience to future global-health risks, constrain our economic potential and lead the NHS further down an unsustainable path. This is morally, fiscally and economically untenable.

A Paradigm Shift

Radical change is needed. But this cannot simply be more money for the NHS, although this will be required. Focusing solely on addressing supply, without resolving the root causes of demand, is no longer a fiscally sustainable approach given the ever-growing proportion of our country's economic output that health spending consumes. The UK government spent £229 billion on health care in 2021. [16] Around 44 per cent of all day-to-day public-service spending is expected to go towards health by 2024–2025 [17] and by 2050, the Office for Budget Responsibility (OBR) forecasts the UK will spend more than 13.7 per cent of its GDP on health. [18]

Focusing almost exclusively on treating sickness is no longer viable. The UK reached diminishing returns for every pound spent, even before the most recent crises. Yet almost 99 per cent of all health spending currently goes towards treating ill health as opposed to promoting health and wellbeing. This is despite estimates that public-health interventions are three to four times more productive at the margin than average health-care expenditures. [19]

Figure 1 – The UK government's total health spend for 2021 far outweighed the public-health grant for 2021–2022



Source: ONS

Instead, public-health funding has been severely reduced since 2015, leaving the system woefully under-resourced. As a prime example, the public-health grant – funding paid to local authorities to deliver preventative services and support health more widely – has been cut by 26 per cent per person in real terms since 2015–2016. [20] The most deprived areas have tended to see the most severe reductions, further ingraining regional health inequalities.

A paradigm shift is needed. The priority must be creating and maximising health, not just avoiding sickness or providing a safety net when things go wrong. Much greater political attention and public funding must be directed towards preventative-health measures. This means greater focus on primary prevention, to prevent disease, greater focus on secondary prevention to enable early detection and intervention, and greater focus on tertiary prevention to avoid further complications. But it's not just about funding. The delivery and adoption of new technologies that can enable health professionals to make earlier and more effective diagnoses, and can empower individuals to take greater personal control and responsibility over their own health, will be vital.

Prevention alone is insufficient. We must go further and stop looking at health as a deficit model, limited to only slowing an inevitable decline. We need a tougher regulatory approach to make it easier for

individuals to make healthier choices and we need the institutional framework which can hold government to account on public health.

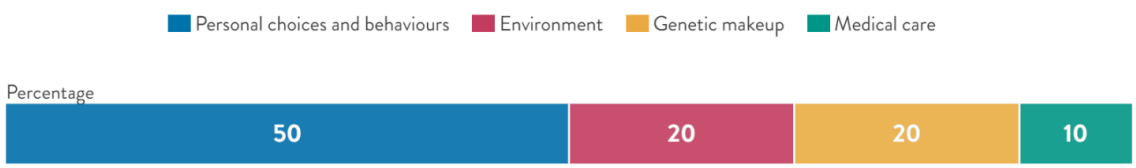
Health can be improved. And healthier individuals and communities will lead to improved quality of life and economic productivity. If we think of health as a national asset that can drive social and economic prosperity, then health creation should be our goal. [21] This "shift-left" means focusing more attention and resources on the drivers of good health including personal, environmental and workplace factors as well as preventing and treating ill health. This distinction is more than semantic: the drivers of health are not necessarily the converse of those causing disease. The government must create the conditions in which health can flourish.

Unfortunately, the recent Spring Budget 2023 underlined the government's lack of ambition and willingness to address these underlying issues. While the chancellor announced a helpful £400-million support package to improve mental health and musculoskeletal resources for workers, [22] this is a relatively small sum compared to the estimated £118 billion [23] impact that mental health alone is estimated to have on the UK economy every year. And it remains targeted too far downstream. Meanwhile, the public-health-grant allocations for 2023–2024 were subject to a flat real-terms settlement, giving local authorities little time to prepare and little room to manoeuvre ahead of the next financial year. [24]

No More Waiting for Life's Lottery

The country needs to be more strategic and much bolder. Scientific and technological advancements are making prevention and health creation more achievable when we choose to invest in them. Advances in genomics, data science and AI mean that in many cases it is possible to anticipate what lies around the corner, equipping people with the information they need to live longer and healthier lives. Personalisation of health increasingly allows for an understanding of individual circumstances, needs and risks ever more precisely and proactively. This is enabling improved population-health measures, but also the targeted identification of risk at an individual level.

