

Shifting left to prevention:
innovation for fairer health

A report on the UK's prevention
and early detection landscape

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Executive summary

Prevention and early detection of disease are central to improving the health and prosperity of the UK, yet our health system continues to face persistent challenges in realising their full potential. The burden of disease is rising, healthy life expectancy is declining, and the gap between the most and least deprived is widening. As this happens, costs for individuals, the NHS and the wider economy are mounting each year.

Despite robust public health thinking in the UK and evidence of the cost-effectiveness of prevention, investment and action remain misaligned. There is an urgent need for a more ambitious approach to put in place existing, well-evidenced policies alongside the development of new interventions to secure long-term impact for the prevention and early detection of disease.

The narrative around prevention and early detection in the UK indicates that they are valued, with government strategies in each nation signalling the intention to prioritise these areas, and health services already successfully implementing a range of prevention and early detection strategies and programmes. However, there remains a huge opportunity to move the system towards prioritising the prevention of illness rather than its treatment. To make the most of this opportunity, funding must be meaningfully redistributed to support prevention, which has experienced a real-terms cut of more than 25% between 2015–2016 and 2025–2026, despite recent small rises.¹ We are also yet to fully optimise regulation and taxation for prevention, remaining slow to adopt the benefits for areas such as obesity and alcohol in England.

As outlined in the Life Sciences Sector Plan, the UK has real strengths in innovations such as genomics, data science and biomarkers. These areas present significant opportunities to support health systems in the shift to prevention, but require the right policy, governance and incentives to be in place to be realised. Barriers to realising innovations in prevention include the level of maturity of the technologies, challenges with accessing and linking data, unclear regulatory standards, limited workforce and system capacity and inadequate research funding and investment incentives.

This report sets out the case for urgent action, provides evidence of the economic and health impact of prevention, reviews the current policy and innovation landscape, and outlines our intended work to unlock the transformative potential of prevention and early detection in the UK and globally.

Our programme will explore the policy, governance and incentive changes required for health systems to harness public health innovations and deliver sustainable, equitable and resilient population health.

To do this, we will focus on the broad areas of innovation, systems, economy and inclusion, exploring the following questions as a starting point:

¹ The Health Foundation (2025). *Investing in the public health grant*. <https://www.health.org.uk/reports-and-analysis/analysis/investing-in-the-public-health-grant>

- If everyone agrees that prevention is crucial, why is it still so difficult for health services to move beyond rhetoric and make it a reality?
- How can we support innovations like genomics, polygenic risk scores, and biomarkers to reach their full potential and how do we embed accountability throughout the system?
- Do current evaluation frameworks such as quality-adjusted life year (QALY)-driven approaches properly capture the full economic value of secondary prevention and early detection, or are we overlooking impacts that matter most for the health and productivity of the population?
- Do employers recognise their power to champion prevention and early detection at work, or are they missing a vital opportunity to transform workforce health?
- Will current strategies for prevention and early detection tackle health inequalities, or could they risk widening the gap?

All countries are grappling with how to pivot health systems towards prevention, taking varied approaches and achieving different results. However, the UK has considerably higher rates of avoidable mortality than many comparable high-income countries. As part of this programme, we have commissioned an international comparative analysis exploring health prevention policy across the UK and other high-income countries to inform learning and policy dialogue. The analysis examines comparative patterns in prevention spending, preventable mortality, and policy approaches across countries to better understand how countries are responding to this shared challenge, and what the UK might learn from comparative experience.

The programme will be guided by our Oversight Group:²

- Professor Philippa Saunders FMedSci, Professor of Reproductive Steroids, University of Edinburgh
- Sir Harpal Kumar FMedSci, Chief Scientific Officer & President International, GRAIL
- Professor Nadeem Sarwar, Founder and Head of the Transformational Prevention Unit, Novo Nordisk

It will involve the convening of small time-limited Expert Groups to respond to priority areas with a clear policy mandate. These groups will be drawn from a wider pool of experts with insights from across public health, prevention, economics, life sciences innovation and policy.

We invite stakeholders to actively engage with us in this programme. Your insights, expertise, and collaboration are vital in shaping our work to develop effective prevention and early detection strategies and to achieving meaningful improvements in population health. Please reach out to prevention@acmedsci.ac.uk to share your perspectives as we work together to drive innovation for fairer health.

² Members of our Oversight Group are contributing to the programme of work in their own capacity and not as representatives of their organisations. All have declared their interests.

The burden of preventable disease

The UK ranks among the worst of high-income nations for preventable, treatable and avoidable mortality, with the top two leading causes of avoidable mortality being cancer and cardiovascular disease. There is a wealth of evidence demonstrating the benefits to individuals, society and the economy by shifting to prevention.

Avoidable mortality and morbidity

Deaths due to avoidable mortality in those aged under 75 years remain higher than before the COVID-19 pandemic in England, Wales and Scotland (Northern Ireland data only available to 2019).^{3,4,5} Such deaths are avoidable through effective public health and primary prevention, or through timely and effective healthcare interventions, including secondary prevention and treatment. In England, 21.6% of mortality is avoidable, in Wales it is 22.7%, and in Scotland it is 26%. There is a strong relationship between deprivation and treatable mortality.^{6,7} Comparing treatable mortality rates globally, the UK does poorly in comparison to other Organisation for Economic Co-operation and Development (OECD) countries.⁸

The leading cause of avoidable mortality across England, Wales and Scotland is cancers, followed by cardiovascular disease.^{9,10,11} Obesity is a key risk factor for both. In 2024 across the four UK nations, around one-third of adults were obese, and a further one-third were overweight.^{12,13,14,15} Prevalence is highest in more deprived areas. The financial burden on

³ Office for National Statistics (2025). *Avoidable mortality in England and Wales: 2023*. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2023>

⁴ National Records of Scotland (2025). *Avoidable mortality: 2023*.

<https://www.nrscotland.gov.uk/publications/avoidable-mortality-2023/>

⁵ Office for National Statistics (2021). *Avoidable mortality in England and Wales: 2019*.

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2019>

⁶ Office for National Statistics (2025). *Avoidable mortality in England and Wales: 2023*.

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2023>

⁷ National Records of Scotland (2025). *Avoidable mortality: 2023*.

