



# Valuing Health

Why prioritising population health  
is essential to prosperity



## Acknowledgements

Professor Modi and the team would like to thank everybody who has helped develop our ideas and thinking for this report. This includes everyone who attended our stakeholder workshops and helped to co-produce the *Declaration for National Wellbeing* as well as everyone who met with Professor Modi during her time as President to share examples of work and discuss the barriers and solutions to health being a central focus of policy-making.

This report is the work of Professor Modi and a number of staff from the BMA's Population health team who contributed to drafting the report and the project overall, including Olivia Lines, Alanna Wurm, Sarah Arnold, Ahmed Binesmael, Isabelle McLaren, Claire Chivers and Suzanne Wood. We also thank the BMA's design team and colleagues from across the BMA's Communications team, and colleagues in the BMA Wales, Scotland and Northern Ireland teams, who have supported the publication and promotion of the report and the wider project.

## Contents

<b>Key points</b>	<b>2</b>
<b>About this report</b>	<b>3</b>
<b>Introduction</b>	<b>4</b>
<b>Action is urgently needed to improve poor UK population health</b>	<b>4</b>
Life expectancy in the UK is stagnating	5
Health inequalities affect life expectancy across the UK	5
The need to improve healthy life expectancy is recognised but is not backed by effective policies	8
<b>The foundations of good health start before birth and a life-course approach is needed to ensure healthy trajectories are maintained</b>	<b>8</b>
<b>Healthcare is not the primary determinant of health</b>	<b>9</b>
<b>Health service pressures are exacerbated by a failure to address the underlying causes of poor population health</b>	<b>10</b>
<b>A healthy population is essential for a prosperous economy</b>	<b>11</b>
The current policy focus on economic growth is damaging population health	12
Poor health is bad for the economy	13
Good health and wellbeing are economic and social assets	14
<b>There are a number of barriers to health becoming a central policy focus</b>	<b>14</b>
<b>Moving beyond GDP as the predominant measure of success</b>	<b>15</b>
GDP is a flawed measure of national success and can result in policies that harm health	15
There is a growing consensus on the need to move beyond GDP and introduce a more balanced set of measures	15
But barriers remain to replacing GDP	17
<b>Cross-government accountability for health is essential</b>	<b>17</b>
A 'health in all policies' approach can help to ensure health is considered in policies across government departments	17
High-level buy-in is needed across Government to ensure health is prioritised	18
Independent scrutiny and accountability for population health is also required	19
<b>Improvements are also needed to how policies are assessed and evaluated</b>	<b>20</b>
Improving the Green Book	20
<b>Conclusions</b>	<b>23</b>
<b>A Declaration for National Wellbeing</b>	<b>24</b>
<b>References</b>	<b>25</b>

## Key points

- Good population health is essential for sustainable economic growth. However, a key barrier to health being a central focus of government policy is the flawed view that economic growth drives population health. Many components of economic growth, as measured by Gross Domestic Product (GDP), are damaging to population health, nor does population health improve if governments do not distribute the benefits of economic growth to improve health and reduce inequalities. We call for Government and policy-makers to value population health as a driver of economic success instead of viewing economic growth as a means of improving population health, and to move away from GDP growth as the predominant measure of national success.
- The health of the UK population is declining and health inequalities widening. Since 2014, life expectancy has more or less flat-lined at around 79.2 years for men, and 82.9 for women. In 2020, the impact of COVID-19 led to a further decline in life expectancy, a sharp reversal of previous trends. There are also large differences in life expectancy and healthy life expectancy between the most and least deprived areas of the country, which are well documented.
- Poor population health is not just bad for the individuals affected. It impacts adversely on national productivity and prosperity, and increases pressures on health services, which are already struggling to cope with the growing demands of an increasingly unhealthy population, and the challenge of recovering from the backlogs in care exacerbated by the impact of the COVID-19 pandemic.
- The UK Government has expressed a desire to improve population health, including improving life expectancy and healthy life expectancy but what little action there is often appears narrowly focused on the NHS, rather than the wider determinants, which have the greatest influence on the health of individuals and the population.
- In order to address these challenges and improve population health, it is necessary for health to be a primary focus of government, prioritised in policy development across government departments. Achieving this requires governments to recognise and understand that the key contributors to health start before birth and are shaped by wider determinants that act across the life-course. Policies to improve health and tackle inequalities must therefore focus on building the foundations of good mental and physical health from pre-conception through the early years and sustain these through policies that prioritise health in all sectors.
- Building on promising developments in the UK, including the ONS Health Index and work in Scotland and Wales to measure health and wellbeing alongside more traditional economic measures will be an important step towards ensuring governments' value health and embed this as a core outcome of policy across sectors and departments.
- A cross-government strategy for health, supported by mechanisms that break down siloed working across government departments and foster collaboration and cooperation is also needed. This will help ensure that government is working towards agreed outcomes and considering health in all policy decisions. A firm commitment to, and accountability for, improving population health and reducing inequalities at the highest levels of government across the UK will set the framework and help support decision making and policy development at all levels of government.
- There is also room to improve guidance on assessing the value of health in policy appraisal processes, namely the Green Book which is the government's key policy appraisal guidance. In theory, the Green Book provides opportunity to ensure policies take account of all relevant impacts, including effects on health but, in reality, many policy decisions do not do so, and assessing health impacts is not mandatory.
- Improved guidance on policy appraisal, and support and training for those undertaking appraisal, is required to ensure it is clear, well understood and achieves the desired effects, ensuring that policy decisions are not detrimental to health and, more positively, improve health. An overreliance on external consultants has contributed to the loss of in-house expertise that also needs to be rebalanced.

## About this report

This report forms part of a project initiated by Professor Neena Modi, BMA president 2021–22. Professor Modi focuses on promoting the need for recognition of human health and wellbeing as an essential requirement for a sustainable future. Preserving and enhancing human health and wellbeing is as necessary as tackling climate change and destruction of the environment, and therefore warrants an equivalent position as a primary policy focus for governments worldwide. The BMA has a long history of advocating for policy action to improve health. The President's project is an opportunity to dig deeper into the barriers that are impeding actions to improve population health and halt the decline that the UK is currently witnessing.

The report draws on published data and is further informed by conversations with a wide range of government officials, academic experts in the UK and internationally, and workshops with external stakeholders, which also led to the development of the *Declaration for National Wellbeing*.

We focus on the UK, with examples of actions from across its four nations, and around the world. One of the challenges in writing a pan-UK report is the complex nature of devolution. A key premise of our report is that action is needed across all government departments, including some for which the Westminster Government has responsibility and some that are devolved to individual nations, or local authorities. Throughout the report, we highlight differences between UK nations, particularly mentioning Wales and Scotland, which are making progress on many of the issues we discuss. The principles we set out, and the *Declaration for National Wellbeing*, are also of global relevance.

## Introduction

The health of the UK population is declining and health inequalities are widening, as discussed in more detail further below. This is bad for the individuals affected, the health services that treat them, and the productivity and future prosperity of the nation. It also has wider cross-generational implications as poor parental health has adverse consequences for their children, fuelling further repercussions for future national wellbeing and prosperity. This tragic downward spiral is inevitable without action. There can be no excuse for inaction as science is providing a deep and growing understanding of the causal determinants of health, which could and should form the basis of effective policies to break this destructive cycle.

It is therefore imperative that the health of the population is a primary policy focus for government. It is also crucial that government underpins all policies with an understanding that the wider determinants of health – namely the conditions in which people are born, grow, go to school, live, work and age – have a greater impact on health than the receipt of healthcare services. People's exposures and experiences from the womb through early childhood, combined with their genetic endowment, are key to determining their future health. However, the probability of developing a disease is not fixed. Further exposures and experiences throughout life amplify or lessen these risks. This provides opportunity for effective interventions to improve health at all stages of the life-course, including in old age.

However, instead of seizing the chance to reverse the current downward trend in UK population health, policy-makers persist with policies and perspectives that are not sufficient to address the scale and complexity of the challenge. Now, despite possessing the knowledge to improve population health, we are seeing it worsening. Effective health policy demands a long-term vision, cross-departmental and cross-sector collaboration. It also requires knowledge of the evidence of what improves health and what is damaging, and a sound understanding of what a life-course approach means.

A major barrier to improving population health is the perception that economic growth will automatically lead to better health. We challenge this perception in our report as it ignores the complex relationship between economic growth and health. Economic growth in itself is not sufficient to improve health and poor population health will ultimately have an inevitable adverse impact on the economy, a consequence that holds true in high as well as low and middle-income countries.

We outline how the failure of successive governments to prioritise population health has led to a 'ticking time-bomb'. We summarise the inevitable consequences of declining population health for the economy, no less individuals and society. We emphasise the need for urgent action to improve population health and reduce health inequalities. We show that this will benefit not just individuals, but also society, the economy, and national prosperity. We offer solutions based on the science of the causal determinants of health.

