MEASURING WHAT MATTERS

An annual assessment of UK medical science

July 2026

ACADEMY OF MEDICAL SCIENCES

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Foreword

UK medical science is one of our greatest national strengths. It improves lives, drives innovation, supports economic growth and underpins the resilience of our health system. In a rapidly changing world, its importance will only grow.

But if we are to sustain and strengthen that contribution, we must be clearer about how we measure success and where we need to do better. Better measurement leads to better decisions, better investment and better outcomes.

This report is rooted in a simple conviction: to maximise the impact of medical science, we need a stronger and more coherent evidence base. That means collecting data more consistently, connecting it more effectively and using it more intelligently. It also means focusing on the domains that matter most, so that we can assess progress honestly, identify priorities confidently and target interventions where they will have the greatest effect.

The provisional framework proposed here is designed to support that ambition. It offers a practical foundation for assessing progress against the Academy's goals: making the UK the best place in the world for a career in medical science; improving health outcomes in the UK and internationally; mobilising the health system to turn discovery into practice; and strengthening public trust in medical science at a time when misinformation can spread rapidly and widely.

The UK already has many of the data assets needed to begin this work. This report highlights a number of them and shows how they can be used to tell a clearer story about capability, impact and opportunity. But this is only the beginning. We intend for this assessment to become an annual exercise, creating over time a more robust, consistent and actionable picture of the state of UK medical science.

Medical science should be recognised for what it is: not only a source of discovery, but a strategic national asset. If we are serious about improving health, increasing prosperity and maintaining public confidence, we must be equally serious about the evidence that informs our decisions.

We hope this report will provide a basis for collaboration across the sector, and we look forward to working with partners to build the evidence framework we need to support excellence, accelerate impact and strengthen trust.

Professor Sir Andrew Morris CBE FRSE PMedSci, President, Academy of Medical Sciences

Rosalind Campion, Chief Executive Officer, Academy of Medical Sciences

Executive summary

This report provides a provisional framework for a high-level assessment of the trajectory, data and policy relating to UK medical science. It proposes a set of domains that we should value and support, to deliver world-class medical science that benefits patients, the public and the wider economy.

We will not fix everything simply by having better data, and we recognise that health inequalities exist due to broader structural issues. However, we hope that this report provides a helpful starting point for how we can use data to review the outlook for UK medical science and identify where progress is needed to reach its full potential. As noted, our assessment is provisional and based on judgements of the data rather than a systematic average. We would be delighted to work with the medical science community as we develop this framework further and fill the gaps.

Creating a healthier population and reducing health inequalities

Trajectory assessment

Concerning: The Government has set an ambition in the National Health Service (NHS) 10 Year Health Plan for England to reduce health inequalities. But healthy life expectancy **continues to decline** and **there are health inequalities between the most and least deprived areas**.

Data assessment

There are informative national datasets, including from the Office for National Statistics (ONS) and the Organisation for Economic Co-operation and Development (OECD), that can help to **assess the health of the UK population**, across localities and demographics and compared with other nations. We should consider how to use this data to inform decisions on regional policy and investment, as well as whether it indicates international partnership opportunities to address global challenges.

Policy assessment

We need to **better map, understand and address health inequalities**, with a stronger focus on equity, across the broad spectrum of health and healthcare. We should explore if regional variations can be addressed by **reducing any unhelpful fragmentation within the system**.

Detecting and preventing health issues at an earlier stage

Trajectory assessment

Concerning: The **proportion of adults living with obesity has risen since the early 1990s**, while **childhood vaccination coverage continues to decline**. There is variation in vaccines uptake and coverage between different communities.

Data assessment

Aligning data from the Department of Health and Social Care (DHSC), the National Health Service (NHS) and the UK Health Security Agency (UKHSA) on preventative measures and avoidable health issues can **support the shift from sickness to prevention**. The data can help us identify where there are health disparities and where challenges are avoidable or could be addressed at earlier stages, with a view to making targeted interventions.

Policy Assessment

The shift from sickness to prevention is vital for creating healthier lives and reducing health service pressures. The data shows **a need to invest in and value this shift**, to reduce rates of low vaccination, obesity, and avoidable hospital admissions.[1]

Delivering world-class health research

Trajectory assessment

Strong: The UK's health research is high quality. It is encouraging to see the life sciences highlighted as a growth sector and the broad increase in R&D spend. However, **targeted investment in health R&D is below that in many other nations**. UK universities' low-cost recovery for research activities means that it is cross subsidised from other sources.

Data assessment

Data from the Government, health funders and universities helps us to **examine current rates and distribution of investment in health research**, and **how the UK performs in terms of impact and output**. We should use this data to maximise the UK's life sciences strengths and ensure we can convert research into innovative outputs that support population health.

Policy assessment

The strength and financial sustainability of the UK's research institutions underpin both the training of talented researchers and their ability to contribute to the health and wealth of the UK. There is also a unique interdependency of funding across the Government, commercial and not-for-profit sectors. As the data shows, **we should not take this for granted**, especially given the financial challenges faced by universities (and other sectors).

Building capacity to accelerate the development of new health treatments

Trajectory assessment

Developing: The latest figures show **progress on clinical trials set-up times** and a positive trajectory towards meeting the targets set by the Government. There are differences, however, in the progress of commercial and non-commercial trials, and improvement is needed in **trial recruitment and the transparency of outcomes**, to ensure the UK remains a leader in clinical research.

Data assessment

It is helpful to see **data from the DHSC on performance against targets set by the Government last year**. Through published performance metrics and transparency data, we can identify where to showcase the UK as a leading environment for health innovation, and where further progress could be made.