<https://www.nrscotland.gov.uk/publications/avoidable-mortality-2023/>

⁸ Nuffield Trust (2025). *Mortality rates*. <https://www.nuffieldtrust.org.uk/resource/mortality-rates>

⁹ Office for National Statistics (2025). *Avoidable mortality in England and Wales: 2023*.

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2023>

¹⁰ National Records of Scotland (2025). *Avoidable mortality: 2023*.

<https://www.nrscotland.gov.uk/publications/avoidable-mortality-2023/>

¹¹ Office for National Statistics (2021). *Avoidable mortality: 2019*.

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2019>

¹² NHS England Digital (2026). *Health Survey for England 2024: adults' overweight and obesity*.

<https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2024/adults-overweight-and-obesity>

¹³ Scottish Government (2025). *Scottish Health Survey 2024: volume 1 – main report (obesity)*.

<https://www.gov.scot/publications/scottish-health-survey-2024-volume-1-main-report/pages/10--obesity/>

¹⁴ Welsh Government (2025). *National Survey for Wales: headline results, April 2024 to March 2025*.

<https://www.gov.wales/national-survey-wales-headline-results-april-2024-march-2025-html>

¹⁵ Department of Health (Northern Ireland) (2025). *Health Survey Northern Ireland: first results 2024/25*.

<https://www.health-ni.gov.uk/news/health-survey-ni-first-results-202425>

the NHS in England as a result of obesity and related illnesses was estimated in 2022 at £6.5 billion.¹⁶

Recent analysis from Cancer Research UK identified that 34% of cancer cases in England in 2023 were attributable to known, modifiable risk factors.¹⁷ Within this, 41% were attributable to smoking, and 24% to obesity. For cardiovascular disease, modelling from the British Heart Foundation estimates that the annual total of early deaths could rise to 44,000 in 2035.¹⁸ With a range of measures, including improved management of high blood pressure and cholesterol, and introduction of mandatory measures to incentivise the food industry to make everyday foods healthier, this number could be reduced by 25%.¹⁹ A separate assessment from Genomics plc suggests that using polygenic risk scores on 40–69-year-olds in the UK would identify nearly 2 million additional people at high risk for cardiovascular disease; treating these individuals with statins would avoid approximately 45,000 cardiovascular events over the next decade.²⁰

For healthy life expectancy (HLE), the latest figures show that HLE at birth in the UK for both males and females has decreased to the lowest levels since initiation of the Office for National Statistics (ONS) data series in 2011–2013.²¹ The trend seen since the onset of the COVID-19 pandemic of increasing spatial inequality in HLE has continued, with the latest figures showing a gap in HLE between the most and least deprived percentiles of 14.7 years for males and 15.8 years for females. Analysis from the McKinsey Health Institute found that the average person now spends 10.2 years in poor health (up from 8.7 in 2000), rising to 11.4 years by 2050 if no changes are made.²² However, scaling of proven interventions, could lead to an average gain of 9 more years of healthy lifespan, with nearly two-thirds of this impact coming from preventative interventions. In measures of HLE in the UK, this encompasses chronic conditions including cardiovascular disease, diabetes, musculoskeletal conditions, respiratory conditions, cancers and conditions of the digestive system. In addition to chronic health conditions, poor recent wellbeing and mental ill-health are also associated with poor HLE.

In the context of improving health, research commissioned by the Association of the British Pharmaceutical Industry in 2022 showed that increased use of four classes of drugs by the 1.2 million additional eligible patients would deliver an additional 429,000 years in good health, as well as £17.9 billion in productivity gains, of which £5.5 billion would return

¹⁶ NHS England Digital (2026). *Health Survey for England 2024: adults' overweight and obesity*. <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2024/adults-overweight-and-obesity>

¹⁷ Cancer Research UK (2026). *Preventable cancer cases in England: 2023 (analysis brief)*. https://assets.ctfassets.net/u7vsjnoopqo5/KbTGODcfD0AHEINvHCPvL/2de2c454717db9287f06156df49a026f/Preventable_Cancers_in_England_2023_Analysis_Brief_final.pdf

¹⁸ British Heart Foundation (2024). *Action now could avoid up to 11,000 cardiovascular disease deaths a year by 2035*. <https://www.bhf.org.uk/what-we-do/news-from-the-bhf/news-archive/2024/september/action-could-avoid-11000-cvd-deaths-a-year-2035>

¹⁹ British Heart Foundation (2024). *Action now could avoid up to 11,000 cardiovascular disease deaths a year by 2035*. <https://www.bhf.org.uk/what-we-do/news-from-the-bhf/news-archive/2024/september/action-could-avoid-11000-cvd-deaths-a-year-2035>

²⁰ Genomics (n.d.). *Genomics and the NHS*. <https://www.genomics.com/nhs>

²¹ Office for National Statistics (2026). *Healthy life expectancy, UK: between 2011 and 2013 and 2022 to 2024*. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/between2011to2013and2022to2024>

²² McKinsey Health Institute (2026). *The health of nations: stronger health, stronger economies*. <https://www.mckinsey.com/mhi/our-insights/the-health-of-nations-stronger-health-stronger-economies#/>

through taxes.²³ These drugs include direct oral anticoagulants – to prevent deep vein thrombosis and pulmonary embolism, and prevent stroke in atrial fibrillation; sodium–glucose cotransporter-2 inhibitors – to reduce major cardiovascular and renal outcomes in type 2 diabetes; severe asthma biologics – to reduce occurrence of asthma exacerbations; and vasopressin V2-receptor antagonists – to slow disease progression in kidney disease.

Economic impacts of preventable disease

Over 20% of working-age people are now out of work and not looking for work, higher than many comparator countries.²⁴ Ill-health is the most significant driver of economic inactivity, with a 40% rise since 2019 in the number of working-age people not working due to health conditions. Modelling by Schindler and Scott in 2025 has shown that in the UK context, a 20% reduction at all ages in the incidence of cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, musculoskeletal conditions and mental health conditions leads to increases in life expectancy, HLE and length of expected working life, and in turn increases in labour supply and gross domestic product (GDP).²⁵ Importantly, increases in GDP can be seen after 5 years, falling closer to the short-term timescales that influence policy decisions within a single government term.