We hope this report will be of wide interest but primarily aim our recommendations at policy-makers and government ministers, including the UK Treasury.

## Action is urgently needed to improve poor UK population health

The health of our nation is declining, and health inequalities are widening. Good health enables people to live well and engage fully with society and the things that matter most to them. Poor health, on the other hand, adversely affects quality of life, reduces productivity, life expectancy, and healthy life expectancy; it increases healthcare costs and societal burdens, and parents in suboptimal health transmit risks to their children through a variety of pathways.

Before the COVID-19 pandemic, concern was growing about the rising prevalence of chronic non-communicable physical and mental diseases. These debilitating conditions are responsible for just over 70% (41m) of annual global deaths.<sup>1</sup> The pandemic has highlighted the dangers of such a rise, as individuals with such diseases were more likely to die or suffer adverse effects from COVID infection. One example of this is diabetes, a disease that has

doubled in prevalence over the last 15 years in the UK; the number of people living with diabetes hit an all-time high in 2021, reaching over 4.9m. With a further 13.6m people at increased risk of developing type 2 diabetes,<sup>2</sup> ill health is not only likely to increase but will likely exacerbate the adverse impact of future infectious outbreaks.

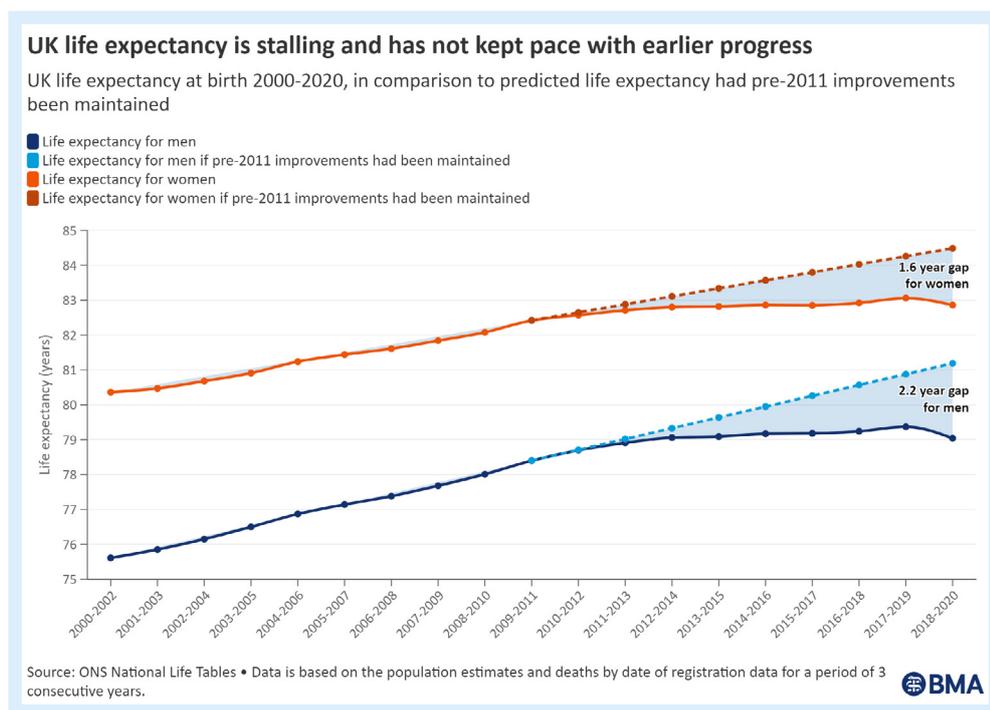
These examples are evidence that the nation is facing a 'ticking time-bomb' of ill health, and as we set out below, we call for more to be done to recognise and reverse this to avoid the growing damage to individual lives, the nation and the economy. Urgent action is needed to reverse the current direction of travel, the seemingly inexorable rise in the prevalence of chronic non-communicable diseases, the health consequences of the COVID-19 pandemic, and the likelihood of future threats from other infectious diseases.

## Life expectancy in the UK is stagnating

Since 2014, life expectancy in the UK has more or less flat-lined at around 79.2 years for men, and 82.9 for women.<sup>3</sup> In 2020, the impact of COVID-19 led to a further sharp decline in life expectancy. This is a stark reversal of previous trends; life expectancy in the UK increased throughout the 20th century by nearly three years every decade.<sup>4</sup> However, since 2011, improvements have stalled.

Figure 1 shows that if pre-2011 improvements in life expectancy had continued at the same rate, current life expectancy at birth would be 2.2 years higher for men and 1.6 years higher for women than it is now.<sup>5</sup>

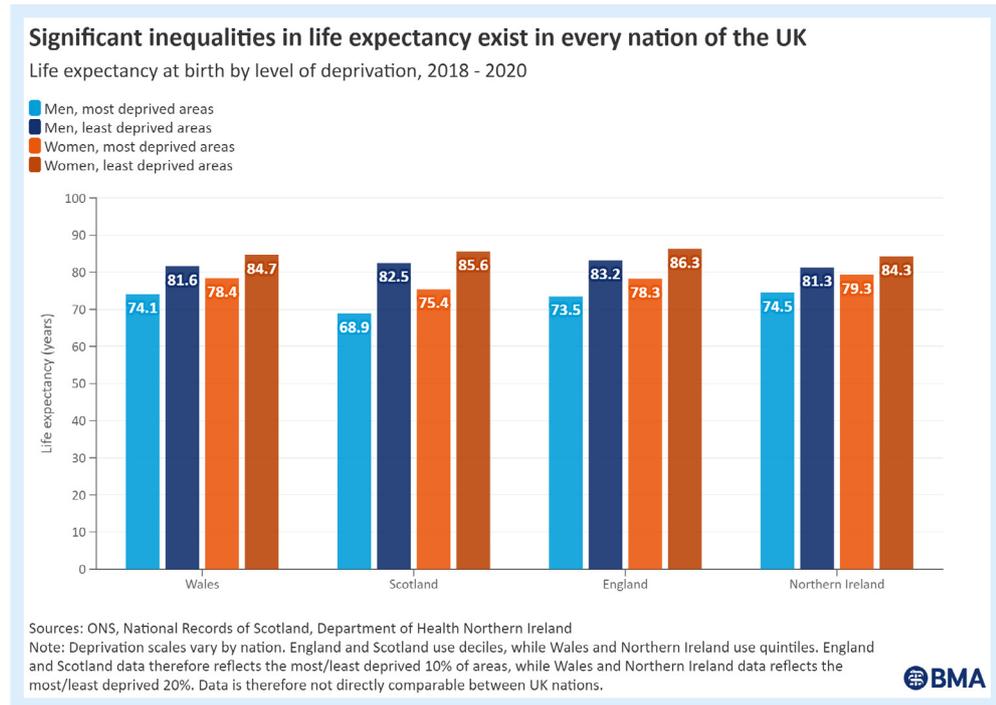
**Figure 1: UK life expectancy at birth since 2000**



## Health inequalities affect life expectancy across the UK

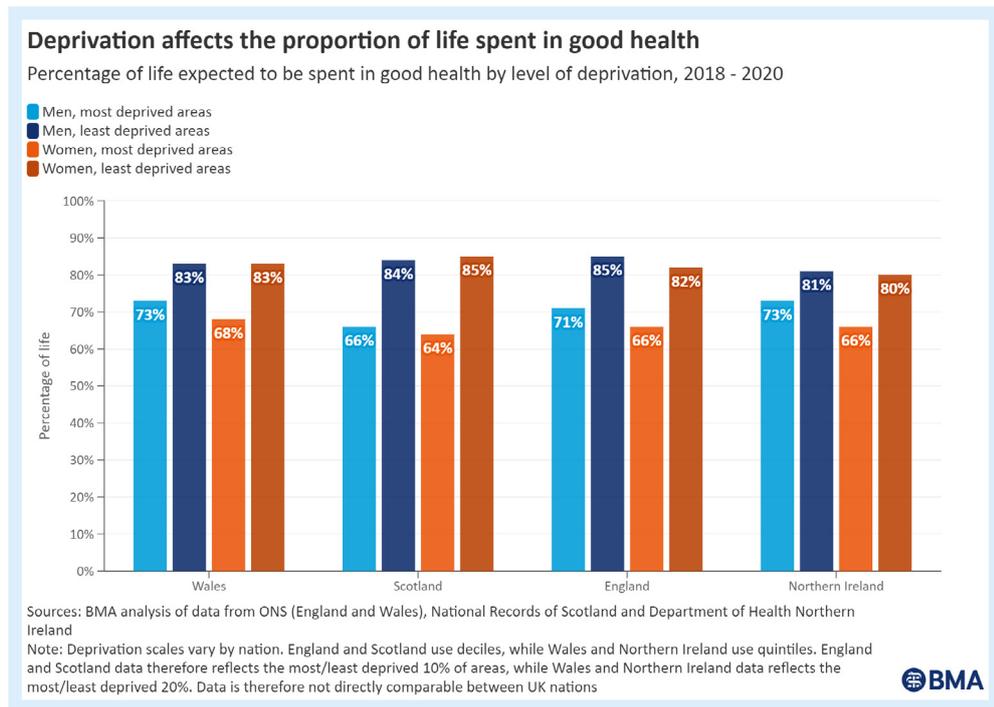
There are significant differences across the UK in life expectancy, and healthy life expectancy (the number of years that someone can expect to live in good health). Life expectancy and healthy life expectancy illustrate health inequities clearly. Over the period 2018–20 in all nations of the UK, those in the least deprived areas could expect to live far longer when compared to those living in the most deprived areas. For men, the gap in life expectancy was 6.8 years in Northern Ireland, 7.5 years in Wales, 9.7 years in England and 13.6 years in Scotland. A similar trend existed for women, with a life expectancy gap of 5.0 years in Northern Ireland, 6.3 years in Wales, 8.0 years in England and 10.2 years in Scotland (see Figure 2).<sup>6</sup>