Policy Assessment

We need to **further enhance the clinical trials environment**, by speeding up regulatory processes, increasing transparency and data on activities, and encouraging participation in research. Sustaining

[1] The Academy has a flagship policy programme on **maximising the impact of medical sciences in prevention and early detection**.

and building on progress will require continued focus from system partners, particularly in **reducing variation between sites and embedding best practice**.[2]

Increasing public trust and engagement in medical science

Trajectory assessment

Developing: It is encouraging to see that **the public values science and understands the importance of R&D in improving the NHS and developing new treatments**.[3] However, we need to address the uncertainties and mistrust around artificial intelligence (AI) and perceived '*profit-driven motivations*' of business R&D. We also need to put greater efforts towards **converting this public interest into improved engagement in clinical trials and studies**.

Data assessment

Survey data from UK Research and Innovation (UKRI), Ipsos and the Campaign for Science and Engineering (CaSE) allows us to **monitor public sentiment in science and technology**, which in turn helps to identify how we can engage with people from all backgrounds to outline the value of medical science, discuss concerns and build trust in the process.

Policy Assessment

We need to make sure we **maintain and build trust in medical science**, particularly as we find ways to adopt emerging technologies such as AI. And to achieve health equity, we need to **create more supportive environments** for everyone to participate in medical science.[4]

Developing a workforce fit for the future

Trajectory assessment

Concerning: There have been **worrying trends in the clinical academic workforce**, both in absolute numbers and as a proportion of the expanding NHS workforce. While there have been improvements in workforce diversity, men still hold a high proportion of senior roles. The workforce is also ageing, which is of concern for the future of research activity. Further, career mobility has long been identified as an issue in medical science, particularly **a lack of formal and structured opportunities** to move between academia, industry and the NHS.

Data assessment

Analysis from the Medical Schools Council (MSC) is helpful for understanding trends in clinical academic employment, a key part of the medical science workforce. However, **workforce data needs to be embedded more strongly in national data collection**. Following the reports on clinical academics commissioned by the Office for Strategic Coordination of Health Research (OSCHR), we hope that improvements to data collection in the Higher Education Statistics Agency (HESA) record and the Research Excellence Framework (REF) will be implemented.

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[2] The Academy has a flagship policy programme on **transforming the generation and application of clinical evidence to speed up translation from discovery to patient impact, ensuring equitable inclusion of underserved groups**. We also want to **mobilise the health system to turn discovery into practice**.

[3] CaSE (2026). *Reimagining R&D: What future does the sector want for UK R&D?* https://www.sciencecampaign.org.uk/analysis-and-publications/detail/reimagining-rd-what-future-does-the-sector-want-for-uk-rd/

[4] The Academy has a programme of work on **increasing public trust in medical sciences in an era of misinformation**, as well as on **making the UK a leader in responsible, effective and equitable AI and data use across the biomedical sciences**.

Following a recommendation in our Future-proofing UK Health Research report, the Academy was pleased to see the Department for Science, Innovation and Technology (DSIT) include a section in their Research and Innovation Workforce Survey on the **prevalence, drivers and barriers to cross-sector mobility**.[5]

Policy assessment

To reverse the decline in clinical academic numbers, we need to **establish a clearer national career framework**, which supports flexible training pathways, backed by support from leaders and mentors, with appropriate pay and funding.[6]

We also need to **improve the porosity between academia, industry and the NHS** so that research and innovation activities are maximised for medical science. This includes opportunities to move between sectors, as well as incentives for organisations to share R&I infrastructure.[7]

Supporting economic growth through medical science

Trajectory assessment

Developing: **The number of people employed by businesses in the life sciences industry has increased**, with medical technology accounting for the largest subsector in terms of employment. Turnover generated by the UK life sciences industry has also increased, and there has been a **recent uplift in estimated inward foreign direct investment** into the UK. However, there has been a **substantial rise in people deemed economically inactive since 2019**, which will only increase if action is not taken. This is leading to significant additional costs to the NHS.

Data assessment

Data on turnover, employment and investment from the Office for Life Sciences (OLS) underlines the life sciences as a key growth sector. Data also shows **the benefits of investing in medical science**, in terms of how a healthy population improves economic performance.

Policy assessment

In the Industrial Strategy, there are ambitions for UK to be, by 2035*, 'the third most important Life Sciences economy globally, after the US and China'*.[8] To meet this ambition, **we need the policy landscape to value medical science as a core UK strength in ways that support consistent decision-making**, which will improve its ability to attract clinical research investment.

[5] Academy of Medical Sciences (2023). *Future-proofing UK Health Research: a people-centred, coordinated approach.*
[6] An Academy organisational priority is to **work with others to stabilise and begin to reverse the decline in early career clinical academic posts**.
[7] The Academy has established a **UK Medical Science Careers Taskforce** to identify the gaps and fixes for medical science careers. This will consider how we can enhance the cross-sector interface.
[8] DBT (2025). *The UK's Modern Industrial Strategy 2025.* https://www.gov.uk/government/collections/the-uks-modern-industrial-strategy-2025

Why is medical science important?

Medical discovery and innovation improve health outcomes, support the delivery and transformation of the UK's healthcare system and generate economic growth. They also help to tackle a triple health threat facing the UK.[9]

Threat	Opportunity
Poor health outcomes. The UK has comparably low life expectancy, high rates of avoidable mortality (preventable and treatable) and significant health inequalities.	**Preventing ill health.** Medical science can transform the NHS into a more preventative healthcare system.
Health service pressures. The NHS faces operational and financial pressures, while demographic changes are increasing healthcare demands.	**Supporting innovation.** Medical science allows us to understand and utilise new pathways and emerging technologies to maximise the use of health data.
Low economic growth. Economic growth is the Government's key mission, but this is complex and a significant challenge. Health is a significant driver of the UK's economy.	**Growing the economy.** Medical science can build clinical research capability and capacity to deliver inward investment and support economic growth.