Figure 2 – Individual behaviours, the environments in which people live and genetics are the biggest determinants of health

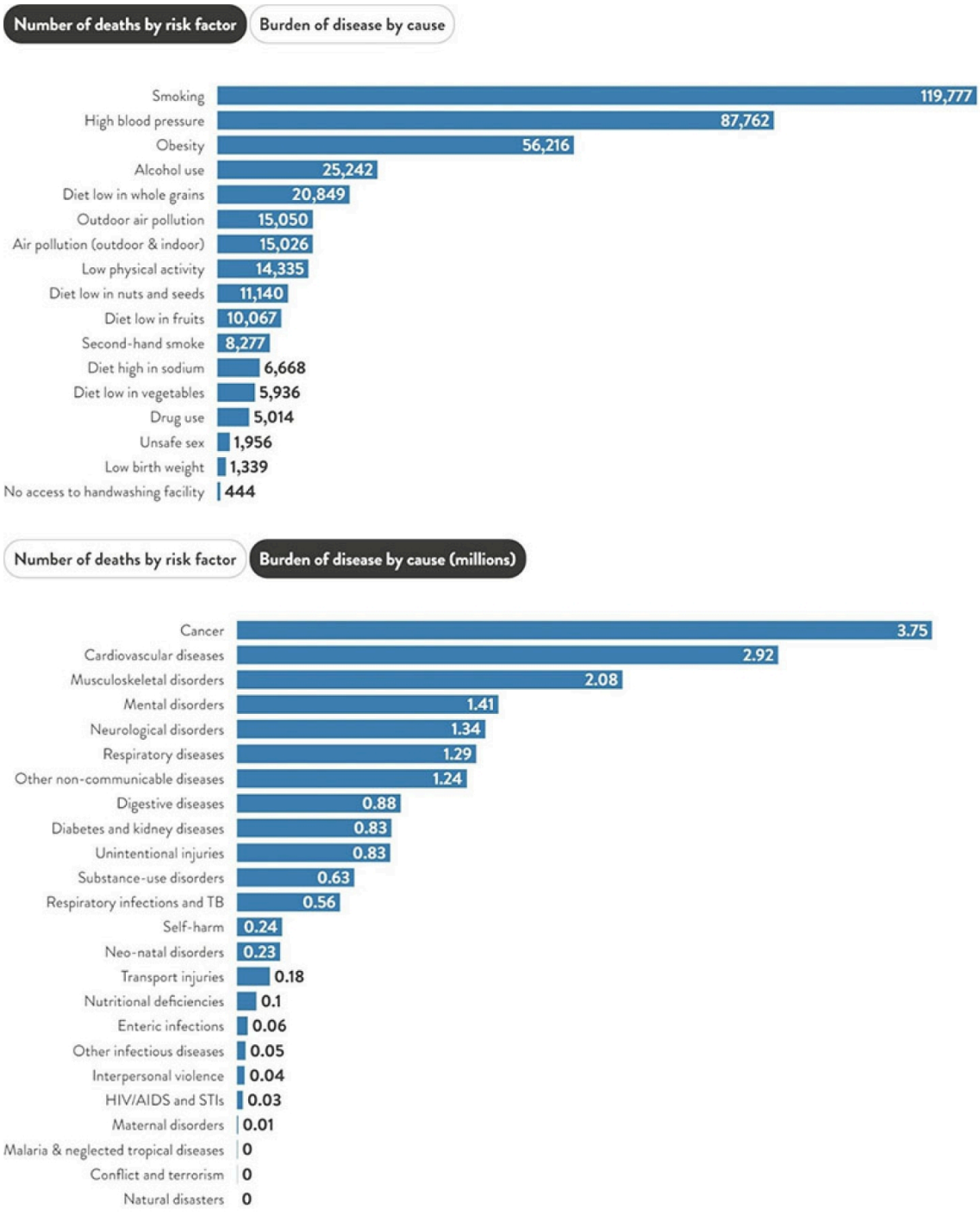


Source: Health Affairs

While the causal links are complex and detailed evidence on the drivers of population ill health is still emerging, it is clear that genetics, environment and, most significantly, behaviours account for between 70 and 90 per cent of what constitutes health. In contrast, treating sickness accounts for as little as 10 per cent but continues to consume more than 90 per cent of available resources.

