ILC Future of Ageing – Acting now: shifting from sickness service to prevention for healthier lives

Chair: Arunima Himawan
Speakers: Professor Karen Glaser, Dr Adrian Hayter

Opening remarks

Arunima Himawan:
With multimorbidity rising and health systems under growing pressure, we need to improve how we approach prevention. That means learning from models around the world and adapting them closer to home. One example is the Brazilian community health model, elements of which are now being explored within parts of the NHS in London.

Do current health systems reflect people's everyday lives?

Arunima Himawan:
To what extent do current health systems reflect the reality of people's everyday lives, and where do you see the biggest gaps?

Professor Karen Glaser:
Current health strategies do recognise many aspects of people's everyday realities. There is widespread acknowledgement of the Social Determinants of Health, and this is reflected in many health policy frameworks.

However, the biggest gap is weak integration. While the Social Determinants of Health are recognised, responses remain siloed. There is still a strong emphasis on lifestyle change and individual responsibility, particularly in care.

There is also recognition of the role of carers and the negative impacts caring can have on health and employment. But the system continues to rely heavily on informal care to meet care needs. Care is still treated primarily as a family responsibility, and this overwhelmingly affects women's employment.

Another gap concerns policies promoting longer working lives without addressing the health dimension. Working longer in lower-paid or physically demanding jobs can have significant negative impacts on health. Without better integration, structural inequalities will continue and may widen.

Arunima Himawan:
At the global level, it is important to understand the relationship between working longer and the type of work people do. Both can have significant impacts on health outcomes, so we need to consider them together.

The role of general practice in prevention

Arunima Himawan:
What role could – or should – general practice play in shifting towards a preventive approach to medicine?

Dr Adrian Hayter:
I have worked in general practice for more than 30 years, and over that time the wider social determinants of health have increasingly come together in our understanding of health outcomes. GPs are very interested in the power of that intersection.

I currently work with around 54,000 members to think about clinical policy and how we can improve outcomes. One statistic that really stands out is that in 2023 around 22% of deaths in the UK were considered avoidable, with 65% potentially preventable. That equates to around 200 people a day dying from causes that could be prevented.

At the height of the pandemic the figure was closer to 1,000 per day, and in 2022 it was around 300. But prevention is not only about mortality – it is also about years of healthy life expectancy.

We recognise that small actions can make a big difference: moving more, socialising and paying closer attention to health.

In general practice we have gradually lost some focus on health promotion. The Stott–Davies model of consultation sets out four elements: addressing the immediate problem, managing chronic conditions, supporting self-care and promoting health. The gap now lies between the first three elements and health promotion, particularly with the rise of e-consultations.

As a college, over the next year or two we are focusing strongly on preventive medicine. We want to promote an evidence-based, whole-person approach across the life course – emphasising continuity, holistic care and personalised support, while also reducing inequalities.

The 2025 GP Voice Survey found that around 75% of GPs do not have enough time to offer preventive health advice – for example on vaccinations, self-care and healthy lifestyles. That is not a failure of GPs. It is a failure of the system.

Arunima Himawan:
Our research shows how important GPs are as advocates for their patients. It is therefore essential that they have the time and space to address prevention effectively.

Professor Karen Glaser:
The life course perspective is crucial. If we only focus on older people, we are already intervening too late.

Dr Adrian Hayter:
Exactly. We know that some diseases begin developing in people's thirties, which means we have to act much earlier.

If you could redesign one part of the system

Arunima Himawan:
If you could redesign one part of the health or local government system to prioritise prevention, what would it be and why?

Professor Karen Glaser:
Social care critically needs reform. Reform would support independence and strengthen communities, but it would also have wider knock-on effects through better integration between health and social care systems.

Dr Adrian Hayter:
I agree that integration is key. But there are limits to what integration can achieve, particularly where social care delivery is organised locally and resources are constrained. If you look at a place like Singapore, the whole system is designed more cohesively.