From a glance at the data, we can see why medical science is so important for the UK:

- From a **health outcomes** perspective, life expectancy in the UK is lower than most comparable countries for males and the lowest for females. The gap between the UK and most comparable countries grew between 2019 and 2023.[10]
- From a **health systems** perspective, there is data which highlights where mortality could be avoided through prevention and treatment.[11]
- From an **economic perspective**, there are nearly three million people economically inactive for health reasons.[12] If no further action is taken, it is estimated that this will increase by 600,000 people by 2030.[13]

Successive governments have rightly acknowledged the role and value of medical science in the UK. The Government's 10 Year Health Plan for England, UK Industrial Strategy and Life Sciences Sector Plan all show strong ambitions to unlock the potential of biomedical and health research, save lives and power innovation and investment.[14,15,16] These ambitions were supported by the £86 billion of

[9] Informed by unpublished research commissioned by the Academy from Future Health
[10] Raleigh, V. (2025). *Is the UK becoming the 'sicker man' of Europe?* https://www.kingsfund.org.uk/insight-and-analysis/blogs/uk-sicker-man-europe
[11] *Ibid.*
[12] ONS (2025). *Economic inactivity due to long-term sick or disabled, by health condition and change over time, Scotland and UK, selected years.* https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/adhocs/3123economicinactivityduetolongtermsickordisabledbyhealthconditionandchangeovertimescotlandandukselectedyears
[13] DWP, DBT (2026). *Keep Britain Working: Final report.* https://www.gov.uk/government/publications/keep-britain-working-review-final-report/keep-britain-working-final-report
[14] DHSC (2025). *10-Year Health Plan for England.* https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future
[15] DBT (2025). *The UK's Modern Industrial Strategy 2025.* https://www.gov.uk/government/collections/the-uks-modern-industrial-strategy-2025
[16] OLS (2025). *Life Sciences Sector Plan.* https://www.gov.uk/government/publications/life-sciences-sector-plan

R&D funding announced at the June 2025 Spending Review.[17] More recently, we've seen the Government publish a 'Life Sciences Sector Plan: One Year On' report, alongside a dedicated Jobs Plan, which was informed by the Academy's UK Medical Science Careers Taskforce.[18,19,20]

However, to realise the growth potential of the medical sciences sector and build an NHS fit for the future, we need to find the right ways to measure, and subsequently improve, performance.

How do we know if UK medical science is on the right trajectory?

While the UK is a global leader in medical science, we are yet to unlock its full potential. To assess and improve the landscape of UK medical science, we have identified the following domains:

Domain	Importance
Creating a healthier population and reducing health inequalities	Investment and progress in medical science should translate into good health outcomes.
Detecting and preventing health issues at an earlier stage	Downstream health problems and costs are reduced by enabling early diagnosis and treatments.
Delivering world-class health research	High-quality research and sustainable institutions underpin discovery and the implementation of effective and efficient interventions.
Building capacity to accelerate the development of new treatments	The speed of, and ability to translate research from, clinical trials is key to developing timely solutions.
Increasing public trust and engagement in medical science	The quality of, and trust in, medical science are improved by patient and public involvement throughout.
Developing a workforce fit for the future	A thriving, empowered research workforce makes medical science possible.
Supporting economic growth through medical science	Medical science has the potential to enhance productivity, create jobs and leverage investment.

[17] UK Government (2025). *Transformative £86 billion boost to science and tech to turbocharge economy, with regions backed to take cutting-edge research into own hands.* https://www.gov.uk/government/news/transformative-86-billion-boost-to-science-and-tech-to-turbocharge-economy-with-regions-backed-to-take-cutting-edge-research-into-own-hands
[18] OLS (2026). *Life Sciences Sector Plan: One Year On.* https://www.gov.uk/government/publications/life-sciences-sector-plan-one-year-on
[19] OLS (2026). *Life Sciences Jobs Plan.* https://assets.publishing.service.gov.uk/media/6a4e701e559c26eacf438f53/life-sciences-jobs-plan.pdf
[20] Academy of Medical Sciences (2026). *New national taskforce to secure the future of UK medical science careers.*

How does existing evidence help us to assess the landscape?

Plenty of data exists to help us better understand the environment of UK medical science within these domains. In addition to national datasets from the ONS, the NHS has also developed a public data gateway, while the DHSC and the OLS publish progress against targets and comparative performance data.[21,22,23] By bringing this together, we can:

- Explore trends in the **health of the population** through metrics such as healthy life expectancy, avoidable mortality rates, and differential health outcomes.
- Consider how well **health issues have been detected and prevented** by reviewing vaccine uptake, stages of diagnosis, and control of modifiable risk factors.
- Assess the **performance and potential of medical research** by comparing its outcomes, investment and sustainability to other countries.
- Analyse the **acceleration of health innovations** through the number of clinical trials and their set-up times.
- Review **public trust and engagement in medical science**, through surveys on public attitudes and more integrated patient and public involvement (PPI) in research.
- Look at how **future-proofed the medical science workforce** is, by monitoring data on student and staff numbers, clinical academic capacity and cross-sector mobility.
- Examine **contributions to economic growth** by looking at job creation and private investment from life sciences activity.

But the data is not perfect. There are time lags between financial, academic and other reporting years. It is difficult to track the rates at which research activity is embedded into health service strategy and delivery. Further, the medical science community includes academia, charities, industry, the NHS and the Government, all of which collect data in different ways.