Modelling by the McKinsey Health Institute estimates that enhancing global health could add \$12.5 trillion to global GDP – an increase of about 7% over baseline economic projections, with the vast majority of this gain coming from increased participation in the workforce.²⁶ This represents an estimated four-fold return on investment on the increased healthcare investment required to achieve this. For the UK, analysis by Deloitte found that by valuing benefits across healthcare, earnings, productivity, broader public sector and societal costs, and friends and family, as well as quality-adjusted life years (QALYs), the UK stands to gain £8 in socioeconomic returns on investment for every £1 spent on prevention, whilst increasing the percentage of UK health expenditure on prevention from 6% to 10% could return £42 billion within 10 years.²⁷ In line with the Academy's previous work on the value of interventions in childhood,²⁸ early interventions were also found to offer the most substantial returns, with estimates showing that early-life prevention interventions could return £13.50 per pound, with later-life interventions returning £5.30 per pound.

The value of preventative versus treatment approaches

Analysis from the Institute for Public Policy Research (IPPR) and Lane, Clark & Peacock (LCP) Health Analytics modelled projected healthcare spending in England in the context of two scenarios: (1) flat HLE and NHS productivity growth of 0.5% each year (in line with

²³ Association of the British Pharmaceutical Industry (2022). *Transforming lives, raising productivity*. <https://www.abpi.org.uk/publications/pwc-transforming-lives-raising-productivity/>

²⁴ Department for Work and Pensions (2025). *Keep Britain Working review: final report*. <https://www.gov.uk/government/publications/keep-britain-working-review-final-report/keep-britain-working-final-report>

²⁵ Schindler Y & Scott AJ. (2025). *The macroeconomic impact of chronic disease in the United Kingdom*. JEoA **32**, 100590. <https://www.sciencedirect.com/science/article/pii/S2212828X25000453>

²⁶ McKinsey Health Institute (2026). *The health of nations: stronger health, stronger economies*. <https://www.mckinsey.com/mhi/our-insights/the-health-of-nations-stronger-health-stronger-economies#/>

²⁷ Deloitte (2025). *The shift to prevention: realising the socio-economic potential*. <https://www.deloitte.com/content/dam/assets-zone2/uk/en/docs/industries/life-sciences-health-care/2025/the-shift-to-prevention-realising-the-socio-economic-potential-v2.pdf>

²⁸ Academy of Medical Sciences (2024). *Prioritising early childhood to promote the nation's health, wellbeing and prosperity*. <https://acmedsci.ac.uk/file-download/96280233>

historical trends); or (2) combined implementation of government ambition on prevention and growth in productivity at 2% each year, with the regional gap in HLE halved by 2033–2034.²⁹ In scenario 1, government healthcare spending will need to rise to 10% of GDP in the next decade to maintain the current level of services. In scenario 2, by delivering on prevention and productivity, annual spending would be maintained at 8.1% of GDP, saving £21 billion per year on health by the end of this parliament, and £53 billion per year by 2034–2035.

In a separate analysis examining the responsiveness of mortality to variations in healthcare and public health expenditure in 2013–2014, it was found that for each additional £1 billion spent on public health, 206,938 additional QALYs are generated, whilst for the same spend on healthcare, only 67,060 QALYs are generated.³⁰ These benefits are seen despite the limitations of QALYs in the evaluation of preventative interventions.

Although QALYs are the most commonly used metric to evaluate the cost-effectiveness of health interventions, their application in public health and preventative programmes faces criticism. Most notably, QALYs focus primarily on health outcomes and overlook the broader societal benefits that are particularly relevant in the context of prevention, including enhanced productivity and economic gains. The long-term nature of preventative interventions means their benefits accumulate gradually over time, making them less likely to be fully captured in current assessments, especially when higher discount rates are applied to future outcomes. As highlighted earlier in this report, analysis by Deloitte calculated that if the wider societal impacts of prevention are included in assessing the impact of interventions, an eight-fold return on investment is expected.³¹

²⁹ Institute for Public Policy Research (2025). *Realising the reform dividend: a toolkit to transform the NHS*. <https://www.ippr.org/articles/reform-dividend-transform-nhs>

³⁰ Martin S, Lomas J & Claxton K (2020). *Is an ounce of prevention worth a pound of cure? A cross-sectional study of the impact of English public health grant on mortality and morbidity*. *BMJ Open* **10**, e036411

³¹ Deloitte (2025). *The shift to prevention: realising the socio-economic potential*. <https://www.deloitte.com/content/dam/assets-zone2/uk/en/docs/industries/life-sciences-health-care/2025/the-shift-to-prevention-realising-the-socio-economic-potential-v2.pdf>

Strategies and frameworks on prevention and early detection

The government narrative around prevention and early detection in the UK indicates that prevention and early detection are valued, with UK Government strategies signalling the intention to prioritise these areas. Programmes to improve prevention and early detection of disease have been successfully led by the NHS and will be further supported by continued advancement of initiatives such as Our Future Health, Genomics England and UK Biobank.

Healthcare strategy

In England

The NHS England 'Fit for the Future: 10 Year Health Plan for England' report includes shifting from sickness to prevention as one of the three fundamental shifts in the plan designed to deliver better care for all patients.³² The ambition of the shift to prevention is to increase productivity, reduce inequality, restore public trust in the NHS and reduce demand on acute services. The plan outlines the possibility of a system where: genomics and polygenic risk scores identify at-risk individuals early; data infrastructure and the application of AI turn risk information into actionable insight; screening and improved diagnostics are applied to intervene earlier in disease pathways; and continuous monitoring and neighbourhood services prevent deterioration. In this vision, the system is underpinned by innovation to continuously improve the capability of preventative interventions.

Specific commitments in the NHS England 10 Year Plan include:

- a new genomics population health service, accessible to all, by the end of the decade
- universal newborn genomic testing
- population-based polygenic risk scoring, implemented alongside other diagnostic tools
- full roll-out of lung cancer screening for people with a history of smoking
- increased uptake of HPV vaccination to support the long-term goal of eliminating cervical cancer

The plan also outlines the intention to establish partnerships between the NHS and authorities leading in devolution and population health, creating 'prevention demonstrators' to test innovative approaches to prevention – the first of which is the Greater Manchester Combined Authority. 'Prevention accelerators' will also support the plan, testing new delivery models for secondary prevention through the Neighbourhood Health Service. They will initially run in selected integrated care boards (ICBs) and focus on community-led methods to tackle variation in uptake of high-impact cardiovascular disease and diabetes interventions. The recent announcement of new health devolution deals for Greater Manchester and South Yorkshire will support a greater focus on preventative healthcare in these areas as part of the government's 10 Year Health Plan and the 'English Devolution

³² Department of Health and Social Care (2025). *Fit for the future: 10 Year Health Plan for England*. <https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf>

and Community Empowerment Bill', in alignment with Greater Manchester's status as a prevention demonstrator, and South Yorkshire's proposal for prevention accelerator status.³³

Sustained and sufficient public health funding will be fundamental to the success of the 10 Year Health Plan's ambitions for prevention. Continued attention on strengthening workforce capacity, infrastructure support, and delivery of inclusive and accessible digital solutions is also needed to help maximise the plan's effectiveness and reduce the risk of widening health inequalities. As innovative approaches are rolled out, ongoing and robust monitoring will be essential to ensure that gains in early diagnosis do not create unsustainable demand on services. For some disease areas, the incoming Modern Service Frameworks offer an important opportunity to address these challenges.