Strong political leadership is needed to address this problem and tackle the major drivers of population ill health – from environmental factors such as poor air quality to behavioural factors including poor diet and inactivity. Lessons from Japan, [25] Singapore [26] and Sweden [27] have shown the effectiveness of delivering on strategic public-health policies. These interventions have been shown to work in the UK too. Take smoking. In 2007 one of the biggest public-health interventions for a decade was introduced to protect both smokers and those harmed by passive smoking. It became illegal to smoke in any pub, restaurant, nightclub, most workplaces and work vehicles. Research suggests that after the ban, the prevalence of smoking in the UK fell from 20 per cent in 2011 to 14 per cent in 2019, with reduced rates of hospital admissions for heart attacks. [28, 29] Similarly, the introduction of minimum pricing on alcohol in Scotland was associated with significant reductions in deaths and hospitalisations wholly attributable to alcohol consumption. [30]

Figure 3 – The main drivers of disease and death in the UK (2019)



Source: Our World in Data

Crucially, these interventions are both effective *and* cost effective. Studies show that public-health interventions [31] present better value for money than further investments in the NHS. A recent study by York University concluded that "public-health expenditure, at about £3,800 per [quality-adjusted life-

year] QALY, appears to be about three to four times more productive at the margin than health-care expenditure (which costs about £13,500 per QALY)". [32]

The benefits of focusing efforts on improving population health could be enormous. McKinsey & Company's *Prioritizing Health* report estimated that by applying known health interventions, the global disease burden could be reduced by 38.2 per cent. [33] Applying this model to UK data suggests the country's individual disease burden could be cut by approximately 32 per cent. The economic benefits of achieving this would be significant. Health creation must therefore be a prerequisite of any serious growth strategy. The pandemic has resulted in a heightened focus on health. Political leaders must seize on this momentum and the opportunities offered by advances in data and technology to deliver a new agenda on health. We can't afford incremental change. A paradigm shift is needed.

Fit for the Future

The case for change is clear, but progress has been slow. Indeed, the debate about moving the NHS towards a preventative model has been live for almost as long as the health service has existed. Despite strategies and policies over the years, progress towards a truly preventative (and health-creation) model has been slow, failing to hold back the deterioration in health outcomes previously described. For example, since 1992, 14 different obesity strategies have been published by successive governments, yet levels have continued to rise, with almost 28 per cent [34] of the UK population now considered obese.

Ineffective policy design – typically relying solely on individual agency – and poor implementation in response to fears of nanny-statism [35] have partly been to blame here. But more broadly, there have been three overarching barriers to successful public-health policy.

First, the continued reliance on outdated delivery models that are too heavily focused on the NHS. Prevention and health creation cannot be addressed by one sector or organisation alone. Health, as opposed to care, pervades all aspects of life and is helped or hindered by decisions made by many. Individuals, employers and communities, alongside government, must be empowered and incentivised to act. Our current public-service-delivery model, in combination with a predominantly medical approach to health, does not reflect this sufficiently and needs significant redesign.

Second, the need to simultaneously spend on health and health care, given the time lag between investing in prevention and seeing reductions in health-care demand. This tension between fiscal and economic priorities is not unique to health but must be addressed to put the UK, and the NHS, on a more sustainable footing.

Third, the problem of political short-termism and courage. As has been seen previously with climate change, there is limited political will to act in the long-term interests of the country and take on vested interests when political cycles are short, and the media focus is on NHS performance. But mechanisms have been found to bind governments into action on climate change so similar ones should be applied to prevention and health creation.

A new public-service model, with enabling policy infrastructure, is needed to drive progress and hold the government to account to begin turning the tide on individual and population health – and make Britain fit for the future.

Recommendations: Creating the Right Policy Infrastructure to Achieve a Paradigm Shift

The ambition to create health, not just treat sickness, is not new. However, too often policies have been pursued without addressing fundamental political, structural and cultural barriers. As a consequence, many well-intended policies have been inadequately implemented, as the example of obesity strategies illustrates. [36]

To break this cycle, a new policy architecture to drive progress is needed. Recognising that it is impossible to bring about the required paradigm shift through incremental changes alone, the recommendations below reflect the complexity and range of architecture needed for the transition. Central to this transition is acknowledging the complexity of service provision and being prepared to devolve policy design locally as part of a modern public service while ensuring that health creation is hardwired into the machinery of government. In essence, the three critical barriers of delivery, funding and political short-termism, which will enable the transition towards prevention and health creation, need to be overcome to succeed.