[21] NHS England (N.D.). *NHS England public data gateway.* https://data.england.nhs.uk/
[22] DHSC (2026). *Government drives forward its 150-day clinical trial target.* https://www.gov.uk/government/news/government-drives-forward-its-150-day-clinical-trial-target
[23] OLS (2026). *Life sciences competitiveness indicators 2026.* https://www.gov.uk/government/publications/life-sciences-competitiveness-indicators-2026/life-sciences-competitiveness-indicators-2026-summary

Examples of data collection by sector

Academia	Industry	NHS	Government
Student and staff numbers Research outputs / impact International collaborations Research sustainability and infrastructure	Commercial trials and manufacturing Innovations Investment and trade	Health outcomes data Health interventions, including treatment and early detection Workforce numbers	Investment in research and medical science Key performance measures and comparative performance datasets

The domains we have identified are also impacted by structural and resource-driven issues that cannot be solved simply by having better data. We need to consider broader issues such as funding, system fragmentation, weak incentives and a constrained workforce. Further, we recognise that there are distinct data sets and policy considerations for the Devolved Nations, distinctions which we hope to explore further. However, by enhancing the collection and application of medical science data, we can improve our understanding of how we can help to create a healthier population and a thriving research and innovation environment, wherever they are located.

A snapshot of UK medical science

The next section of this report uses 30 figures to provide a high-level assessment (ranging from **concerning**, to **developing**, to **strong**) of medical science across the seven selected domains set out earlier. These assessments are based on current state, trajectory and international comparisons, and are judgements of the data rather than a systematic average. Although they do not attempt to provide a holistic appraisal of the sector, they review important measures, indicate where we could build our understanding further over time, and identify where improvements can be made. Data sources are included in Annex 1.

Domain 1: Creating a healthier population and reducing health inequalities

What we want to see

Investment and progress in medical science should translate into good health outcomes.

How we can measure it

Evidence about the health of the UK population, how it has changed over time, and how it compares with other countries.

Indicative metrics

Healthy life expectancy

Figure 1: Healthy life expectancy at birth by sex, UK, 2011-13 to 2022-24

Mortality rates for deaths from avoidable causes

Figure 2: Age-standardised mortality rates for deaths from avoidable causes, England and Wales, registered between 2001 and 2024

Figure 3: All-Cause Mortality in England by Index of Multiple Deprivation Decile, 21 March 2021 to 31 January 2023

International comparisons of health status and risk factors

Figure 4: OECD comparisons of health status and risk factors, 2025 statistics

Trajectory assessment

Metric	Assessment
Healthy life expectancy	**Concerning**: Despite Government ambitions, healthy life expectancy continues to decline.
Mortality rates	**Developing**: Mortality rates are improving, but there are health inequalities between the most and least deprived areas.
International comparisons of health status and risk factors	**Developing**: The UK performs better than the OECD average in 5 out of 10 key indicators measuring health status and risk factors. The UK performs worse than the OECD average in preventable mortality and obesity.

Data assessment

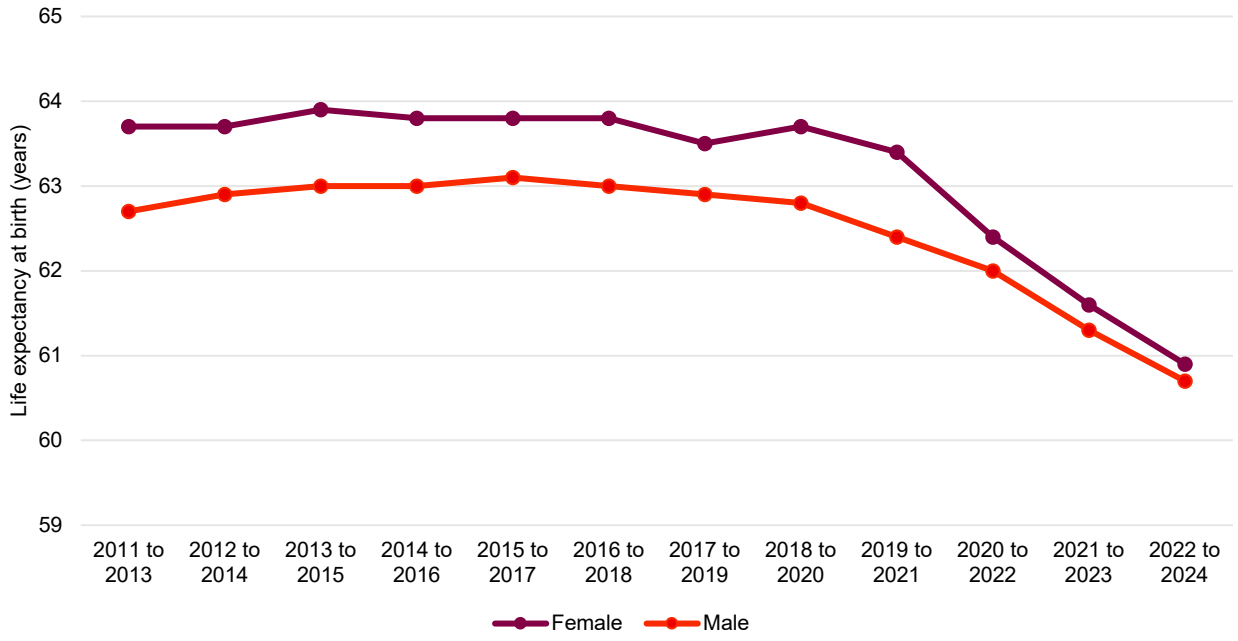
- There is a broad range of national datasets that can help to assess the health of the UK population, across localities, demographics and show how it compares internationally.
- We should consider how to use this data to inform decisions on regional policy and investment, as well as international partnership opportunities to address global challenges.

Policy assessment

- The Government has set an ambition in the NHS 10 Year Health Plan for England to reduce inequalities. We need to map, understand and address these health inequalities, with a stronger focus on equity, across the broad spectrum of health and healthcare.
- We should explore whether regional variations can be addressed by improving coordination of decision-making within the system, where it weakens delivery.