**Figure 2: Life expectancy at birth in all four UK nations by level of deprivation**



Across the UK, there are even starker inequalities for healthy life expectancy. For men and women in all four nations, the gap in healthy life expectancy at birth between the most- and least-deprived areas is at least 11 years, with the gap widening to almost 20 years in England and 25 years in Scotland.<sup>7</sup> These inequalities in healthy life expectancy mean, for example, that women in the most deprived areas of England can expect to live only 66% of their life in good health compared to 82% for women in the least deprived areas (see Figure 3).<sup>8</sup>

**Figure 3: The percentage of life expected to be spent in good health in all four UK nations by level of deprivation**



There are many other examples of worsening population health and growing inequalities. An example is the rising prevalence of overweight and obesity (see Box 1), alongside the rise in diabetes highlighted above, which is a major and rapidly growing public health problem in the UK and globally.

Inequalities affect every age group. On average compared with the least deprived sections of the population, people in the areas of highest deprivation develop long-term conditions 10 years earlier.<sup>9</sup>

### Box 1: The impact of overweight and obesity on health

The prevalence of people who are overweight or obese, which for the past 15 years has consistently affected around one in five five-year-olds and one in three 11-year-olds in England, rose sharply during the COVID-19 pandemic with the largest single-year increase for both age groups.<sup>a</sup>

It is estimated that around eight in 10 obese children remain obese as adults,<sup>b</sup> increasing the risks of developing multiple long-term conditions such as type 2 diabetes, hypertension, and cardiovascular disease. These reduce life expectancy and the number of years people can expect to live in good health, and impose high personal, societal, and financial burdens. Risks are then transmitted to successive generations, with children born to obese parents more likely to be obese themselves.<sup>c</sup>

In all UK nations overweight and obesity prevalence in children is highest in the most deprived areas,<sup>d</sup> and in England this prevalence is over 70% greater in the most deprived areas compared to the least deprived areas.<sup>e</sup>

## The need to improve healthy life expectancy is recognised but is not backed by effective policies

The UK Government's [Levelling Up white paper](#), published in February 2022, set a target for increasing healthy life expectancy by five years by 2035 and narrowing inequalities in healthy life expectancy (by an unspecified amount) by 2030. Governments in the devolved nations all acknowledge the need to improve healthy life expectancy and narrow the gap but none has set a specific target (although Wales is currently [consulting](#) on one).

Ambitions such as these to improve healthy life expectancy are welcome, but analysis by the Health Foundation has shown that, on current trends, it will take 192 years for men to achieve the UK Government five-year target for improvement in healthy life expectancy in England.<sup>10</sup> The size of the gap between aspiration and reality is illustrative of the challenges ahead, which extend beyond recognising the urgency and magnitude of the problem. Radical, sustained action is needed. An important starting point, discussed in the next section, is the need for strong policies that target the causes of ill health.

## The foundations of good health start before birth and a life-course approach is needed to ensure healthy trajectories are maintained

Factors within and outside an individual's control determine health. Hence, health policy must begin with an understanding of the science of the origins of health and disease.

Health trajectories are established early, before conception and in fetal life. An individual's genetic endowment has a role in determining their health trajectory, especially if they inherit a gene or genes that cause a particular disease, such as cystic fibrosis or Huntington's disease, or increased health risks in other ways. However, though they can be devastating, genetic diseases are rare.

a <https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2020-21-school-year>

b <https://www.nejm.org/doi/full/10.1056/nejmoa1703860>

c <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2019/>

d BMA analysis of the most recent data in [England](#) (2021), [Scotland](#) (2019), [Northern Ireland](#) (2018) and [Wales](#) (2017).

e BMA analysis of data from NHS Digital: <https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2020-21-school-year>

What happens in early life also matters greatly and can influence pathways to good or poor health beyond, and on top of, genetic endowment. Babies born too soon (preterm), too small (low weight for gestational age) or too big (heavy weight for gestational age), or to a mother who is overweight or obese, for example, are at higher risk of developing diabetes, high blood pressure and cardiovascular diseases, than babies born at the right time and of normal weight.<sup>11</sup> In the UK today, around one in 13 babies are born too early,<sup>12</sup> one in 15 are born too small, one in 10 are born too heavy,<sup>13</sup> and half of all women of child-bearing age are overweight or obese.<sup>14</sup>

The early years of a child's life are also the period during which good mental health trajectories are established. Factors that increase parental stress and parenting ability, such as a mental health condition, substance addiction, or living in poverty can negatively affect the child's own mental health development. Establishing good physical and mental health trajectories in infancy therefore starts with policies that drive good maternal and parental physical and mental health, value and incentivise parenting, promote good child development, and address wider issues such as poverty.

Good trajectories, once established, require reinforcement at critical stages throughout the life-course – such as adolescence and young adulthood, when interest in personal health is growing, and during and after pregnancy, when the health and wellbeing of children becomes a focus – and continuing through to supporting people to age healthily.

The risk of developing long-term conditions increases with age, but they are not inevitable. Hence, a cardinal aspect of a life-course public health approach must include policies designed to promote healthy ageing. Long-term conditions, as outlined earlier in the report, reduce the ability for senior citizens to contribute to society and enjoy a healthy old age. In 2015, 54% of people aged over 65 had two or more long-term health conditions, and a UK study predicts this will rise to 68% by 2035.<sup>15</sup>

## Healthcare is not the primary determinant of health

Present health policy predominantly focuses on healthcare, but healthcare is not the primary determinant of health. It is estimated that in high-income countries, only about 20% of the variance in health is explained by healthcare, and in low-income countries, no more than 50%.<sup>16</sup>

As set out above, the conditions in which people are conceived, born, grow, live, work and age are the prime determinants of future health.<sup>17</sup> However, individuals have little control over many of these factors – such as the quality of the air they breathe, the water they drink, or the buildings in which they live – and as they affect populations, there is a clear mandate for government to assume responsibility.

Yet, despite the irrefutable evidence about the impact of external influences on health, policy-makers too often fail to draw the connection between health and wider policies around, for example, air quality, waste and sewage disposal, housing insulation, transport infrastructure, the cost of food, and work environments.<sup>18</sup> Policy decisions around health too often focus on treating ill health, and the structure, organisation and funding of healthcare. Health services are important but are not what drives health.<sup>19</sup>

A further unhelpful framing of discussions around health is that it is primarily a matter of personal choice. The fallacies inherent in this view are self-evident: for example, none of us individually can influence the quality of the air we breathe, the cost of healthy foods, access to green spaces, or regulations governing housing insulation. Consider too that a real reduction in the prevalence of smoking only occurred when governments banned smoking in public; prior decades of exhortation and information about the health dangers of smoking had little effect.

Similar bold government action is required to tackle obesity, poor physical fitness, and higher risk alcohol use. Yet all too often, lobbying by industry obstructs attempts to implement effective policies. Cries that governments are creating 'nanny states' further fuels opposition<sup>20</sup> and the final death blow is often the argument that enacting policies to

improve health would lead to loss of jobs, damage to the industry, and an adverse impact on the economy. Opposition on the basis that it would 'damage the economy' has been responsible for obstructing many great societal advances such as abolishing child labour in the 19th century. It also contributed to the delay in implementing a public smoking ban for many years despite recognition of smoking as a cause of lung and other cancers. Similar opposition is damaging efforts to reverse the obesity epidemic and its downstream health consequences.

A strong challenge to those opposing effective public health policies is the evidence that supporting industries that are damaging to individual health will ultimately have a worse impact on the economy through effects on population health.