Although responsibility for prevention spans national government, the NHS, local authorities and devolved administrations, coordination across these actors remains fragmented, weakening effective deployment and delivery. Strengthening joint accountability, shared priorities, and aligned delivery mechanisms would provide a clearer pathway to more coherent implementation and greater impact on population health.

In Scotland

'Scotland's Population Health Framework', developed jointly with the Convention of Scottish Local Authorities (COSLA), places a particular emphasis on primary prevention, outlining a whole-system response where prevention is embedded across all parts of government and across all sectors.³⁴ The framework outlines five prevention drivers of health and wellbeing: a prevention-focused system; social and economic factors; places and communities; enabling healthy living; and equitable access to health and care. It also includes a 'health in all policies' approach to ensure that health considerations are evaluated as part of policy development.

Cross-sector approaches are echoed by Public Health Scotland through their recent paper, which also seeks to offer a unified language and framing for approaching prevention across the system.³⁵ Whilst the paper acknowledges NHS Scotland's efforts in secondary and tertiary prevention, which is largely disease-specific and service-based, it calls for greater NHS investment in primary prevention, in order to meet the scale of the shift required to address Scotland's health challenges in low and falling life expectancy and widening health inequalities. However, the Scottish Budget for 2025–2026 shows clearer financial commitments to secondary and tertiary prevention as opposed to primary prevention.³⁶

³³ Department of Health and Social Care (2026). *Health devolution in Greater Manchester and South Yorkshire*. <https://www.gov.uk/government/news/health-devolution-in-greater-manchester-and-south-yorkshire>

³⁴ Scottish Government (2025). *Scotland's Population Health Framework 2025-2035*. <https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2025/06/scotlands-population-health-framework/documents/scotlands-population-health-framework-2025-2035/scotlands-population-health-framework-2025-2035/govscot%3Adocument/scotlands-population-health-framework-2025-2035.pdf>

³⁵ Public Health Scotland (2023). *A public health approach to prevention and the role of NHSScotland*. <https://publichealthscotland.scot/media/17437/public-health-approach-to-prevention-and-the-role-of-nhsscotland.pdf>

³⁶ Scottish Health Equity Research Unit (2025). *Prevention Watch: January 2025*. <https://scothealthequity.org/prevention-watch-january-2025/>

In Wales

Prevention is a key focus of 'A Healthier Wales', the Welsh Government's long-term plan for health and social care, alongside prioritising early intervention and addressing health inequalities.³⁷ The 'Prevention-Based Health and Care Framework' from Public Health Wales provides a model for embedding prevention in the health and care system in Wales, and is designed for use across NHS Wales.³⁸ It incorporates primary, secondary and tertiary prevention, and encompasses both population-focused and person-centred approaches. There is an emphasis on systematically implementing primary and secondary prevention interventions as the best opportunity to reduce health inequalities. Wales also has a number of underpinning policies and duties for improving population health and wellbeing and reducing health inequalities, including the 'Well-being of Future Generations (Wales) Act 2015', which places health and wellbeing at the centre of all government policy and decision-making, and mandates collective working between public bodies.³⁹ This reflects the system-wide tone to the approach to prevention, similar to that seen in Scotland; however, achieving consistent and widespread system transformation to match the ambition of the approach continues to be a challenge.

In Northern Ireland

In Northern Ireland, a system-wide approach to prevention is also framed. From 2013 to 2023, the Department of Health's 'Making Life Better' provided the strategic framework for public health to prevent and improve ill-health and poor wellbeing and reduce inequalities.⁴⁰ It has a focus on wider determinants, and continues to underpin public health policy and prevention activity, with key indicators continuing to be monitored in 2025. The subsequent 'Health and Wellbeing 2026: Delivering Together' plan links early intervention and prevention to the long-term sustainability of services, and provides a roadmap for reform and transformation of Health and Social Care Services, outlining a shift from treatment to prevention.⁴¹ Further to this, the 'Public Health Agency Corporate Plan 2025–2030' frames prevention within laying the foundations for healthy life from pre-birth through to adolescence, living well, and ageing well, alongside a focus on health protection.⁴² It focuses on the wider determinants of health, health inequalities and building a system-wide approach.

³⁷ Welsh Government (2018). *A healthier Wales: our plan for health and social care*. <https://www.gov.wales/sites/default/files/publications/2021-09/a-healthier-wales-our-plan-for-health-and-social-care.pdf>

³⁸ Public Health Wales (2024). *Prevention-based health and care framework*. <https://publichealthwales.nhs.wales/services-and-teams/primary-care-division/prevention-based-health-and-care/prevention-based-health-and-care-framework/>

³⁹ NHS Confederation (2025). *What is population health?* <https://www.nhsconfed.org/publications/what-population-health>

⁴⁰ Department of Health, Social Services and Public Safety (2014). *Making life better: a whole system strategic framework for public health 2013-2023*. https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/making-life-better-strategic-framework-2013-2023_0.pdf

⁴¹ Department of Health (Northern Ireland) (2017). *Health and wellbeing 2026: delivering together*. <https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf>

⁴² Public Health Agency (Northern Ireland) (2024). *Draft corporate plan 2025-2030: preventing, protecting, improving – better health for everyone*. <https://www.publichealth.hscni.net/sites/default/files/2024-11/PHA%20Draft%20Corporate%20Plan%202025-2030%20for%20consultation%2028%20November%202024.pdf>