Figure 1: Healthy life expectancy at birth by sex, UK, 2011-13 to 2022-24

Source: Office for National Statistics (ONS)



The ONS noted that *'healthy life expectancy (HLE) at birth in the UK, for both males and females, decreased to its lowest level since the ONS time series began in 2011 to 2013. HLE has also decreased in the majority of areas within every constituent country and every region of England.'*

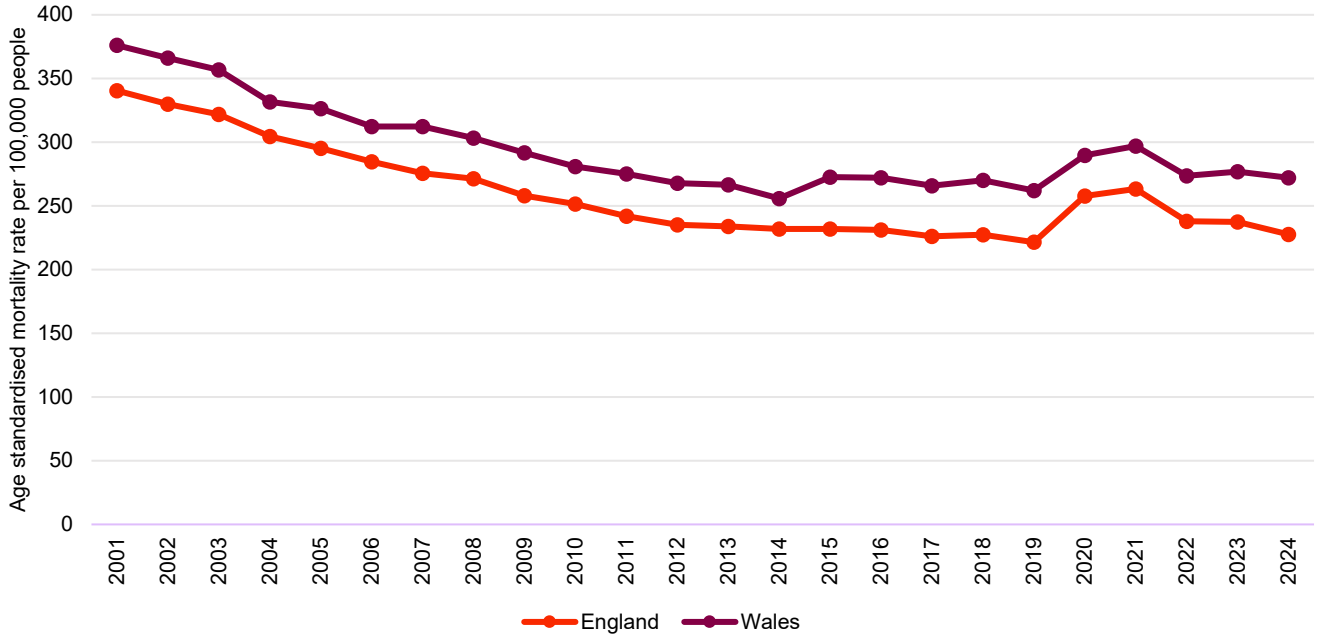
There are also notable differences between the four nations; in 2022 to 2024, England had the highest HLE for both males (60.9 years) and females (61.3 years), Scotland had the lowest HLE for males (59.1 years), and Wales had the lowest for females (58.5 years).

In 2024, the Government Actuary's Department suggested that *'the UK has some catching up to do in terms of HLE when compared to some of its European and worldwide counterparts'*.[24] We need to ensure that medical science helps move us in the right direction.

[24] Government Actuary's Department (2024). *Healthy life expectancy - Mortality Insights.* https://www.gov.uk/government/publications/mortality-insights-from-gad-december-2024/mortality-insights-from-gad-december-2024

Figure 2: Age-standardised mortality rates for deaths from avoidable causes, England and Wales, registered between 2001 and 2024

Source: ONS



The ONS noted that in 2024, *'around one in five deaths were considered preventable or treatable in England and Wales, with age-standardised avoidable mortality rates falling to levels similar to the years preceding the coronavirus (COVID-19) pandemic'*. We need to make sure this downward trend continues, by maximising the impact of medical sciences in prevention and early detection.

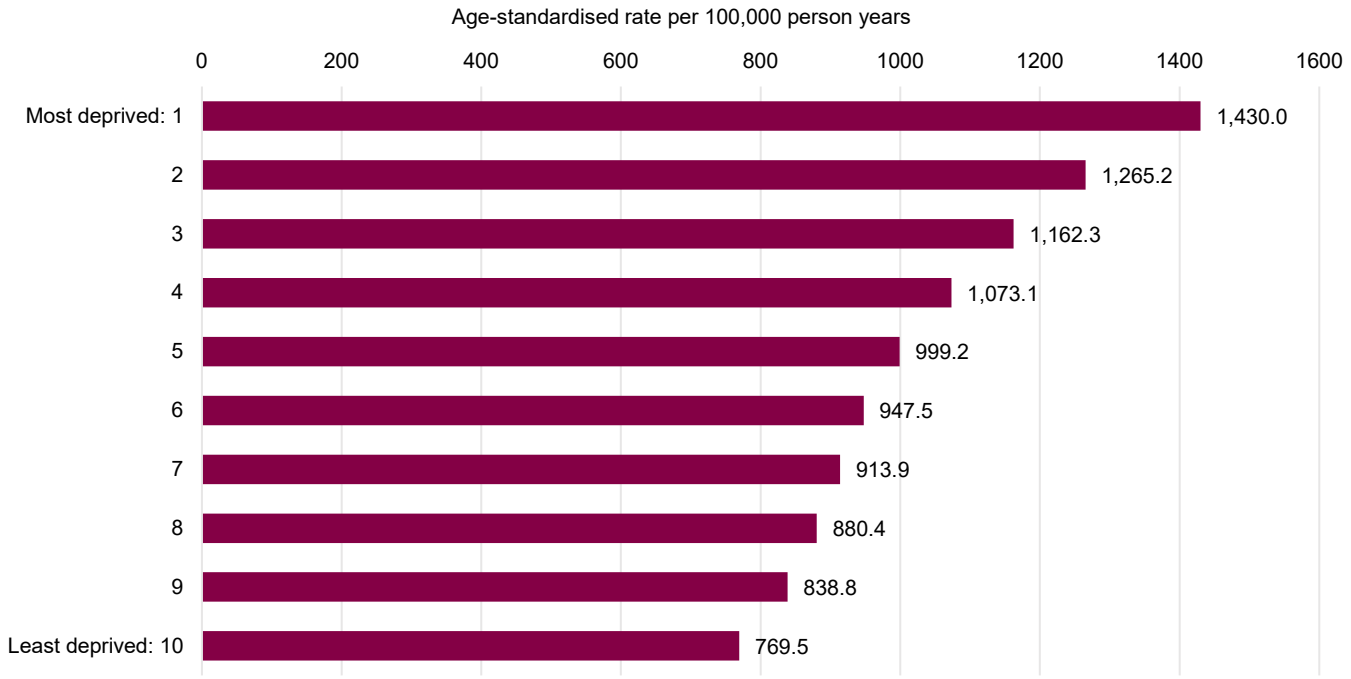
In England, the highest rates of avoidable mortality were in the north east, with the lowest rates in the south east. Further, there are higher rates of avoidable mortality in more deprived areas, with the ONS noting that *'in both England and Wales, the most deprived areas had avoidable mortality rates nearly four times higher than the least deprived areas'*.