## Health service pressures are exacerbated by a failure to address the underlying causes of poor population health

Failure to make population health a priority, and to act on clear evidence of the determinants of health, leads to the imposition of a growing burden of poor physical and mental health on the NHS. An estimated 29m people in the UK are currently living with one or more long-term health conditions (Table 1),<sup>21</sup> many of which good public health policies could have prevented. Examples include cardiovascular disease, some cancers and type 2 diabetes, the leading causes of ill health and premature death in the UK.<sup>22</sup>

The cost of treating these conditions is enormous. In 2011, analysis by the York Health Economics Consortium estimated that diabetes alone cost the UK's health services around £10bn per year in direct costs (2010/11 prices) and predicted at the time that this would increase to almost £17bn per year by 2035.<sup>23</sup> Hence, in addition to the moral imperative, there are powerful economic reasons for governments to take prevention seriously.

Doctors and other healthcare professionals are all too often aware of the impacts of external conditions on health, over which patients have little control. Currently, the treatment and care of people living with often preventable, long-term conditions are responsible for around 50% of GP appointments and 70% of hospital days.<sup>24</sup> GPs and other healthcare professionals also report that they spend around 20% of their time dealing with issues that are non-medical, but related to social or economic pressures.<sup>25</sup> This problem is likely to increase given the enormous stresses of the current cost of living crisis, the rise in fuel prices and the looming threat of economic recession.

Worsening population health adds to the long-standing pressures the NHS already faces through sustained failure to address workforce shortages, crumbling infrastructure, loss of morale and inadequate, erratic and poorly targeted funding. Thus, public and policy discourse about health centres around the need to increase NHS capacity, staffing and funding to enable health services to cope better with the increased demand.

Health services have been innovative in developing ways to deal with the wider social issues affecting health, such as the development of inclusion health teams or introducing link workers into primary care to work with patients in the most socio-economically deprived areas (more examples are available in the BMA's [health inequalities toolkit](#)). However, meaningful progress in improving population health requires acknowledgement that the solutions to reducing pressure on health services lie predominantly outside their remit. While the UK, of course, needs properly resourced, efficient and effective health services, it also needs a serious, sustained focus on stemming – not just reacting to – the growing burden of ill health.

**Table 1: The estimated number of people in each UK nation living with at least one long-term health condition**

Nation	Estimated percentage of the population living with at least one long-term health condition	Estimated number of people living with at least one long-term health condition
England (2019 data)	43%	24,203,410
Scotland (2020 data)	47%	2,569,020
Wales (2020 data)	48%	1,521,600
Northern Ireland (2021 data)	41%	780,271

Sources: [NHS Health Survey for England 2019](#), [Scottish Health Survey 2020](#), [National Survey for Wales 2020](#), [Health Survey Northern Ireland](#), ONS population estimates ([England 2019](#), [Scotland 2020](#), [Wales 2020](#)) and [Northern Ireland Census 2021](#).

Note: Table shows the most recent data available in each nation

## A healthy population is essential for a prosperous economy

The traditional view is that economic growth drives population health, so growing the economy has been viewed as a way of improving health. We challenge this simplistic assumption, as the reality is more complex. In some countries, and some eras, periods of economic growth occurred in conjunction with improvements in population health. The economies of the post-industrial revolution were able to improve sanitation, provide clean water, and better food and housing, all of which drove better population health.

However, in many wealthy countries in the 21st century, the association between a country's wealth and the health of its population is weakening, as shown by falling life expectancy even prior to COVID.<sup>26</sup> This is because the factors now driving poor population health have changed. In wealthy countries, the principal determinants of poor population health are no longer lack of food, poor sanitation and unclean drinking water.

In 2020, Professor Anne Case and Nobel Prize winner Professor Angus Deaton, economists from Princeton University, published [Deaths of despair and the future of capitalism](#). In this they provide evidence showing that lack of opportunity, growing inequalities, and a bleak social and economic outlook are driving these changes, despite the position of the USA as one of the richest countries in the world. They describe the huge deterioration of health in middle-aged white Americans, and the rise in the rate of deaths, driven by suicide and drug and alcohol use. [The Marmot Review: 10 Years On](#), also published in 2020, shows similar forces at work in the UK.

Other empirical evidence shows that a decline in population health can accompany economic expansion, while population health improvements can accompany economic recessions.<sup>27</sup> A study of 27 European countries before and after the recession of 2007 found that in countries where the crisis was particularly severe, mortality rates fell.<sup>28</sup> A similar relationship has been observed in other periods, in both Europe and the USA. This is because economic growth, as currently measured, tends to involve activities that harm health, such as pollution. Moreover, as the work cited above highlights, fair distribution of the gains of growth is not necessarily the norm,<sup>29</sup> meaning that growth may lead to better health for some but harm the health of others; in other words, widening health inequities (inequalities in health that could be avoided). As we have shown, both overall population health and health inequity indices are worsening in the UK today.

The flaw in continuing to place the economy before health is to conflate an association with a causal relationship. In post-industrial Britain, the economy did not improve health; the economy enabled the provision of better living conditions that were the true causal determinants. In 21st-century Britain, a stronger economy alone will not improve health; what matters is how governments use the economy. As we describe in this report, there is ample evidence that governments are not using UK wealth to improve population health by attention to the causal determinants. Economic growth may be associated with improved health, but economic growth will not automatically lead to improved health. Hence, to focus on economic growth as a route to improving health is flawed and short-sighted. In fact, there may be immense gains from flipping the picture and considering how improved population health can drive economic growth.

Policies aimed at improving population health can lead to a prosperous economy and a sustainable future. Good health can be an important factor in economic success. Improving population health increases the labour supply and improves the productivity of workers.<sup>30</sup> Improved population health also benefits the economy indirectly, through reduced healthcare expenditure, greater innovation and scientific and artistic exploration, though these effects are unmeasured and hence unvalued. Yet policy-makers rarely factor these important attributes of the human condition into their decision-making processes. We discuss this point further in later sections of the report.

## The current policy focus on economic growth is damaging population health

Currently, economic growth seems to be the pre-eminent goal. Despite the clear evidence of the fallacy of this approach summarised in this report, Government has consistently placed the economy before the health of the population, failing to recognise the potential for health to drive sustainable, equitable economic growth.

Throughout the COVID-19 pandemic, for example, we saw the promulgation of the false dichotomy that Government needed to choose between measures to control transmission of the virus and measures to bolster the economy. An example was the 'Eat Out To Help Out' scheme to support the hospitality sector following the first wave of the pandemic. Analysis of the scheme found that in areas where there was higher take-up, COVID-19 cases increased.<sup>31</sup> This will have increased absence from work, decreased productivity, increased health and care costs, and damaged long-term productivity and health because of long COVID. This narrative continues as the UK moves beyond the acute phase of the pandemic and looks toward recovery. The recent decision of the UK Government to delay the implementation of measures to restrict the sale and marketing of junk food, under the auspices of the cost of living crisis, is a prime example of this.<sup>32</sup>

Such behaviours on the part of policy-makers and governments reflect a failure to acknowledge the nature of the relationship between population health and the economy in the 21st century; how countries grow and use their economies matters more than growth itself. The world was too slow to face up to the consequences of climate change and the destruction of natural habitats; though the cost of inaction is clear, governments around the world are repeating this mistake for health. In the next sections, we outline the relationships between health and the economy in more detail, before setting out a vision of the change needed.

## Poor health is bad for the economy

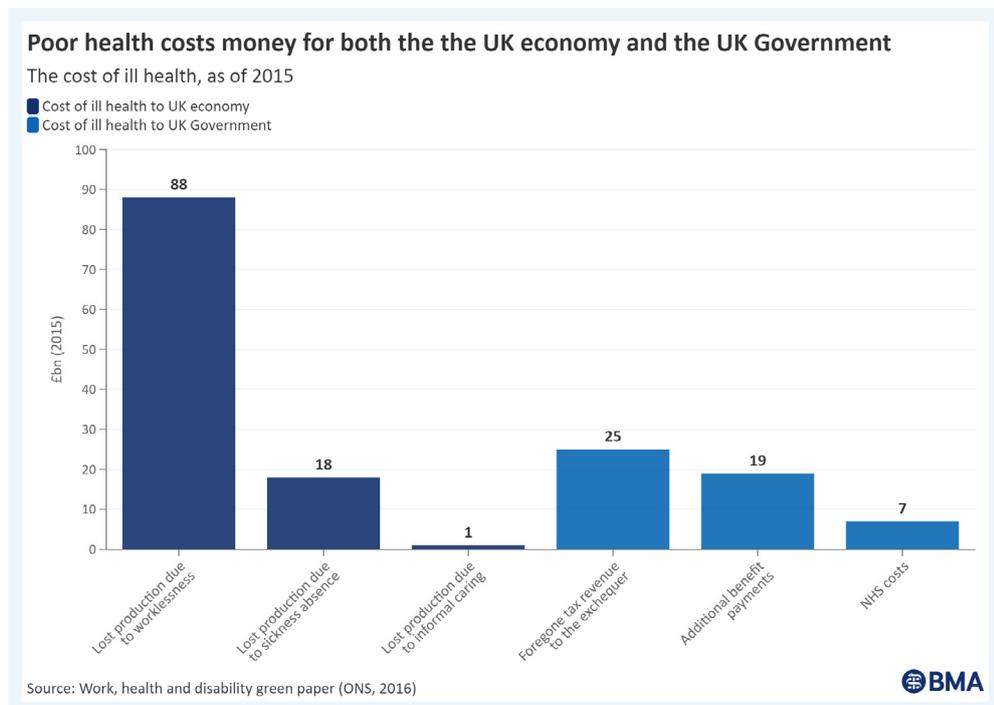
The failure to prioritise health, as set out above, adversely affects individuals, communities, health services and the nation's ability to thrive. In 2015 it was estimated that ill health cost the wider UK economy £95-130bn a year (2015 prices).<sup>33</sup> The largest component (£73-103bn) was due to poor health preventing people from working. Sickness absence (£15-20bn) and the impact of caring responsibilities (£1bn) also contributed.