Existing NHS programmes and interventions

Prevention efforts within the health system centre around a number of disease-specific programmes. The NHS Diabetes Prevention Programme in England has been associated with significant reduction in disease incidence, and was likely to be cost-effective and generate greater QALY gains than the standard care approach.^{43,44,45} For Wales, evaluation of the All-Wales Diabetes Prevention Programme also found associations with reduced blood sugar levels and reduced disease progression.⁴⁶ In Scotland, health boards offer diabetes prevention courses at a local level, for which evaluation is limited, although funding was announced in 2025 for a digital course to be available nationally.⁴⁷ A similar approach exists in Northern Ireland, with a national diabetes prevention programme recently launched by the Public Health Agency.^{48,49}

Weight-loss programmes targeting obesity exist across all four nations. In England, the NHS Digital Weight Management Programme demonstrates short-term effectiveness in achieving moderate weight loss and clinically meaningful outcomes.⁵⁰ Positive weight-loss outcomes were also recorded for Scotland's NHS weight management services.⁵¹ In Wales, patients can be referred to the All-Wales Weight Management Pathway, but limited assessment has been made across a wide range of variation in provision. Limited outcome evidence is also available for Northern Ireland's community weight management programmes; however, a new specialist obesity service is set to launch in 2026.⁵²

Evidence also exists for the success of NHS Stop Smoking Services in England through pharmacological and behavioural interventions, which shows these services are associated with higher long-term quit-rates consistently, and a suggested reduction in premature

⁴³ Bower P, et al. (2025). *The effectiveness and cost-effectiveness of the NHS Diabetes Prevention Programme (NHS-DPP): the Diploma long-term multimethod assessment*. <https://www.ncbi.nlm.nih.gov/books/NBK614155/>

⁴⁴ McManus E, et al. (2024). *Evaluating the long-term cost-effectiveness of the English NHS Diabetes Prevention Programme using a Markov model*. *PharmacoEcon-Open* **8**, 569–83. <https://pmc.ncbi.nlm.nih.gov/articles/PMC11252105/>

⁴⁵ McManus E, et al. (2022). *Population level impact of the NHS Diabetes Prevention Programme on incidence of type 2 diabetes in England: an observational study*. *Lancet Reg Health Eur* **19**, 100420. [https://www.thelancet.com/journals/lanepi/article/PIIS2666-7762\(22\)00114-4/fulltext](https://www.thelancet.com/journals/lanepi/article/PIIS2666-7762(22)00114-4/fulltext)

⁴⁶ Public Health Wales (2025). *Findings for the outcome evaluation of the All Wales Diabetes Prevention Programme*. <https://phw.nhs.wales/services-and-teams/primary-care-division/all-wales-diabetes-prevention-programme/findings-from-the-outcome-evaluation-of-the-all-wales-diabetes-prevention-programme/>

⁴⁷ Scottish Government (2025). *Improving health through prevention*. <https://www.gov.scot/news/improving-health-through-prevention/>

⁴⁸ Public Health Agency (Northern Ireland) (n.d.). *Diabetes prevention programme – Northern Ireland*. <https://www.familysupportni.gov.uk/Service/7206/health-and-wellbeing/diabetes-prevention-programme--northern-ireland>

⁴⁹ Public Health Agency (Northern Ireland) (2019). *New diabetes prevention programme launched across Northern Ireland*. <https://healthwell.eani.org.uk/node/3368>

⁵⁰ Taylor K, et al. (2024). *Early outcomes of referrals to the English National Health Service Digital Weight Management Programme*. *Obesity* **32(6)**, 1083–1092.

⁵¹ Public Health Scotland (2024). *Adult weight management: national report*. <https://publichealthscotland.scot/media/26286/2024-03-26-weight-management-report-adult.pdf>

⁵² Department of Health (Northern Ireland) (2025). *Northern Ireland to get its first obesity management service*. <https://www.health-ni.gov.uk/news/ni-get-its-first-obesity-management-service#:~:text=Date%20published:%2021%20May%202025,a%20very%20significant%20step%20forward>.

deaths.^{53,54} Whilst evaluation of services across Wales, Scotland and Northern Ireland is lacking, recent data show the programmes reach large numbers, with high initial self-reported rates of quitting.^{55,56,57}

For cardiovascular disease, the prevention tool QRISK is used to trigger interventions with strong evidence of benefit, such as statins, blood pressure control and smoking cessation. It is used in NHS Health Checks in England and Wales, and more broadly by general practitioners (GPs) in Northern Ireland. In England specifically, the CVDPREVENT audit assesses NHS performance on prevention of cardiovascular disease. Recent analyses show that whilst improvements have been made in testing and treatment for those at risk of cardiovascular disease, there remain inequalities in treatment and outcomes for some ethnic groups.⁵⁸

More broadly, the NHS Health Check in England is associated with lower risk across all multiorgan disease outcomes and reduced rates of all-cause mortality for those who attend.⁵⁹ However, uptake stands at around 45%–50%, with significant geographic and socioeconomic variation.⁶⁰ The NHS also offers a set of nationally commissioned adult screening programmes designed to detect and reduce preventable illness. Core adult programmes include breast, cervical, bowel, and abdominal aortic aneurysm screening, each targeted at specific age groups where evidence shows the greatest benefit. Alongside these, sits diabetic eye screening, for everyone aged 12 and over with type 1 or type 2 diabetes, aiming to detect early signs of diabetic retinopathy before vision is affected, and enabling timely intervention to prevent sight loss. The NHS also offers screening for 10 rare but serious conditions in newborn babies.

In addition, the NHS in England is rolling out the national Lung Cancer Screening Programme, with full coverage expected by 2030.⁶¹ Seventy-six percent of cancers diagnosed as a result of the screening were at stages 1 and 2, where the disease is more

⁵³ Dobbie F, et al. (2015). *Evaluating long-term outcomes of NHS Stop Smoking Services (ELONS): a prospective cohort study*. HTA **19(95)**, 19950. <https://www.journalslibrary.nihr.ac.uk/hta/HTA19950>

⁵⁴ Bauld L, et al. (2016). *English stop-smoking services: one-year outcomes*. Int J Environ Res Public Health **13(12)**, 1175. <https://pmc.ncbi.nlm.nih.gov/articles/PMC5201316/>

⁵⁵ Welsh Government (2025). *NHS smoking cessation services: September to December 2024*. [https://www.gov.wales/nhs-smoking-cessation-services-september-december-2024-html#:~:text=During%20the%20current%20financial%20year%20\(April%20to,quitting%20at%204%20weeks%20post%20quit%20date](https://www.gov.wales/nhs-smoking-cessation-services-september-december-2024-html#:~:text=During%20the%20current%20financial%20year%20(April%20to,quitting%20at%204%20weeks%20post%20quit%20date)