It is worth exploring whether some of this regional variation can be addressed by improving coordination of decision-making within the system.[25]

[25] Academy of Medical Sciences (2026). *Shifting left to prevention: innovation for fairer health.*

Figure 3: All-Cause Mortality in England by Index of Multiple Deprivation Decile, 21 March 2021 to 31 January 2023

Source: ONS



Data from the ONS shows that, in 2023, age-standardised mortality rates (ASMRs) were *'higher among males than females for all-cause mortality and most individual conditions; however, females had higher rates of mortality involving asthma and dementia'*.

The Academy's research has noted that health inequalities within a country usually result in those from lower socioeconomic backgrounds, or from minority and marginalised groups, having poorer health.[26] The data shows that ASMRs for all-cause mortality and most individual conditions were *'generally highest in the most deprived areas and among people who were long-term unemployed or had never worked; the largest differences by deprivation were observed for mortality involving chronic obstructive pulmonary disease, followed by lung cancer and asthma'*.

The Academy's work with the InterAcademy Partnership recommended that we need to *'map, understand and address health inequalities and to develop pandemic preparedness plans with a stronger focus on equity across the broad spectrum of health and healthcare'*.[27]

[26] Academy of Medical Sciences (N.D.). *Health inequalities.*
[27] Academy of Medical Sciences, IAP (2022). *Global Health Inequalities: Research for a fairer future.*

Figure 4: Comparisons of health status and risk factors, 2025 statistics

Source: OECD

	OECD	Worst	Best	UK
Life expectancy at birth Years of life at birth	81	76	84	81
Preventable mortality Deaths per 100,000 population	145	304	78	156
Treatable mortality Deaths per 100,000 population	77	175	34	71
Suicide rate Deaths per 100,000 population	11	23	4	9
Poor health (self-reported) % of the population aged 15+	8	15	1	8
Daily smokers % of the population aged 15+	15	28	6	11
Alcohol consumption Litres per person aged 15+	9	12	2	9
Insufficient physical activity % of the population aged 18+	30	61	11	22
Obesity % of the population aged 15+	19	35	5	29
Air pollution Micrograms per cubic metre	11	23	5	10

Green colour means UK performance is better than the OECD average

The OECD's 'Health at a Glance 2025' publication notes that *'the UK performs better than the OECD average on 5 out of 10 key indicators measuring health status and risk factors for health'*. However, the UK performs worse than the OECD average in preventable mortality and obesity. Life expectancy at birth was also 0.1 years below the OECD average, with the data in the figure above shown to one decimal place.

The Academy's work on global health inequalities shows that the research community has a critical role to play in generating the evidence to shape a future where good health is more equally shared. This includes community engagement, using data to understand root causes and bringing together interdisciplinary expertise.[28]

[28] Academy of Medical Sciences, IAP (2022). *Global Health Inequalities: Research for a fairer future.*

Domain 2: Detecting and preventing health issues at an earlier stage

What we want to see

Downstream health problems and costs are reduced by enabling early diagnosis and treatments.

How we can measure it

Coverage and uptake of prevention-based interventions and times to diagnosis and treatment.

Indicative metrics

Coverage and uptake of vaccination and screening programmes

Figure 5: Difference in uptake of national immunisation programmes in England between the least deprived and most deprived Upper Tier Local Authorities Index of Multiple Deprivation deciles in 2024/25

Figure 6: Children vaccinated in England by their first or second birthday, 2006/07 to 2024/25

Times to diagnosis and treatment

Figure 7: Cancer waiting times, 2021/22 to 2025/26

Prevalence and control of modifiable risk factors

Figure 8: Trend in adults living with obesity in England, 1993 to 2022

Long-term condition incidence trends

Figure 9: Prevalence of adult long-standing conditions in England, 2024

International comparisons of avoidable hospital admissions

Figure 10: Avoidable hospital admissions per 100,000 population, OECD comparisons, 2023

Trajectory assessment

Metric	Assessment
Coverage and uptake of vaccination and screening programmes	**Concerning**: Childhood vaccination coverage continues to decline and immunisation inequity persists in England.
Times to diagnosis and treatment	**Developing**: Performance of cancer waiting times has improved across all the selected indicators. However, not all the targets have been met.
Prevalence and control of modifiable risk factors	**Concerning**: The proportion of adults living with obesity has risen since the early 1990s.
Long-term condition incidence trends	**Developing**: While stabilising, more than two fifths of adults aged 16 and over have at least one longstanding illness or condition.
International comparisons of avoidable hospital admissions	**Developing**: The UK performs better than the OECD average when it comes to avoidable hospital admissions per 100,000 population.