These figures do not include the direct costs to government of ill health through lost tax revenue, benefit payments and NHS costs (Figure 4), so it is likely to be an underestimate.<sup>34</sup>

There will also be lost productivity because of people going to work in poor health, especially poor mental health. The Centre for Mental Health estimated the cost of this so-called 'presenteeism' at £21bn per annum (2017 prices), which is more than double the cost of absenteeism due to mental ill health (£10bn per annum in 2017 prices).<sup>35</sup>

The pandemic further increased the costs of ill health, not least due to the emergence of long COVID, and widened health inequalities. The final report of the BMA COVID-19 review, *The impact of the pandemic on health and health inequalities*, contains a detailed discussion of these issues.<sup>36</sup>

**Figure 4: The cost of ill health to the UK economy and UK Government, as of 2015**



## Good health and wellbeing are economic and social assets

Despite the evidence of the relationship between health and the economy, and the stark statistics about the cost of poor health to the economy, policy-makers traditionally do not consider improving health as a means to stimulating economic growth.<sup>37</sup>

Were policy-makers to recognise good population health as an asset, policies aimed at establishing good health trajectories in infancy, and reinforcing them through the life-course, would become an essential component of driving economic success.

Good physical and mental health is also an issue of social justice, with benefits that extend beyond economic concerns. Good health enables people to live well and engage fully with the things that matter most to them. It has benefits for communities, society and successive generations. Interventions that support good health, such as physical activity, promote creativity, which in turn can broaden horizons and support wider societal progress and development.

## There are a number of barriers to health becoming a central policy focus

The complex relationship between health and the economy, and the interplay between the different wider determinants on health, illustrate the challenge of embedding health as a central policy focus across the whole of government.

In addition, insufficient understanding or recognition of the determinants of health across all of the different actors that need to act in concert to address them, the prioritisation of short-term economic considerations, commercial vested interests, legacy decisions and the short-term nature of political cycles are among the many factors placing barriers in the way of progress.

The nature of political cycles in particular leads governments to focus on short-term benefits and acts as a disincentive to longer-term policies and investments needed to improve population health. Past policy decisions that affect population health negatively leave a legacy that can be hard to reverse.<sup>38</sup> For example, roads and motorways, once built, cannot easily be dismantled, but future improvements to transport infrastructure can prioritise cycling and pedestrian routes. Action to improve population health requires sustained, cross-sector, cross-party action spanning many government departments.

To change the current paradigm, we propose action in three key areas. These are improving how governments measure success and moving away from the narrow economic index of GDP; cross-government accountability for population health that transcends political party boundaries; and ensuring policy-makers fully consider the health impacts of any new decisions.

## Moving beyond GDP as the predominant measure of success

### GDP is a flawed measure of national success and can result in policies that harm health

As set out above, economic growth does not always lead to improvements in population health. Yet most countries around the world use GDP (gross domestic product) as the default standard for measuring a nation's progress and the core metric for prosperity.<sup>39</sup> GDP is a measure of the total monetary or market value of all the goods and services produced in a particular country over a particular period. In the UK the ONS (Office for National Statistics) reports on GDP monthly, with media and decision-makers paying it very close attention.

The appeal of GDP is understandable. It is simple to have a single measure to track progress, and to judge success. Yet as long as GDP has existed as a measure, its use as a catch-all indicator of success has been criticised. Bobby Kennedy famously said in 1968 that GDP 'measures everything except that which is worthwhile'. Simon Kuznets, the economist credited with the concept of GDP, testified to the US Congress that 'the welfare of a nation can scarcely be inferred from a measurement of national income'.<sup>40</sup> For years economists and experts have been calling for decision-makers to move away from what Joseph Stiglitz, a Nobel laureate in economics, has called 'GDP fetishism'.<sup>41</sup>

The criticisms arise because GDP is a narrow indicator, and the reality is that many contributors to this metric actively harm human and planetary health and contribute to climate change. The destruction of the Amazon rainforest and the manufacture and sale of tobacco products are obvious examples. A further important consideration is that GDP does not incorporate activities that actively contribute to human health and wellbeing if they are unremunerated, such as breastfeeding, caring for family members or other loved ones, or parenting.

In addition, GDP itself tells us nothing about the distribution of economic growth, as it is by definition an aggregate measure, providing information on overall output of the nation rather than individual incomes. Thus, GDP might rise, but unless government directs gains from economic growth towards areas of greatest need, population health inequalities will widen, a situation that exists in many countries, including the UK today. This is one example of why focussing on GDP alone is a flawed approach.

### There is a growing consensus on the need to move beyond GDP and introduce a more balanced set of measures

The use of GDP as a catch-all measure has persisted despite criticisms for decades. However, there is a growing consensus emerging around the world that success should be measured in broader ways.<sup>42</sup>

Organisations working on climate change have long recognised this; for example Pushpam Kumar, chief environmental economist at UNEP (the UN Environment Programme), states: 'Market mechanisms [such as GDP] typically fail to reflect the alarming erosion of national capital... [concealing] how the foundations of human wellbeing are weakening even as financial incomes may have risen for most people.'<sup>43</sup> There have been several attempts to develop new metrics that incorporate natural assets, such as clean water; an example is the UNEP Inclusive Wealth Index.<sup>44</sup>

Other measures exist. The United Nations calculates a Human Development Index, which ranks countries based on GDP per capita, but also includes health and education measures such as life expectancy and school enrolment.<sup>45</sup> The Genuine Progress Indicator, developed by academic economists, incorporates the environmental, social and economic costs associated with GDP growth into its measure, although it is not widely used beyond academia.<sup>46</sup>

The UK Government can learn from these developments and move to include measures of human health when evaluating the success of its policies. However, aggregate measures are not always sufficiently helpful for governments to track how policies are affecting population health. International measures are developed for global comparison and therefore rely on data collected commonly in all countries, but many, particularly low-income countries, have limited data available. Therefore, several countries have looked into developing their own bespoke measures or made tangible efforts at a national level to shift their economies away from a rigid focus on GDP growth.

In 2018, Iceland, New Zealand and Scotland established the Wellbeing Economy Government network to transform economic systems so that they deliver collective wellbeing; Wales and Finland have also since joined. Wales has passed a Future Generations Act which puts in place seven wellbeing goals, including health, prosperity and equality. Public bodies are required to work to achieve all of the goals, not just one or two, so they cannot focus solely on the economy.<sup>47</sup> Scotland has introduced a National Performance Framework, which tracks a broad range of national indicators.<sup>48</sup> The UN Sustainable Development Goals form the basis of the Framework, which has 81 national indicators, divided into 17 areas that span social development, health and the economy.<sup>49</sup> The Scottish Cabinet sets national priorities using Framework indicators which in turn guide the work of government departments and encourage collaboration. Recent priorities include child poverty and environmental sustainability.

In England, the ONS has developed a dashboard that aims to measure national wellbeing; this has 10 domains, including health, subjective wellbeing and the economy.<sup>50</sup> However, the dashboard is not updated regularly; it was most recently published in August 2022, with the prior update in October 2019. Furthermore, it does not provide sufficiently granular health information.

A measure must have several characteristics to be useful in aiding decision-makers to understand the impacts their policies have on health.

- Focused on health: changes in health should be able to be isolated to see whether this is improving or worsening
- Local: measures must be available at local level, to identify variation and compare different populations and policies
- Timely: measures must be published regularly, so that up-to-date information is the basis for decision-making.

The ONS dashboard does not yet meet these criteria. However, a measure that might do so is the Health Index, a measure of population health in England, also developed by the ONS (see Box 2).