⁵⁶ Public Health Scotland (2025). *NHS stop smoking services Scotland: April 2024 to March 2025*. <https://publichealthscotland.scot/publications/nhs-stop-smoking-services-scotland/nhs-stop-smoking-services-scotland-april-2024-to-march-2025/#:~:text=Of%20those%20making%20a%20quit,NHS%20and%20non%2DNHS%20settings>

⁵⁷ Department of Health (Northern Ireland) (2025). *Statistics on smoking cessation services in Northern Ireland: 4-week follow up figures for 2024/25, and 52 week follow up figures for 2023/24*. <https://www.health-ni.gov.uk/news/statistics-smoking-cessation-services-northern-ireland-4-week-follow-figures-202425-and-52-week-follow-figures-202324>

⁵⁸ CVDPREVENT (2025). *CVDPREVENT fifth annual report*. <https://static1.squarespace.com/static/65eafc36395e4d64e18a3232/t/6937fb8666a6d23761182c05/1765276550824/CVDPREVENT+Fifth+Annual+Report.pdf>

⁵⁹ McCracken C, et al. (2024). *NHS Health Check attendance is associated with reduced multiorgan disease risk: a matched cohort study in the UK biobank*. BMC Med **22**, 1. <https://link.springer.com/article/10.1186/s12916-023-03187-w>

⁶⁰ Tanner L, et al. (2022). *NHS Health Check programme: a rapid review update*. BMJ Open **12(2)**, e052832. <https://bmjopen.bmj.com/content/bmjopen/12/2/e052832.full.pdf>

⁶¹ Cancer Research UK Cambridge Centre (2026). *NHS England lung cancer screening programme reports positive impact in first five years*. <https://crukcambridgecentre.org.uk/news/nhs-england-lung-cancer-screening-programme-reports-positive-impact-first-five-years>

treatable.⁶² Although uptake of the invitation to screening was less likely in the most deprived socioeconomic groups and in non-white communities, this has improved, possibly reflecting public engagement and work to ensure effective invitation methods.⁶³

⁶² Lee RW, et al. (2026). *Implementation of the NHS England Lung Cancer Screening Programme over 5 years*. *Nat Med* **32**, 1-12. <https://www.nature.com/articles/s41591-026-04292-y>

⁶³ Lee RW, et al. (2026). *Implementation of the NHS England Lung Cancer Screening Programme over 5 years*. *Nat Med* **32**, 1-12. <https://www.nature.com/articles/s41591-026-04292-y>

Government healthcare expenditure on prevention

Despite key government strategies signalling that prevention and early detection are a priority, spending continues to focus on treatment of disease. With the health and care system facing funding and resourcing pressures, prevention is more likely to be deprioritised than immediate acute service delivery, despite the benefits it can provide to the health service in the future.⁶⁴

In the UK, spending on prevention has remained relatively static over the past decade, consistently accounting for around 5%–6% of total healthcare expenditure (Figure 1). While there was a temporary uplift during the pandemic, this increase has not been sustained. Investment has since plateaued, reverting to pre-pandemic levels, and with an overwhelming majority of funding still directed towards the treatment of ill-health. This trajectory is in tension with ambitions to shift the system towards prevention and early intervention, and highlights a gap between aspiration and reality.

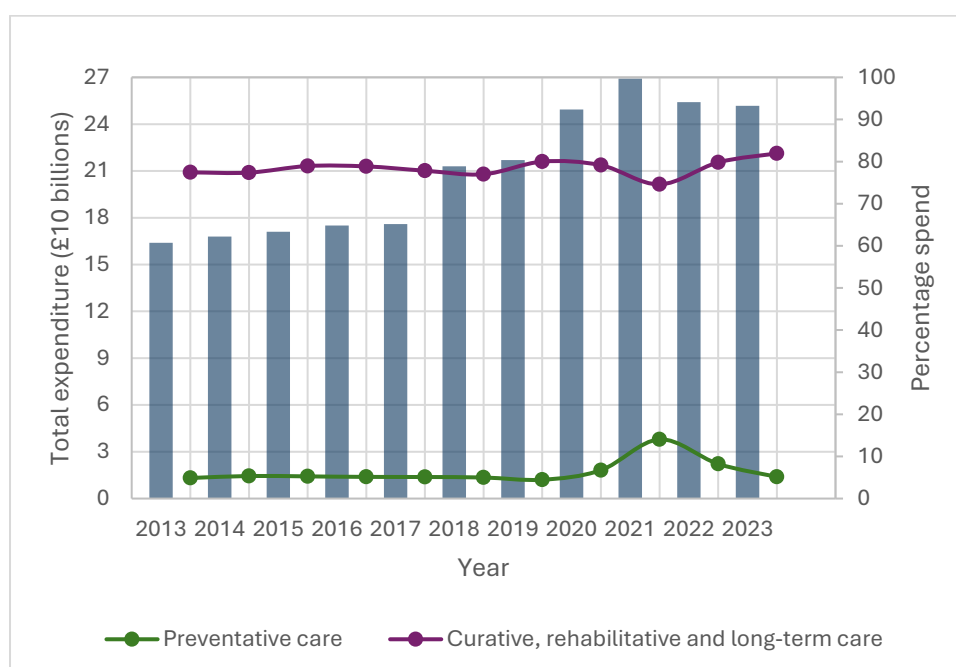


Figure 1: UK Government healthcare expenditure 2013–2023. The percentage of government health expenditure on preventative care (green line) and curative, rehabilitative and long-term care (purple line). The large increase in spend on preventative care between 2020 and 2022 encompasses the COVID-19 response programmes. Total expenditure (in tens of billions of pounds) is represented by the bars. Data are shown from 2013 to 2023, taken from the ONS data on healthcare expenditure, UK Health Accounts.