Empowering Individuals, Businesses and Regional Bodies to Participate in Health Creation

Since health permeates all aspects of life, there is no one sector, organisation or authority that can make it happen in isolation. Empowering individuals, businesses and local leaders to participate in health creation will be crucial.

Central government has a key role in orchestrating the required overall policy direction. This requires recognising the complexity of citizens' lives, differing social and economic conditions, and geographic variances while providing the NHS, local authorities and regional bodies with a higher degree of autonomy. Collaboration across traditional public sectors will be essential, as will working closely with the private sector and local communities.

Only then will individuals have adequate choices, whether by giving them greater access to their health data or implementing bold strategies on smoking, obesity and mental-health issues, which remain the three greatest drivers of ill health in the UK.

1. Providing individuals with more choices and supporting them to make better ones

More than 50 per cent of people in the UK do not think the government has the right policies in place to improve public health. [37] It must therefore strike a better balance between providing individuals with meaningful choices to live healthier lives while enabling greater personal responsibility.

Government has an active role to play in supporting individuals to make better choices. In the past, the biggest gains have come from regulations such as seatbelts, tax on sugary drinks and smoking bans. The public strongly agree that government has the most responsibility for preventing harm from products. Therefore, taking a tougher regulatory approach through the implementation of policies such as those recommended in the Khan review, to make the UK smoke-free by 2030, and those within the National Food Strategy, to help reduce obesity, is now urgent. [38]

But government should also focus on improving the environments in which we live. For example, by building more green spaces and cycle lanes while incentivising the adoption of fitness trackers to increase physical activity. And by incentivising reformulation, restricting junk-food advertising and subsidising healthier-eating options. And by investing in sport and community centres to help people build more social connections. These types of public-health intervention are sometimes criticised as "nanny-statist" but this fails to consider the power that advertising and our local environment has on our ability to exercise healthy choices in the first place. Creating a level playing field is vital.

Of course, individuals also have a responsibility to ensure they stay healthy – a view supported by over 95 per cent of the public. [39] The role of government is to ensure individuals are empowered with the information and access they need to make healthier choices. For example, by making it as easy as possible for each person to see their personal health data and interact with the health-care system. This means investing in the digital infrastructure needed to create digital-health accounts for citizens, which should be easily accessed through the NHS App (with access for others controlled by the patient or health professionals). [40] The accounts should include all relevant health information (including, in time, genomics and epigenomics data), providing a portal for tailored communications on appointments, prescriptions, best-practice guidance, opportunities to participate in relevant clinical trials and health programmes (as with the LumiHealth programme in Singapore). [41]

2. Incentivise business-led health interventions

Employers and the private sector have strong incentives to play a significant role in health creation, given the important link between health and productivity and the direct impact of work on our health. [42] However, there needs to be more awareness of how best they can support this agenda. To address this issue, the CBI recently launched the Work Health Index to help organisations understand this area and establish benchmarks. [43] Government has a vital role in supporting such schemes and has a range of tax, spending and regulatory levers to incentivise health-promoting work cultures. The government's recent

announcement on supporting annual health checks and occupational health subsidies is a welcome move, particularly for small- and medium-sized enterprises, which employ around a third of all employees. [44] However, continued engagement with the CBI, the Federation of Small Businesses and other representative bodies should be prioritised as should action to enable employers to keep their labour force healthy.

3. Put population-level health in the hands of regional and local bodies

Greater autonomy is required for the regional bodies with responsibility for health and care but equally better forms of accountability from these leaders [45]should be demanded to improve population health and address variations. This is radically different from the existing top-down and reactive approach of the NHS and is not being fully realised in the UK, although the power of devolution is starting to be seen. For example, the latest evidence from Manchester suggests that life expectancy is better than it would have been had greater local freedoms not been granted. [46]

The Hewitt review presents an opportunity to expand and codify a devolved operating model across regions by bringing together integrated-care systems, boards and partnerships, local authorities, and those in the public, private and voluntary sectors with a stake in health. The government should capitalise on this opportunity by taking the following three steps.