### Box 2: The ONS Health Index is a promising development

The [Health Index](#) is a new measure developed in England by the ONS (Office for National Statistics). It provides a granular measure of population health that can illustrate how health changes over time and place. The Health Index takes advantage of the high quality of data available across the UK; eg from long-running national programmes such as the Health Surveys for each UK nation.

As well as providing a headline measure of health, the Index can be broken down into domains and subdomains, providing insights into health status, health-related behaviours, personal circumstances, and the impact of the wider determinants of health. The Health Index also provides a measure of health for local authorities and enables comparisons between geographical areas. Though only currently available for England, the measure could be expanded to be UK-wide, which the ONS is exploring.

## But barriers remain to replacing GDP

However, despite recognition of the weakness of GDP as the sole or primary measure of a nation's success, and initiatives to replace it, moving away has proven difficult. GDP is too well-established and its use dominates political and public discourse in most of the world. Attempts to introduce metrics that are crucial to building a sustainable and healthy future remain peripheral to most policy-making and limited to a few countries.

There are several practical barriers to bringing about change. First, policy-makers must recognise the harm arising from a continued focus on GDP, and champion change. Second, they must require the regular reporting of alternative indicators alongside GDP, so that decision-makers become familiar with the new measures. The media can play a crucial role in explaining new indicators and their value, and the shortcomings of GDP, and gathering public support for their introduction.



**It will be challenging to move beyond GDP as the dominant measure of UK success, but it is essential. In order to progress this, we recommend a several key actions:**

- We encourage further development of the ONS Health Index and support its expansion to all UK nations
- We recommend learning from the work undertaken in Wales, Scotland and internationally, on how to embed health in measures of success across the UK
- We call for UK governments to publish regular data on a broader range of indicators, such as the Health Index and the national wellbeing dashboard.

## Cross-government accountability for health is essential

Improving population health and tackling health inequalities needs sustained action across Government. This requires coordination and collaboration across and between departments. In addition, there must be clear accountability at the highest levels of Government for the outcomes of its policies.

The BMA, as a member of the Inequalities in Health Alliance, which has more than 200 members, has for several years called on the UK Government to introduce a cross-government strategy to reduce health inequalities, and for accountability for achieving the strategy's ambitions to lie with the prime minister.<sup>51</sup> This approach can be built on to ensure health becomes a key priority across government.

## A 'health in all policies' approach can help to ensure health is considered in policies across government departments

A HIAP (health in all policies) approach is considered a key method to ensure decision-making processes consider the impact of all major policies on health, and the BMA has long supported HIAP as a way of ensuring cross-government action to improve health. While the roots of a HIAP approach go back decades, it was first introduced as an umbrella term when Finland chose it as a theme for its European Union presidency in 2006.<sup>52</sup> The World Health Organization formally endorsed 'health in all policies' at the 2013 Global Conference on Health Promotion in Helsinki.<sup>53</sup>

The statement from supporting nations at the time encapsulates the approach:

**'Health in all policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity.'**

UK Government departments ostensibly use HIAP approaches, but their adoption has not been universal, and effectiveness is uncertain. Individual departments might not see how it helps them meet their goals, or consider it an additional burden.<sup>54</sup>

Health impact assessments, a practical tool to assess how a policy or programme might affect the health of a population, are one of the main methods policy-makers currently use to implement HIAP. In Wales, there is a legal duty under the Public Health Wales Bill 2016 for public bodies to conduct health impact assessments for policies, plans and programmes at national and local level.<sup>55</sup> However, in England, Scotland and Northern Ireland, health impact assessments are not mandatory.

Health impact assessments are useful, but they do not always ensure the necessary collaborations across government, nor sustain these beyond the narrow remit of a particular policy. Their effectiveness is also by no means certain, as meaningful assessment of the health impact of a policy can be difficult.

The COVID-19 pandemic has brought into sharp focus how a health threat can affect many sectors and aspects of life, and the need for cross-government action to address such challenges. One limitation recently identified is that a HIAP approach focuses on how health and the health sector can benefit if policies in other sectors adopt particular measures (e.g. to reduce air pollution or increase active travel), but does not necessarily consider how other sectors can also reap benefits by focusing on improved health.<sup>56</sup> This includes, as outlined earlier, how improved population health can contribute to improved economic success through increased productivity, for example.

It is therefore important to build on the HIAP approach to support governments to adopt a more sophisticated approach to policy-making that recognises this bi-directional relationship. A recent article in *The Lancet* recommended a shift from a 'health *in* all policies' to a 'health for all policies' approach, that emphasises the mutual benefit to health and other sectors to better understand the contribution of health to wider societal goals.<sup>57</sup> To achieve this, it is also important that there is high-level buy-in and accountability across Government, which we explore in the next section.

## High-level buy-in is needed across Government to ensure health is prioritised

In 2021, when establishing the new OHID (Office for Health Improvement and Disparities), then Secretary of State for Health, Matt Hancock, announced there would be a new cross-government ministerial board on prevention. This is a laudable ambition, although no further details of the structure of the board, its membership or powers have been forthcoming. In addition, OHID was tasked to 'work across the Department of Health and Social Care, the rest of government, the healthcare system, local government and industry to be creative about how we shift our focus towards preventing ill health, in particular in the places and communities where there are the most significant disparities'. However, OHID sits within the Department for Health and Social Care, which may limit its ability to achieve this level of cross-government collaboration. It will also need to overcome existing ways of working that entrench siloed working and focus on individual departments rather than cross-governmental issues and action.<sup>58</sup> Leadership at the highest levels of Government is essential to ensure recognition of the importance of population health to the nation. It will also ensure that responsibility for health is clearly understood by all departments as being part of their role.

Scotland has a model closer to this. In Scotland, Cabinet sets national priorities to meet the Government's commitment to improve health and reduce health inequalities. This in turn guides the work of government departments and encourages greater collaboration to achieve the agreed objectives.

## Independent scrutiny and accountability for population health is also required

Mechanisms are essential for ensuring accountability for population health, as distinct from the delivery of health services. As discussed previously, most of the determinants of population health lie outside the control of the NHS or Department of Health and Social Care. Improving population health and tackling health inequalities requires sustained action across government departments. This requires coordination and collaboration across and between departments, as well as clear ways of measuring progress as outlined earlier, and clear accountability at the highest levels of Government for the outcomes its policies achieve.

In Wales, the Wellbeing of Future Generations Act established the role of the future generations commissioner with a remit to act as guardian for future generations in Wales. The commissioner's role is to scrutinise government departments to ensure they take account of the impact of decisions on future generations. The commissioner has made a number of high-profile interventions to ensure the health impacts of decisions are fully considered. For example, the commissioner used her role to encourage Welsh Government to reverse its initial approval of a new motorway<sup>59</sup> and helped to secure a pause on all new road building projects while a review was carried out, including how the Welsh Government could shift more investment to other areas, including more public transport.<sup>60</sup>

Recently, there have been proposals in England through a private members' bill to introduce a UK Future Generations Bill and establish a commission to fulfil a similar role as the commissioner in Wales (Box 3). This would help to ensure the Government takes population health seriously and better supports the devolved administrations. At present, centralisation of some responsibilities with the Westminster Government limits the ability of the devolved nations to fully adopt policies designed to improve population health.

### Box 3: Wellbeing of Future Generations Bill (UK)

Lord Bird, a crossbench peer in the House of Lords and founder of the magazine *The Big Issue* has introduced a private members' bill based on the Wellbeing of Future Generations Act in Wales.

The Bill contains provisions to ensure that public bodies consider future generations when making decisions and creating new policies. It proposes a 'future generations test' for all new policy changes by setting social, economic and cultural wellbeing targets. The Bill will also establish a Future Generations Commission in the UK comprising a group of individuals appointed by the prime minister, in consultation with the devolved nations. Similarly to the Welsh Commissioner, the Commission will monitor whether public bodies are meeting their wellbeing objectives, and extend the duty of the Office for Budget Responsibility to consider wellbeing and future generations in its work. UK Government departments will have additional responsibilities under the Bill.

The Bill passed its third reading in the House of Lords in February 2022 and its first reading in the House of Commons on 6 May 2022. It is rare for private members' bills to pass into law in the UK. However, a broad coalition of organisations formally support this Bill; these include charities, policy bodies and private companies, through the [Today for Tomorrow campaign](#).

It is also important to find ways to embed an approach that can withstand the short-term nature of the UK political system. It is essential that parties across the political spectrum acknowledge that population health is an issue that transcends politics, and commit to ensuring it remains a central policy focus. The establishment of an independent body tasked with scrutiny of actions and progress would help provide continuity when ministers and governments change.