When looking within overall spending, specifically at the public health grant, analysis by The Health Foundation shows that the public health grant has experienced a real-terms cut of more than 25% between 2015–2016 and 2025–2026, despite recent small rises.⁶⁵ Cuts have tended to be greater in more deprived areas. Comparisons drawn by The King’s Fund also highlighted the disparity in spending on treatment versus prevention with the 2025–

⁶⁴ The King’s Fund (2026). *Measuring a moving target: the complex story of public health and prevention spending in local government*. <https://www.kingsfund.org.uk/insight-and-analysis/blogs/public-health-prevention-spending-local-government>

⁶⁵ The Health Foundation (2025). *Investing in the public health grant*. <https://www.health.org.uk/reports-and-analysis/analysis/investing-in-the-public-health-grant>

2026 per-person budget for NHS spend standing at £3000, compared with less than £70 per person for local authority spend on prevention.⁶⁶

Although the UK allocates a slightly higher percentage of its total health budget to prevention than the OECD average, overall health expenditure per capita remains lower than in many other high-income countries.^{67,68} Despite high proportional spending, the UK continues to experience higher rates of preventable mortality than many of its peers, highlighting the need for sustained, long-term investment in prevention rather than short-term acute responses.⁶⁹ This trend reflects emerging findings from the international comparative analysis commissioned as part of this programme, which will be published in due course.

⁶⁶ The King's Fund (2025). *The King's Fund responds to the announcement of the public health grant allocations in England*. <https://www.kingsfund.org.uk/insight-and-analysis/press-releases/response-public-health-grant-allocations-england-2025>

⁶⁷ OECD (2025). *Health at a Glance 2025: health expenditure on prevention and primary healthcare*. https://www.oecd.org/en/publications/health-at-a-glance-2025_8f9e3f98-en/full-report/health-expenditure-on-prevention-and-primary-healthcare_e65bf24a.html#figure-d1e33054-4220e97733

⁶⁸ OECD (2025). *Health at a Glance 2025: health expenditure per capita*. https://www.oecd.org/en/publications/health-at-a-glance-2025_8f9e3f98-en/full-report/health-expenditure-per-capita_affe6b0a.html

⁶⁹ OECD (2025) *Health at a Glance 2025: avoidable mortality (preventable and treatable)*. https://www.oecd.org/en/publications/health-at-a-glance-2025_8f9e3f98-en/full-report/avoidable-mortality-preventable-and-treatable_e2e21c0b.html

The innovation landscape for prevention

Funding for prevention from public and charitable sources continues to represent one of the lowest proportions within the overall research portfolio, with most support directed towards primary prevention initiatives. Large industry investment is primarily concentrated on vaccine development, small interfering RNA therapies for cholesterol, and the more recent market for weight-loss drugs. Wider commercial sector investment focuses on strengthening the data infrastructure underpinning prevention efforts, including tools for risk stratification. Looking ahead, government infrastructure, such as UK Biobank, Our Future Health and Genomics England, will play a pivotal role in enabling further innovation and advancing the prevention landscape in the UK.

Public and charity funding

Analysis by the UK Clinical Research Collaboration (UKCRC) of the research portfolio across 152 funding organisations in the UK (2022 figures) reports that prevention constitutes 7.1% of funding and is focused on primary prevention (i.e. direct interventions to prevent disease) and promoting wellbeing (i.e. indirect interventions to reduce the risks of ill-health).⁷⁰ This includes vaccines and preventative medicines, and behavioural and environmental interventions. A small amount of prevention-relevant research may also fall under the classification of detection and diagnosis, constituting 11.6% of funding. This category includes biomarker discovery and development, the use of new diagnostic technologies and population screening.

The analysis by UKCRC includes the UK Prevention Research Partnership, a £50 million multi-funder initiative supporting novel research into the primary prevention of non-communicable diseases to improve population health and reduce health inequalities.⁷¹ This initiative followed the 2016 report by the Academy of Medical Sciences, 'Improving the Health of the Public by 2040', and built on the £34 million investment made through the National Prevention Research Initiative between 2005 and 2011.^{72,73} Whilst spending on prevention has increased significantly since 2004–2005 figures, it currently accounts for the second-lowest proportion of research spending across the collective research portfolio. The 'Life Sciences Sector Plan' outlines the UK Government's goal to mobilise public and private investment into prevention through changing its approach to research funding to encourage more research and development (R&D) capital to flow into prevention (primary and secondary), achieving a sustained increase in R&D funding towards prevention by 2030.

National programmes and infrastructure

Many large-scale initiatives in the UK have been implemented to strengthen the UK's prevention research infrastructure. These include UK Biobank, Our Future Health, Genomics England and the NHS Genomics Medicine Service (GMS). The upcoming Health Data Research Service (HDRS) will further strengthen the system in providing a single, secure

⁷⁰ UK Clinical Research Collaboration (2024). *UK health research analysis 2022*. https://hrcsonline.net/wp-content/uploads/2024/09/UK_Health_Research_Analysis_Report_2022_web_v1-2-postpub.pdf

⁷¹ UK Prevention Research Partnership (n.d.). *UK Prevention Research Partnership*. <https://ukprp.org/>

⁷² UK Prevention Research Partnership (n.d.). *Background*. <https://ukprp.org/about-us/background/>

⁷³ The Academy of Medical Sciences (2016). *Health of the public in 2040*. <https://acmedsci.ac.uk/policy/policy-projects/health-of-the-public-in-2040>

gateway for researchers to access linked health and care data across different datasets. In addition to the substantial components of government funding across these initiatives, collaborations and partnerships with industry, charities and private philanthropy represent significant commitment and interest in the opportunities that these resources present.

Driving health innovation and NHS reform is one of the three core pillars of the Life Sciences Sector Plan, with the plan's vision outlining a strong focus on prevention through harnessing the UK's world-leading science and genomics capabilities. The plan sets out actions to catalyse the UK's health data and genomic potential, through establishing the national HDRS and maximising patient benefit from expanding and enhancing Our Future Health, UK Biobank, Genomics England and the NHS GMS. Specific actions for the NHS GMS include rolling out a Unified Genomic Record to integrate data and work with industry in clinical trials and precision medicine access.

Commercial investment

There are varying levels of interest and investment in prevention from the commercial sector. Population-level primary prevention relating to vaccine development by companies such as GSK and AstraZeneca, and pathogen surveillance and pandemic early-warning systems from companies such as Oxford Nanopore Technologies, are the main areas of investment, supported by demand from national and global markets. There has been some success with drugs for secondary prevention, including small interfering RNA therapies to lower cholesterol. Weight-loss medications from Lilly and Novo Nordisk have established a clear and growing market, demonstrating that it is possible to support the development and adoption of medicalised prevention approaches. There remains significant potential for broader population-level prevention strategies, which could deliver substantial long-term benefits if further encouraged and integrated alongside medical innovations. As one example, Lilly is partnering with the government on a health innovation programme to test new ways of supporting patients to manage obesity more holistically.⁷⁴

As mentioned above, commercial investment has also been made in the enabling infrastructure around prevention research and application, such as Amazon Web Services' investment in cloud computing storage access to support UK Biobank, and Oxford Nanopore Technologies' partnership with Genomics England and UK Biobank, and investment in innovative sequencing technology.