First, grant regional bodies greater control over budgets and move to a shared savings model with capitated and pooled budgets to incentivise population-health management, creating the ability for regional health leaders to respond to local needs. This will only work if funding is made available across multiple years to enable longer-term investments.

Second, combine the new funding model with clear outcomes for improvements in population health that allow for transparent tracking and communications. These regional outcomes should be tied to a national measure such as the Health Index for England compiled by the Office for National Statistics (ONS) but accommodate local priorities. For instance, the routine publishing of data showing how different care systems compare on vital indicators such as mortality or cancer-survival rates. These do not exist today and unless there is greater transparency, we will not address the country's significant variations in patient outcomes. This will entail investment in infrastructure at a national level, with a step change in digital maturity to enable routine data capture and outcome monitoring and increase analytical capabilities – but there also needs to be improved support for local delivery and innovation. On this, the Office for Health Improvement and Disparities (OHID) should work with the National Institute for Health and Care Excellence (NICE) to provide accessible and up-to-date value-for-money guides tailored to public-health interventions that build on the World Health Organisation's (WHO) "best buys" [47] and learning from the Education Endowment Foundation Toolkit. [48]

Third, strengthen support for community-based prevention, with investment in a dedicated non-medical workforce that functions alongside the NHS and traditional public-health functions led by local authorities. This new class of health professionals would focus on working with individuals to address wider factors of ill health from poor diet and exercise to lack of access to secure work.

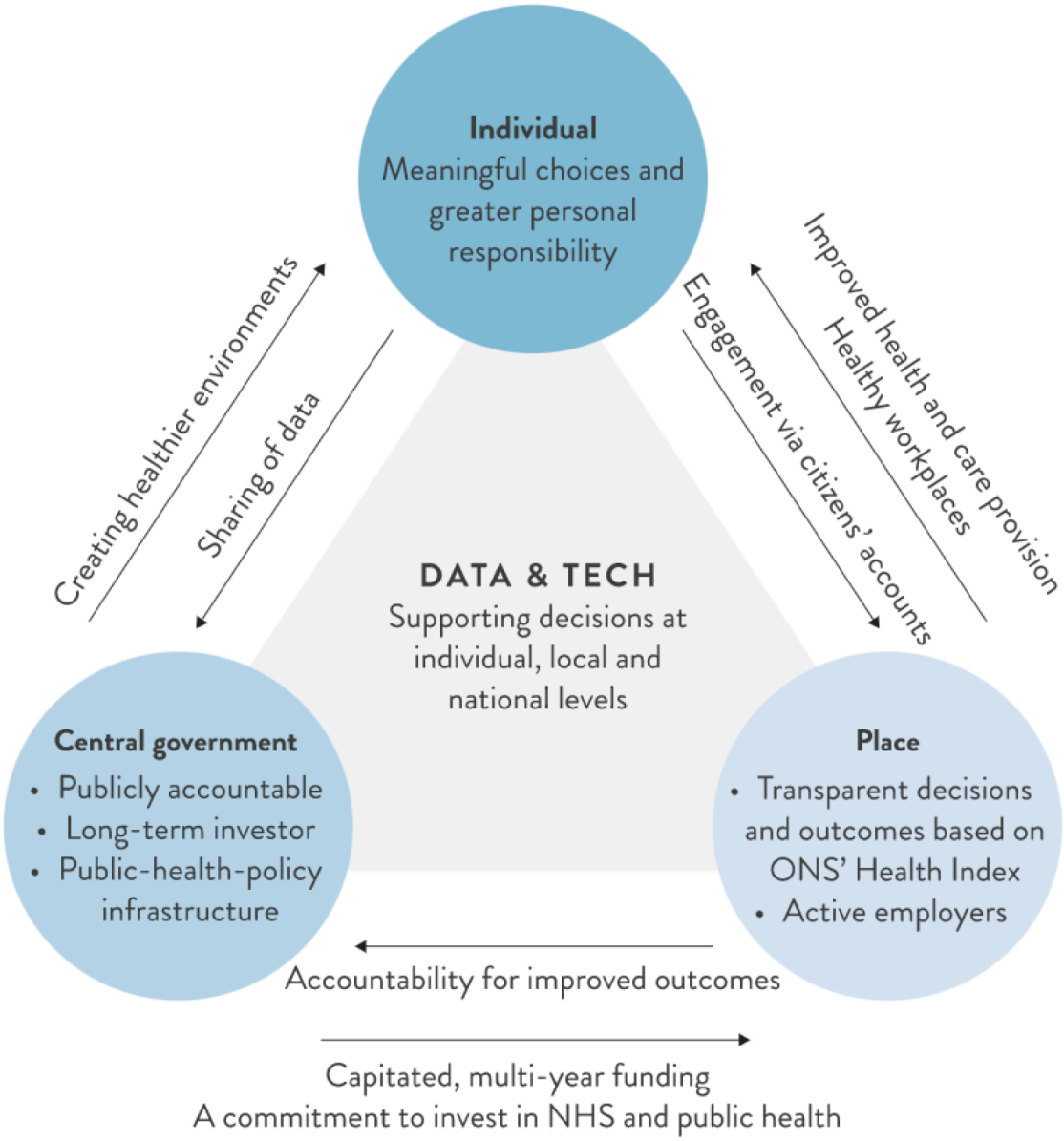
4. Build a coherent policy capacity and capability at the centre of government