Data assessment

- The data can help us to identify where health challenges are avoidable, or could be addressed at an earlier stage, and where there are disparities in these interventions.
- We have previously noted that a barrier to realising innovations in prevention is the challenge of accessing and linking data.

Policy assessment

- Academy commissioned research conducted by Brown University, to be published shortly, has identified that *'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'*.
- However, *'we have seen a shift in the narrative around prevention and early detection in the UK, 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.'*[29]
- The shift from sickness to prevention is vital for creating healthier lives and reducing health service pressures. It is important to invest in and value this shift, to reduce rates of low vaccination, obesity, and avoidable hospital admissions, identifying health issues at the right times.
- All countries are grappling with how to pivot health systems towards prevention, taking varied approaches and achieving different results. The Academy is examining 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.[30]
- The Academy's work with the Northern Health Science Alliance is an example of how the medical science community can: explore the current state of health and health equity across regions, share leading examples of prevention in action, from early years to mental health and nutrition; reflect on the successes of other health systems; discuss the role of cross-sector collaboration in delivering impact at scale; and examine how we incentivise and sustain public and private investment in prevention and early detection.[31]

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[29] Academy of Medical Sciences (2026). *Shifting left to prevention: innovation for fairer health.*
[30] *Ibid.*
[31] Academy of Medical Sciences, NHSA (2026). *Cross-Sector North of England: Future Proofing Northern Prevention Research.*

Figure 5: Difference in uptake of national immunisation programmes in England between the least deprived and most deprived Upper Tier Local Authorities (UTLA) Index of Multiple Deprivation (IMD) deciles in 2024/25

Source: UKHSA

Programme	Age at measurement	National coverage (%)	Coverage in least deprived decile (%)	Coverage in most deprived decile (%)	Difference (pp)
6-in-1 (3 doses)	12 months	91.3	94	87.4	▼6.6
MenB	12 months	91	93.4	87	▼6.4
Rotavirus	12 months	88.8	91.6	83.6	▼8.0
PCV	12 months	93.1	94.6	90.2	▼4.2
6-in-1 (3 doses)	2 years	92.5	94.7	89.4	▼5.3
MenB booster	2 years	87.3	91.2	82.2	▼9.0
MMR1	2 years	88.9	92	84.3	▼7.7
PCV booster	2 years	88	91.4	83.2	▼8.2
Hib/MenC	2 years	88.6	91	84	▼7.0
Influenza	2 to 3 years	56.3	53	30.4	▼22.6
DTaP/IPV booster	5 years	81.3	85.7	76.7	▼6.0
MMR1	5 years	91.8	94.1	89.3	▼4.8
MMR2	5 years	83.7	87.9	79	▼8.9
Influenza	4 to 11 years	54.5	66.7	40.8	▼25.9
HPV (female)	12 to 13 years	71.3	81.1	60.8	▼20.3
HPV (male)	12 to 13 years	65.2	76.7	54.5	▼22.2
HPV (female)	13 to 14 years	62.9	73.6	51.3	▼22.3
HPV (male)	13 to14 years	56.1	66.1	44	▼22.1
MenACWY	14 to 15 years	73.4	81.8	61.1	▼20.7
Influenza (at risk)	6 months to 65 years	49.1	45	33.6	▼11.4
Influenza	65 years and over	79.9	78.3	68	▼10.3
PPV	65 years and over	71.8	75.2	70.4	▼4.8
Shingles	71 years	48.3	50.9	40.8	▼10.1

Data from the UKHSA shows that, in England, vaccination coverage is *'lower in the most deprived decile compared to the least deprived decile'*. The UKHSA notes that:

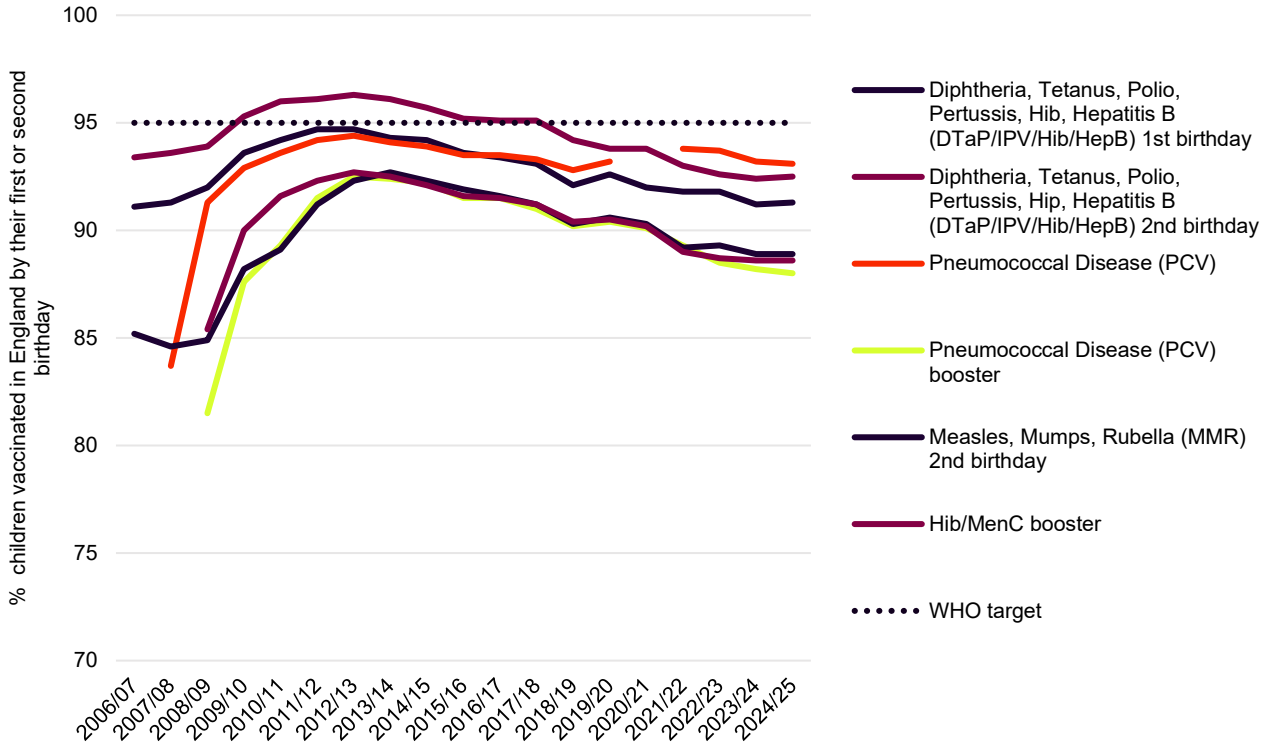
'These patterns [of inequalities] mirror those reported in 2019 but have not meaningfully improved despite system-wide recognition and work by actors across the system to strengthen service access, improve public awareness of and confidence in vaccination, and to develop the infrastructure underpinning immunisation in England [...]'