There has been investment in tools to enable risk prediction and early detection, with examples in this space including the use of polygenic risk scores for stratified prevention through Genomics plc, GRAIL's multi-cancer blood test, the non-invasive biomarker-based tests from companies such as Owlstone Medical, and Kheiron Medical Technologies' AI-powered breast cancer screening tools. A market has also emerged for digital-based prevention tools, including digital health coaching for chronic conditions or day-to-day wellbeing such as from Holly Health or Liva, AI-powered health navigation platforms from Healthily, and Oviva's personalised weight-loss plans combining care and medication.

⁷⁴ UK Government (2025). *New help for patients battling obesity through pharmacies and community access*. <https://www.gov.uk/government/news/new-help-for-patients-battling-obesity-through-pharmacies-and-community-access>

Barriers to the shift towards prevention and early detection

We interviewed 35 stakeholders from January to April 2026 across academia, government, industry, the NHS, charities, funders and national infrastructure, to understand the key barriers stopping the shift to prevention and early detection. Our findings provide a preliminary insight into the challenges faced in making this shift, which our programme will aim to address.

Maturity of prevention tools – many innovations are at an early stage of development relative to the desire to apply them. Biomarker research in particular was highlighted as being underdeveloped, especially for neurodegenerative disease. Challenges also exist in considering the consequences of applying new screening innovations in terms of the risks of both overdiagnosis and underdiagnosis, for example in the use of polygenic risk scores. There is also limited understanding of how individuals respond to risk information. In some cases, even when risks are identified, possible actions are limited as there are no effective interventions available.

Data infrastructure and governance – challenges were highlighted around a current lack of accessibility and linkage of health data in the UK. Impacts were felt in terms of undertaking clinical trials in the prevention space.

Regulatory and adoption pathways – adoption was felt to be hindered by strict regulatory requirements, inconsistent guidance or unclear standards. Insufficient guidance was raised in the context of precision prevention trials. A further challenge raised centred around the lack of transparency and clarity in the NHS decision-making process for adoption of preventative interventions. For digital prevention tools, regulatory and adoption pathways are felt to be fragmented, with no consistent commissioning process within the NHS, making it difficult for these tools to progress beyond pilot programmes and gain widespread acceptance and use.

Investment incentives and barriers to scaling innovation – prevention initiatives are often seen to be economically undervalued, in part due to the long-term nature of their benefits, which are often not captured in the time frame over which they are evaluated, and the application of the discount rate. Challenges also arise in making the case for prevention when faced with ongoing system costs, such as continued monitoring of patients even if disease remission is achieved. Specific barriers were also raised in the context of drug repurposing, where there are minimal incentives to adapt off-patent medicines for preventative use.

Health system structure – the current health system is structured around the delivery of treatment rather than prevention. However, the strategy needed to achieve the scale of system change required to overcome this is absent, representing a significant barrier to achieving a shift to prevention. Fragmentation within the system, particularly across NHS trusts, also makes it difficult to implement system-wide preventative measures. Complex referral pathways—such as those encountered in obesity services—further impede the effectiveness and accessibility of prevention initiatives.

Workforce culture and behaviour – in primary care settings, it was felt that prevention is no longer a central priority. GPs often face limited capacity and lack adequate incentives to engage in preventative work, which results in initiatives being deprioritised in favour of more immediate clinical concerns. Some feel there is an over-reliance on drug-based interventions, inadvertently displacing necessary behavioural changes. This approach risks undermining long-term outcomes, as evidenced by issues such as weight regain once medication is discontinued.⁷⁵

Research funding – challenges around research funding and clinical trial infrastructure represent significant barriers to the advancement of preventative healthcare through limiting the generation of the robust evidence and knowledge essential for innovation. Research funding tends to be concentrated on a relatively narrow set of primary prevention approaches, resulting in notable gaps in other important areas. Preventative clinical trials are frequently seen to be under-resourced and there is a lack of investment in precision prevention and methodological innovation.

Environmental and social determinants – environmental and social factors play a pivotal role in shaping the effectiveness and uptake of preventative healthcare interventions. Recent reductions in funding for preventative initiatives have disproportionately affected deprived communities. Cuts to these essential resources not only hinder the delivery of interventions but also exacerbate existing health inequalities. Without targeted investment and a commitment to addressing the root social and environmental determinants of health, efforts to improve population health and reduce disparities risk falling short of their potential. One persistent challenge highlighted is the prevalence of obesogenic environments. Such environments can make it significantly more difficult for individuals to engage in and sustain healthy behaviours, thereby limiting the overall impact of prevention strategies.

Political and legislative misalignment – the short-term nature of political and fiscal cycles often clashes with the sustained commitment needed for effective prevention. This results in inconsistent policy direction, unstable funding, and a lack of unified commitment, particularly when linked to the broader health determinants.

We intend to investigate these barriers to unlock the transformative potential of prevention and early detection in the UK and globally. To do this we will focus on the broad areas of innovation, systems, economy and inclusion, exploring the following questions as a starting point:

- If everyone agrees that prevention is crucial, why is it still so difficult for health services to move beyond rhetoric and make it a reality?
- How can we support innovations like genomics, polygenic risk scores, and biomarkers to reach their full potential and how do we embed accountability throughout the system?
- Do current research funding incentives reward treating disease rather than preventing it?

⁷⁵ West S, et al. (2026). *Weight regain after cessation of medication for weight management: systematic review and meta-analysis*. BMJ **392**, e085304. <https://www.bmj.com/content/392/bmj-2025-085304>






- Do current evaluation frameworks such as QALY-driven approaches properly capture the full economic value of secondary prevention and early detection, or are we overlooking impacts that matter most for the health and productivity of the population?
- Do employers recognise their power to champion prevention and early detection at work, or are they missing a vital opportunity to transform workforce health?
- Will current strategies for prevention and early detection tackle health inequalities, or could they risk widening the gap?



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