There needs to be an urgent review of the capacity and skills associated with public-health policy in Whitehall, which changed radically when Public Health England (PHE) was abolished in 2020. PHE's successors, the UK Health Security Agency and OHID, remain underfunded, lack clear strategy and skills, and are at risk of being forgotten in the public consciousness. Their relationship and how they will coordinate work is still unclear, with one particular concern being the separation of responsibility for communicable and non-communicable diseases.

To implement a more coherent and impactful policy infrastructure in Whitehall – agile enough to operate successfully at all times, but crucially stretch during crises – the focus should be less on the structural machinery-of-government changes (for example, how many organisations) and more on building a meaningful operating model and strategy that can provide the necessary resources and skills to advocate for and deliver a modern prevention and health-creation agenda.

Looking beyond the UK's borders, prevention in the broadest sense also means the country needs to play its role on the global stage to be prepared for future health-security risks. The UK must remain at the forefront of this agenda in research and development (of new vaccines, therapeutics and diagnostics), within global political forums (for example, the G7 and G20) and in the provision of funding for global-health initiatives to improve preventative health (for example, the Global Fund).

Figure 4 – A new policy architecture for health creation



Source: TBI

Secure Funding and Ensure Efficient Allocation of Resources

Inevitably, there will be a time lag before a preventative approach to health care produces significant cost savings, but funding needs to be made available to shift health services "upstream" while simultaneously rebuilding a reformed NHS. Health creation has wider economic and societal benefits beyond simply reducing the demand on the NHS. The trend in declining public-health investment must be reversed, with funding allocated as efficiently as possible, to overcome this barrier.

5. Set binding public-spending commitments on health creation

In addition to immediate funding for the NHS, the government must make parallel investments in prevention and health-creation policies that can reduce demand on the health service over the medium term. To ensure adequate funding is set aside, a public commitment should be made to tie any increase in health-care spending to a proportionate increase in public-health spending. For example, for every £1 allocated to the NHS, a further 10p is designated to public-health measures. This should be tightly defined and ringfenced.

Alternatively, the government could commit to relative increases, for example growing the proportion of public-health spending from the existing 1 per cent of all health and health-care spending, to 5 per cent over the next ten years. Such a commitment would sit alongside a tougher regulatory approach and the public-health targets described below.

6. Treat health as a national asset to protect and invest in

The government should take an actuarial approach to estimating the health risk of the country to better inform decision-making and accelerate delivery of the data infrastructure needed for this function.

Under the UK's universal health-care system the state acts as an insurer, but unlike a private insurance company, it is unable to use premiums to offset risk. In the health-insurance sector, health-care actuaries use data and statistics to estimate risk and calculate the cost of premiums. The government should therefore take an actuarial approach to estimating the health risk of the nation, using this information to inform clinical decisions and public-health policy to minimise that risk rather than to raise premiums. This will mean treating health as an asset to account for, protect and invest in.

The absence of such a model is not down to a lack of data. The UK is in a unique position of having anonymised, longitudinal health records for all citizens, which are increasingly sophisticated and much richer than any private health insurer has access to. Importantly, as a state-run system, this model would avoid the adverse selection and moral-hazard issues inherent in private health-insurance markets. However, the government must accelerate delivery of the infrastructure required to bring this data together and invest in the actuarial function (either the existing Government Actuary's Department or a

bespoke NHS one) that could provide the analysis to feed into this decision-making. Moving to such a model will facilitate better clinical outcomes and targeting of resources.