**There are a number of actions we believe Government can take to ensure all relevant actors are able to make a difference to population health, and position it as a central consideration in their decision-making.**

- All government departments should conduct rigorous health impact assessments for new policies and reject or amend new policies if the assessment identifies risks. To support this, health impact assessments should be made mandatory in England, Scotland and Northern Ireland, in line with the approach in Wales
- The UK Government should develop a cross-government framework for health that supports coordination and collaboration across and between departments to prioritise health in all policies and avoid a limited focus on economic disparities; the UK Government Levelling Up programme provides opportunity to facilitate such a framework
- Ensure that OHID has sufficient independence from the Department of Health and Social Care to ensure credibility across all government departments
- The UK Government should support the UK Wellbeing of Future Generations Bill, in line with developments in Scotland and Wales.

## Improvements are also needed to how policies are assessed and evaluated

Processes for evaluating new policies risk undermining efforts to improve the measurement of population health and ensuring buy-in and accountability for health across Government. Currently, these processes do not enable informed decision-making about health impacts. In this section we look, in particular, at issues with how the Green Book – the Government’s key policy appraisal guidance – currently considers health, and set out ways in which it can be improved.

### Improving the Green Book

The HM Treasury Green Book, *Appraisal and Evaluation in Central Government* (2022), is the primary Government guidance on determining which projects, programmes and policies make best use of the nation’s financial resources.

The Green Book provides guidance on how to appraise the impact of new policies by considering to what extent they procure ‘value for money’.<sup>61</sup> In theory, the Green Book provides an opportunity to ensure policies take account of all relevant impacts, including effects on health. The Green Book gives a broad definition of value for money as ‘all significant costs and benefits that affect the welfare and wellbeing of the population, not just market effects. For example, environmental, cultural, health, social care, justice, and security effects are included’, but in reality many decisions do not appear to take health into account; an example is the ‘Eat Out to Help Out’ scheme discussed earlier in the report. This occurs because assessing health impacts is not mandatory. Improved guidance on policy appraisal is required to ensure it is clear, well understood and achieves the desired effects, namely that decisions are not detrimental to health. This is crucial for both policy developers and decision-makers.

Government appraisal processes, and the Green Book in particular, have recently been criticised both within and outside of Government for ‘undermining the Government’s ambition to ... achieve strategic objectives’, of which improving health should be a key priority.<sup>62</sup> A review of the Green Book in 2020 to improve appraisal to ‘make sure that government investment spreads opportunity across the UK’<sup>63</sup> concluded that changes were needed to both the Book and the way it is used, to enable ministers to understand fully what investments they need to make to achieve strategic priorities most effectively.

Notably, the appraisal of health impacts was not part of this review. Therefore, guidance on health impact appraisal, quantification and monetisation of health impacts has not been updated since 2013. This is a problem, because the current guidance lacks clarity.<sup>64</sup> An example of this is the following statement from the supplementary guidance to the Green Book: 'When designing policies, programmes and projects, it may be necessary to think about possible implications for health.' This is weak and vague, with the consequence that policy-makers and ministers may not prioritise or even consider health effects.

Health considerations should be explicitly considered at the initial stages of policy development, to ensure that policies developed are not harmful to health. The Green Book explicitly references the need to consider 'key issues that influence the wider debate which gives rise to policy development' which include political, economic, sociological, technological, environmental and legal issues. Despite health being a key influence on these wider issues, it is not explicitly mentioned. A different approach is possible, as Box 4 sets out, highlighting the approach New Zealand has taken to ensure health is a key consideration in spending decisions.

#### **Box 4: New Zealand's Wellbeing Budget**

In 2019, New Zealand published a Wellbeing Budget, the first country to move directly and publicly beyond GDP as the dominant measure of success.<sup>65</sup> It also specified that any new spending in the budget must advance one of five government Wellbeing Budget priorities:

- Improving mental health
- Reducing child poverty
- Addressing the inequalities faced by indigenous Māori and Pacific Island people
- Thriving in a digital age
- Transitioning to a low-emission, sustainable economy.<sup>66</sup>

Enabling legislation, the Public Finance (Wellbeing) Amendment Act supports the Wellbeing Budget.

The Green Book includes technical guidance on how to quantify and monetise health impacts, but this is not very clear (see Box 5). The lack of clear guidance is particularly concerning when policy appraisals are outsourced. The Green Book review, mentioned above, identified this as an issue.<sup>67</sup> The review noted that consultants to whom assessments were outsourced 'may add value in technical aspects of the appraisal but may also be less familiar with the strategic policy context of the intervention and may have been tasked with producing a high BCR [benefit cost ratio] rather than a properly well-rounded appraisal. This also risks creating a vicious circle where the use of consultants further erodes the expertise of officials'. The costly reliance on external consultants to appraise new policies requires a rethink. Instead, expanding in-house expertise would enable wider contextual and strategic consideration of the UK's best interests.

### Box 5: Guidance on health valuation is not clear and needs to be updated

Valuing and quantifying risks to life and health is a complicated and technical exercise within policy appraisal. The Green Book specifies three main approaches to quantifying and valuing risks to life and health:

- Value of a prevented fatality (VPF)
- Length of life, quantified through statistical life years (SLY)
- Health-related quality of life, quantified through quality-adjusted life years (QALY).

The Green Book gives limited guidance on when to use each measure. For example, it recommends SLY is used over VPF 'where the number of years of life expectancy at risk differs between options', but there is no explanation of what types of interventions would lead this to be the case (eg years of life expectancy might differ between options if interventions are targeted at different age groups).

Guidance on when QALY is appropriate is also not clear; the supplementary guidance clarifies that 'where possible' quality of life should be included as well as quantity of life, but does not indicate which types of situations are suitable or possible for quality-of-life measures.

### The cost-benefit approach recommended in the Green Book does not enable a clear assessment of how a policy will affect health

A further problem is that the Green Book advocates for a social cost-benefit analysis approach to economic appraisal. This consists of adding up all the costs and benefits of a policy to create a single BCR (benefit to cost ratio). A major criticism of this and other economic cost-benefit analyses is that they rely on outcomes that are easily monetisable, which health is not. Therefore, options with benefits that are easy to quantify and assign a monetary value to, such as earnings, tend to dominate the options chosen for consideration. The Green Book provides guidance on quantifying and monetising health outcomes, but this is neither clear nor sufficiently directive.

A related issue is that a BCR aggregates all impacts into a single figure, therefore creating a 'black box' where the methodology is not transparent. The ability of policy-makers to make meaningful decisions is impaired if they do not know how the final BCR was reached. The Green Book review highlighted this problem, stating that decision-makers 'may have to make choices without a well-balanced understanding of whether that investment will deliver their goals'.



**The Green Book requires updating and improving, in relation to the evaluation of the health impacts of policies. This specific recommendation, though technical, is necessary to ensure that suboptimal appraisal of policies does not impair the benefits of the broader changes we recommend. The following changes would be helpful:**

- **The technical guidance on valuing and quantifying risks to life and health should be updated and clarified**
- **There should be clearer narrative reporting standards that explicitly require the disaggregation of benefits and risks of each option, including the impact on health**
- **Government should reduce the reliance on external consultants to undertake policy appraisals and build internal expertise**
- **Treasury should develop training for those undertaking policy appraisal on how to quantify risks to health.**

## Conclusions

Good health is both a social and an economic asset, but over recent years, UK population health has been deteriorating. It worsened during the COVID-19 pandemic, placing added strain upon already struggling health and social care services, and widening existing health inequalities.

The UK Government has spoken of the need to improve population health, but what little action there is often appears narrowly focused on the NHS, rather than the wider determinants, which have the greatest influence on the health of individuals and the population. The failure to tackle the determinants of health at source is exacerbating existing problems, stretching health and care services even further and creating a significant cost for the economy and the UK Treasury.

Despite the lessons of the long battle to recognise and tackle climate change and planetary health, the UK Government appears to have recognised neither the enormous value of good population health nor the ticking time-bomb of deteriorating population health. Deteriorating population health will amplify financial burdens in coming decades, further weakening the economy.

Action in three areas is necessary to change the damaging status quo: moving beyond GDP as the pre-eminent measure of national success; ensuring cross-government accountability for improving health and reducing inequalities, that can withstand political changes; and ensuring frameworks for evaluating new policies reflect the central importance of health.

The BMA has been a long-standing advocate for the health of the UK population. BMA members see the tragic consequences of avoidable ill health daily. Surely, now – after the worst pandemic in a generation – would be a good time to change course, and place population health at the centre of national policy? We call on decision-makers to take note of this report and join us in advocating for change. Health must be valued; it will bring value to people's lives and the nation's economic and social wellbeing.

# A Declaration for National Wellbeing

As part of Professor Neena Modi's Presidential project 2021-22, the BMA, in collaboration with a range of external organisations, have developed this declaration. It sets out a series of principles and actions which, if adopted, would put health at the heart of decision making.