One important step would be recognising the people working at the intersection of services. For example, having a social prescriber in every GP practice who links the community with the health system.

If we invest in those intersection points between local authorities and health services, we can connect people more effectively with support in their communities. Crucially, we also need to measure the outcomes.

Arunima Himawan:
The right evidence base is essential for making informed decisions. In Denmark, for example, health systems place strong emphasis on national registries and evidence to guide the rollout of programmes.

What research is missing?

Arunima Himawan:
What is one area of research that policymakers tend to overlook?

Professor Karen Glaser:
Social care research is still relatively limited. There is some important work

underway linking national social care records with health records, and there is evidence showing that social care provision can reduce hospital readmissions and improve outcomes for older people.

Arunima Himawan:
Denmark is often cited as an example of delivering care effectively within communities.

Professor Karen Glaser:
Yes, and Costa Rica is another interesting example.

Dr Adrian Hayter:
In terms of evidence, we actually have extremely rich data at the local level. In the right hands, that data can make a compelling case for change.

However, sometimes we try to make the evidence base so comprehensive that policymaking becomes stuck. Developing a new policy can take years of evidence gathering, while other countries move more quickly by experimenting and being more flexible. Digital developments, including the work of NICE, are also pushing some of those boundaries.

Audience questions

Audience member:
There is often limited research on how men and women respond differently to treatments. Does the same issue apply to preventive care, and how can we address it?

Dr Adrian Hayter:
A lot of the evidence we rely on comes from populations that are not always representative of the patients we treat. Addressing this is particularly important in primary care.

Prevention operates across three levels: primary prevention such as vaccination, secondary prevention through screening and early detection, and tertiary prevention to manage existing conditions.

We have strong evidence on the consequences of failing to vaccinate populations. But there is still much to learn, especially given the genetic diversity within populations. For example, in cardiovascular medicine we still lack highly granular evidence. There is much more research needed.

Chris Whitty's 2023 work on ageing across different areas of the country also called for more evidence on the strategies we should be adopting.

Professor Karen Glaser:
Researchers are also examining significant gender differences in outcomes,

including mortality, and trying to understand the underlying causes so that prevention strategies can be improved.

Funding prevention

Audience member:
If we want to move from a sickness service to a prevention service, where does the funding come from? Pharmaceutical companies tend to fund research into treatment rather than prevention.

Professor Karen Glaser:
Universities and economists are very interested in studying the effects of social and health care systems. For example, the King's College London longitudinal studies examine outcomes across the life course.

Dr Adrian Hayter:
There is also growing interest in areas such as genomics. The pharmaceutical industry may become more engaged through the genomic element – for example through targeted drugs and large longitudinal studies that identify where investment could have the greatest impact.

Professor Karen Glaser:
Those studies also help identify the most effective points in the life course for intervention. The UK has a rich set of data sources, including English Longitudinal Study of Ageing and a range of birth cohort studies.

The costs and savings of prevention

Audience member:
Prevention and coordination are important, but what will it cost – and what will it save? If we prevent people dying today, what will they die from later?

Dr Adrian Hayter:
If we increased spending on prevention in primary care from around 5% to 6%, we could potentially save around £42 billion. Even small changes in consultation time can make a difference. For example, increasing appointments from ten minutes to fifteen minutes would mean seeing around forty patients instead of sixty, but it would create more space for prevention.

The voluntary sector is also a crucial partner in prevention. There is strong evidence showing the impact of voluntary sector programmes, although the outcomes are often measured in terms of wellbeing rather than hard clinical outcomes. Integration will not be effective unless investment in the voluntary sector is recognised as genuine investment rather than simply expenditure.

Dr Adrian Hayter:
In my experience, one of the most effective investments was a voluntary sector falls prevention programme, which significantly reduced fall risk and admissions to A&E. The key issue is how partnerships operate – they need to be well coordinated, synergistic and sustainable.

End-of-life care and the hospice sector also present important opportunities for partnership and preventive approaches.