7. Create a national-health balance sheet and an OBR-type independent watchdog

The government should create a unit of currency, a national-health balance sheet and an independent watchdog (akin to the OBR) for health so that the nation's health can be accounted for and scrutinised in a similar way to the public finances and our impact on the environment.

The OBR has noted that "there are clear benefits from taking a wider view of the public-sector balance sheet of assets and liabilities when thinking about long-term fiscal sustainability", particularly broader measures that recognise natural assets not accounted for by economic statistics and standard accounting. Recognising this, the ONS publishes the UK Environmental Accounts and UK Natural Capital Accounts, in addition to the National Accounts, to provide a platform for the economic consideration of climate-change impacts.

Through its Health Index for England, the ONS already produces a comprehensive measure of national health. This could become the unit of currency used to develop similar "UK Health Accounts" that could provide a platform to consider the impacts of changing public health on the economy – performed by the OBR or a specific health institution. This chosen body would also scrutinise planned government policies with significant consequences for health (also accounted for in a health budget) while providing an independent forecast of the net impact of these measures on the "UK Health Accounts" and wider public finances. These functions would demonstrate the link between health and wealth more explicitly. [49]

8. Designate public-health spending as investment, evaluating programmes over longer horizons

To better incentivise and evaluate long-term investment in public health, new categories of spending should be designated. As health, like other areas of public spending, is subject to annual budgets, frequent spending reviews and five-year HM Treasury scorecard horizons, perverse incentives are created as is uncertainty over the funding. This discourages investment that requires long-term funding or takes multiple years to produce a return. Moreover, much of public-health spending is considered current spending – as opposed to capital investment – and is therefore subject to stricter fiscal constraints.

As this problem goes beyond health, HM Treasury should designate new categories of spend within the existing resource and capital departmental-expenditure limits to delineate between those that represent investment in productive assets (such as health) and those based strictly on consumption. All investment expenditure should be considered non-current spending (therefore enabling some fiscal loosening) and be guaranteed, where appropriate, over a multi-year horizon for greater certainty and better planning. Major (non-capital) public-health projects should be evaluated and funded over much longer timeframes

(for example, decades), similar to defence or infrastructure projects, and be subject to the same type of scrutiny by the Major Projects Authority (MPA).

9. Create a level playing field for public-health versus health-care funding decisions

To create the right conditions for a fairer playing field, it will be necessary to level up funding for the National Institute for Health and Care Research (NIHR) to invest in prevention programmes, clarify the role for NICE and ask harder questions about general NHS funding.

On paper, public health and the NHS may follow similar evidential requirements for funding. In practice, though, public health has a much higher bar to prove its cost-effectiveness than general NHS funding. This is despite the available evidence suggesting that public-health interventions are three to four times more productive than health-care expenditures. [50]

The very nature of public health makes it harder to apply evaluation methods such as randomised control trials, commonly used for drugs or medtech. The funding the NIHR receives for public-health research is a fraction of the grants allocated to medical studies while the acceptance of relatively lower-impact thresholds for novel drugs is crowding out more cost-effective public health interventions. NICE's role in evaluating and advising on public health is also being increasingly eroded.

To evaluate public-health interventions more effectively, NIHR funding must be levelled up while the role of NICE in assessing evidence must be made clearer.

10. Incentivise risk-sharing across public and private institutions

Sharing investment risks between the private and social sectors, on the basis of delivering outcomes akin to social-impact bonds, should be considered as part of an overall funding strategy.

For example, the North East devolution deal, which guarantees government investment over 30 years, has already led to a public-private prevention fund that sits outside the public-health grant (allocated by the Department for Health and Social Care (DHSC)) and which focuses on health as an economic asset. Innovations in prevention will be supported – for example, through startups, and digital and social-enterprise activity – while new interventions to address public-service problems will be generated, as will a financial and economic return to the regional economy. This will build on the region's existing strong health assets, fast-growing tech sector and a political willingness to proactively address its research-and-development and venture-capital funding gaps.