We call on national and local UK governments to:

- **Acknowledge** that good population health and wellbeing, together with tackling climate change and environmental degradation, are crucial to a sustainable future
- **Promote** greater equity in health and address inequalities
- **Recognise** that well-functioning health systems are important, but the principal determinants of health and wellbeing lie outside healthcare
- **Prioritise** population health and wellbeing across the life-course in policy decisions
- **Incorporate** metrics of population health and wellbeing into measures of national progress and performance

The following organisations have endorsed this declaration and we would encourage more organisations to do so. If you would like more information or are interested in endorsing the declaration, please email [info.phh@bma.org.uk](mailto:info.phh@bma.org.uk)



PUBLIC POLICY PROJECTS



WIJNGAARDS INSTITUTE FOR CATHOLIC RESEARCH

Theirworld

## References

- 1 <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>
- 2 <https://www.diabetes.org.uk/professionals/position-statements-reports/statistics>
- 3 Life expectancy at birth in the UK was an average of 79.2 for males and 82.9 for females from the period 2013-2015 until the period 2017-2019: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/datasets/nationallifetablesunitedkingdomreferencetables>
- 4 <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/englishlifetablesno17/2015-09-01>
- 5 Between the periods 2000-2002 and 2009-2011, life expectancy improved by an average of 0.31 years for men and 0.23 years for women. If this improvement had continued from the period 2010-2012 onwards, life expectancy in 2018-2020 would be 81.19 for men and 84.49 for women.
- 6 Life expectancy at birth (2018-2020) in [Northern Ireland](#), [Wales](#), [England](#) and [Scotland](#). Deprivation scales vary by nation meaning that data between UK nations is not directly comparable.
- 7 Healthy life expectancy at birth (2018-2020) in Northern Ireland, Wales, England and Scotland.
- 8 BMA analysis of data on life expectancy at birth and healthy life expectancy at birth (2018-2020)
- 9 <https://www.health.org.uk/news-and-comment/news/people-in-most-deprived-areas-of-england-develop-multiple-health-conditions-10-years>
- 10 <https://www.health.org.uk/news-and-comment/charts-and-infographics/healthy-life-expectancy-target-the-scale-of-the-challenge>
- 11 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6451766/> and <https://pubmed.ncbi.nlm.nih.gov/30486715/>
- 12 <https://www.tommys.org/pregnancy-information/premature-birth/premature-birth-statistics>
- 13 <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthcharacteristicsinenglandandwales>
- 14 <https://diabetologia-journal.org/2019/06/19/uk-study-shows-obesity-in-pregnant-women-associated-with-a-3-5-times-increased-risk-of-type-2-diabetes-in-the-child/>
- 15 <https://academic.oup.com/ageing/article/47/3/374/4815738>
- 16 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4121875/>
- 17 <https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf> and <https://www.health.org.uk/publications/reports/creating-healthy-lives>
- 18 <https://www.health.org.uk/publications/reports/reframing-the-conversation-on-the-social-determinants-of-health>
- 19 <https://www.health.org.uk/blogs/health-care-only-accounts-for-10-of-a-population%E2%80%99s-health>
- 20 See for example <https://www.express.co.uk/news/politics/1608168/queens-speech-nanny-state-buy-one-get-one-free-deals-ban>
- 21 BMA analysis of the latest health survey data available in [Northern Ireland](#) (2021), [Wales](#) (2020), [England](#) (2019) and [Scotland](#) (2020) compared to population estimates for the same year ([ONS](#) for Wales, England and Scotland, and [NISRA](#) in Northern Ireland).

- 22 <https://www.health.org.uk/blogs/the-economic-case-for-preventing-ill-health>
- 23 <https://jdrf.org.uk/wp-content/uploads/2015/10/Hex-and-Bartlett.pdf>
- 24 <https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-long-term-conditions-multi-morbidity>
- 25 <https://www.bmj.com/content/352/bmj.i1436.full>
- 26 <https://www.bmj.com/content/362/bmj.k2562>
- 27 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2734206/>
- 28 <https://onlinelibrary.wiley.com/doi/10.1002/hec.3495>
- 29 <http://www.homepages.ucl.ac.uk/~uctp39a/Blundell-Etheridge.pdf>
- 30 <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/prioritizing-health-a-prescription-for-prosperity>
- 31 <https://academic.oup.com/ej/article/132/643/1200/6382847>
- 32 <https://www.gov.uk/government/news/government-delays-restrictions-on-multibuy-deals-and-advertising-on-tv-and-online>
- 33 <https://www.gov.uk/government/statistics/work-health-and-disability-green-paper-data-pack>
- 34 <https://www.gov.uk/government/statistics/work-health-and-disability-green-paper-data-pack>
- 35 <https://www.centreformentalhealth.org.uk/publications/mental-health-work-business-costs-ten-years>
- 36 <https://www.bma.org.uk/advice-and-support/covid-19/what-the-bma-is-doing/the-impact-of-the-pandemic-on-population-health-and-health-inequalities>
- 37 <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/how-prioritizing-health-could-help-rebuild-economies>
- 38 <https://www.instituteforgovernment.org.uk/sites/default/files/publications/The%20S%20Factors.pdf>
- 39 <https://www.scientificamerican.com/article/gdp-is-the-wrong-tool-for-measuring-what-matters/>
- 40 [https://ec.europa.eu/environment/beyond\\_gdp/key\\_quotes\\_en.html](https://ec.europa.eu/environment/beyond_gdp/key_quotes_en.html)
- 41 [https://www8.gsb.columbia.edu/faculty/jstiglitz/sites/jstiglitz/files/2009\\_GDP\\_Fetishism.pdf](https://www8.gsb.columbia.edu/faculty/jstiglitz/sites/jstiglitz/files/2009_GDP_Fetishism.pdf)
- 42 See for example [https://www.oecd-ilibrary.org/economics/beyond-gdp\\_9789264307292-en](https://www.oecd-ilibrary.org/economics/beyond-gdp_9789264307292-en) and <https://www.bu.edu/pardee/files/documents/PP-004-GDP.pdf>
- 43 <https://www.unep.org/news-and-stories/story/beyond-gdp-making-nature-count-shift-sustainability>
- 44 <https://www.unep.org/resources/inclusive-wealth-report-2018>
- 45 <https://hdr.undp.org/content/measuring-human-development-future>
- 46 <https://oxfordre.com/environmentalscience/view/10.1093/acrefore/9780199389414.001.0001/acrefore-9780199389414-e-776>
- 47 <https://www.futuregenerations.wales/about-us/future-generations-act/>
- 48 <https://nationalperformance.gov.scot/measuring-progress/national-indicator-performance>
- 49 <https://nationalperformance.gov.scot/measuring-progress/national-indicator-performance>
- 50 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/937700/Green\\_Book\\_Review\\_final\\_report\\_241120v2.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/937700/Green_Book_Review_final_report_241120v2.pdf)

- 51 <https://www.rcplondon.ac.uk/news/powerful-stories-make-case-cross-government-strategy-reduce-health-inequalities>
- 52 <https://journals.sagepub.com/doi/full/10.1177/1403494817743895>
- 53 <https://www.who.int/publications/i/item/9789241506908>
- 54 <https://www.local.gov.uk/sites/default/files/documents/health-all-policies-hiap--8df.pdf>
- 55 [https://senedd.wales/Research%20Documents/Public%20Health%20\(Wales\)%20Act%202017/17-025-Web-English.pdf](https://senedd.wales/Research%20Documents/Public%20Health%20(Wales)%20Act%202017/17-025-Web-English.pdf)
- 56 [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(22\)00155-4/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(22)00155-4/fulltext)
- 57 [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(22\)00155-4/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(22)00155-4/fulltext)
- 58 [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(22\)00199-2/fulltext?rss=yes](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(22)00199-2/fulltext?rss=yes)
- 59 <https://www.futuregenerations.wales/news/sophie-howe-future-generations-commissioner-for-wales-welcomes-the-news-that-all-new-road-building-projects-in-wales-are-being-paused-by-welsh-government/>
- 60 <https://www.bbc.co.uk/news/uk-wales-politics-57552390>
- 61 <https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-government>
- 62 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/937700/Green\\_Book\\_Review\\_final\\_report\\_241120v2.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/937700/Green_Book_Review_final_report_241120v2.pdf)
- 63 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/937700/Green\\_Book\\_Review\\_final\\_report\\_241120v2.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/937700/Green_Book_Review_final_report_241120v2.pdf)
- 64 <https://www.gov.uk/government/publications/green-book-supplementary-guidance-health>
- 65 <https://www.treasury.govt.nz/information-and-services/nz-economy/higher-living-standards/our-living-standards-framework>
- 66 <https://www.treasury.govt.nz/publications/wellbeing-budget/wellbeing-budget-2021-securing-our-recovery-html>
- 67 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/937700/Green\\_Book\\_Review\\_final\\_report\\_241120v2.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/937700/Green_Book_Review_final_report_241120v2.pdf)