Overcome Political Short-Termism

Like climate change, the challenges to the NHS and public health span multiple election cycles and require sustained policy interventions. Methods such as net-zero targets have been developed to bind

governments into taking action on climate change. As an issue of the same order of magnitude, similar ambition and mechanisms must be applied to revolutionising public-health and health-care delivery.

11. Create an evidence base that makes the indisputable case for change

The government should commission a comprehensive review to analyse the social and economic impacts of declining national health, including rising inequalities.

In 2006, the Stern Review on *The Economics of Climate Change* compelled governments into action by defining climate change as a market failure and quantifying the cost of inaction in economic-prosperity terms. A similar exercise building on the 2002 Wanless Report, [51] a definitive evidence base that sets out the costs of failing to fix the health of the nation, would support government to drive through change, although its completion should not hold back immediate action.

From the outset, the review's approach should include working closely with the public, through public deliberation among other means, to address inherent policy trade-offs head on (for example on data privacy and relative funding allocations). [52] This will allow for the creation of publicly acceptable policy proposals that mitigate the risks set out in the review and that have clear health and economic benefits.

12. Use ONS data to set targets for improving public health and reducing inequalities

Setting clearly defined, outcome-based targets will drive progress. The ONS Health Index for England, [53] which collates detailed data across a broad range of public-health metrics at local and national levels over time, provides a systematic and independent view. Expressed in a single headline score, it can be compared to previous years but is underpinned by detailed analysis. This ONS data could enable decision-makers to set appropriate targets and be held accountable for meeting them.

Any such national targets should focus on high-level missions, such as increasing the country's Health Index score or healthy life expectancy, while reducing regional inequalities. These should be legally binding commitments with a set timeframe to ensure targets are not deprioritised. At the local level, targets will need to be more granular and established in conjunction with integrated care boards or local authorities. These data should also be hardwired into the development of targeted policy interventions and assessment of funding in terms of value for money.

13. Drive cross-Whitehall action and establish a cabinet committee to ensure accountability

Since the wider determinants of health cover other aspects of life including employment, housing and education, this needs to be reflected across Whitehall, with responsibility for health spread across the cabinet table. This is not something the DHSC can drive on its own. Implementation of Health in All Policies (HiAP) is key here. [54] To address this, the government should enact legislation containing statutory obligations requiring the health implications of all public policy to be considered, with

mandatory projections for major measures fed into national forecasts (or a health budget) and a national-health balance sheet.

In addition, a cabinet committee should be established to ensure greater collective responsibility and coordinate cross-departmental initiatives. The committee should be chaired by the prime minister or deputy prime minister and attended by the chancellor, secretaries of state for health and social care, education, and levelling up, housing and communities, as well as the minister for primary care and public health.

14. Establish a new Public-Health Committee (PHC) to hold the government to account

Once legally binding targets are in place, a new Public-Health Committee (similar to the Climate Change Committee) should be established to track progress and hold government to account. This should be an independent statutory body that conducts independent analysis, monitors progress and publishes associated reports. Its purpose should be to advise the UK government and devolved administrations (and possibly local authorities) on target setting and policy recommendations, while also reporting on the government's progress to Parliament. It should work closely with other institutions, such as the ONS and OBR, to inform its work.

Conclusion

One of the top priorities of any state should be the health and wellbeing of its citizens. Aside from the clear moral duty, the fiscal and economic necessity to improve public health is becoming more acute as the population ages and the prevalence of non-communicable diseases becomes more endemic. The latest NHS winter crisis has again brought into sharp focus the shortcomings of health care in the UK, but our failings on health more widely are less prominent in the national debate. Yet the outcomes of these failings are equally, if not more, consequential.

The imperatives to act are clear. Advances in data and technology are opening windows of opportunity to radically improve public health. While the prime minister has named NHS waiting times as one of his top five priorities, the current government remains too focused on the short term. The NHS will rightly remain important to constituents and the politicians who represent them, but beyond health care, health creation must be equally prioritised.

Only by helping people better understand their individual risks and supporting them to have meaningful choices will we help them to live longer and healthier lives. Only by improving population health and prevention will we begin to alleviate unsustainable burdens on the NHS and ensure people can still get access to treatment when they do get sick. And only by investing in our health as a national asset will we create the long-term sustainable economic growth and prosperity that will benefit us all.

Footnotes

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