Further, UKHSA commented on the data collection: *'Despite improvements in the granularity of data available over recent years […] Without improved data capture, linkage, and local intelligence, interventions designed to improve immunisation equity will continue to be poorly targeted and slow to evaluate.'*[32]

[32] UKHSA (2026). *National Immunisation Programme Health Equity Audit 2025.* https://www.gov.uk/government/publications/national-immunisation-programme-health-equity-audit-2025/national-immunisation-programme-health-equity-audit-2025

Figure 6: Children vaccinated in England by their first or second birthday, 2006/07 to 2024/25

Source: QualityWatch

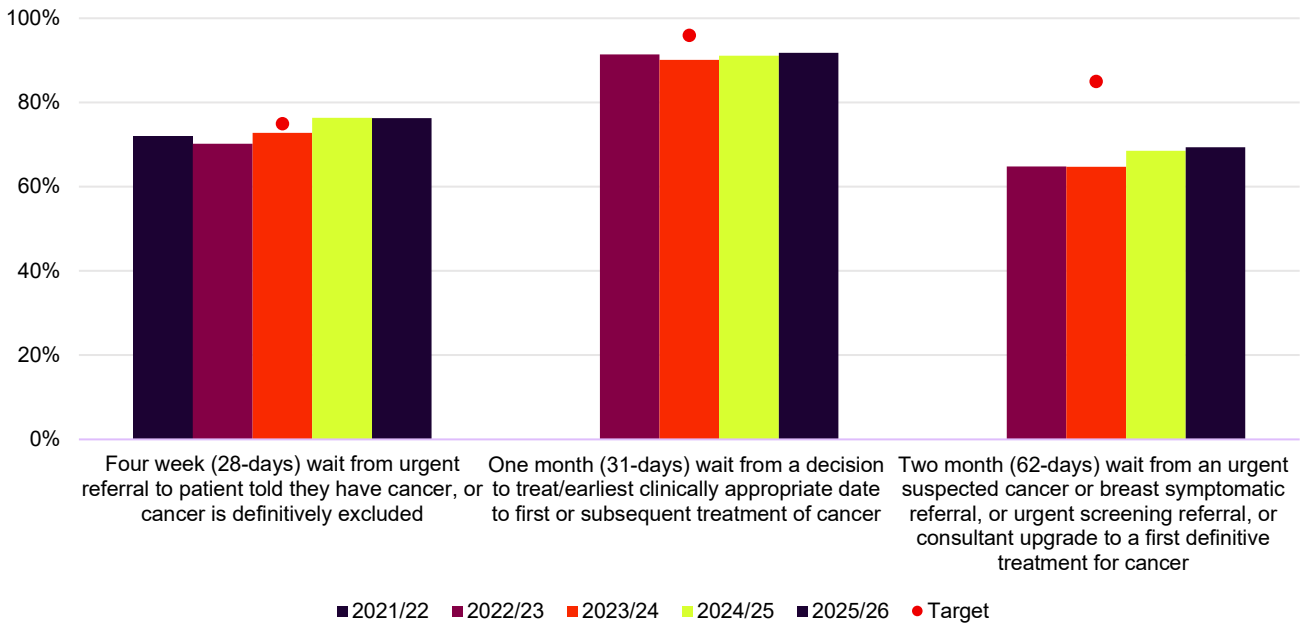


Analyses by QualityWatch show that childhood vaccination rates have steadily declined since 2014/15 and none of the routine vaccinations have achieved the 95% World Health Organization target since 2016/17.[33]

[33] QualityWatch (2026). *Vaccination coverage for children and mothers.* https://www.nuffieldtrust.org.uk/resource/vaccination-coverage-for-children-and-mothers-1

Figure 7: Cancer waiting times, 2021/22 to 2025/26

Source: NHS England



Since 2021/22, cancer waiting times have improved across all of the indicators above. However, some of the targets have not been met. In 2025/26, the 28-days performance was 76.3%, compared with a target of 75% (in March 2026 the target was raised to 80%); the 31-days performance was 91.8%, compared with a target of 96%, and the 62-days performance was 69.4%, against a target of 85%.

Cancer Research UK (CRUK) has commented on the latest updates for April 2026, highlighting the new National Cancer Plan for England while indicating that meeting these targets *'will likely require more investment to increase NHS capacity'*.[34]

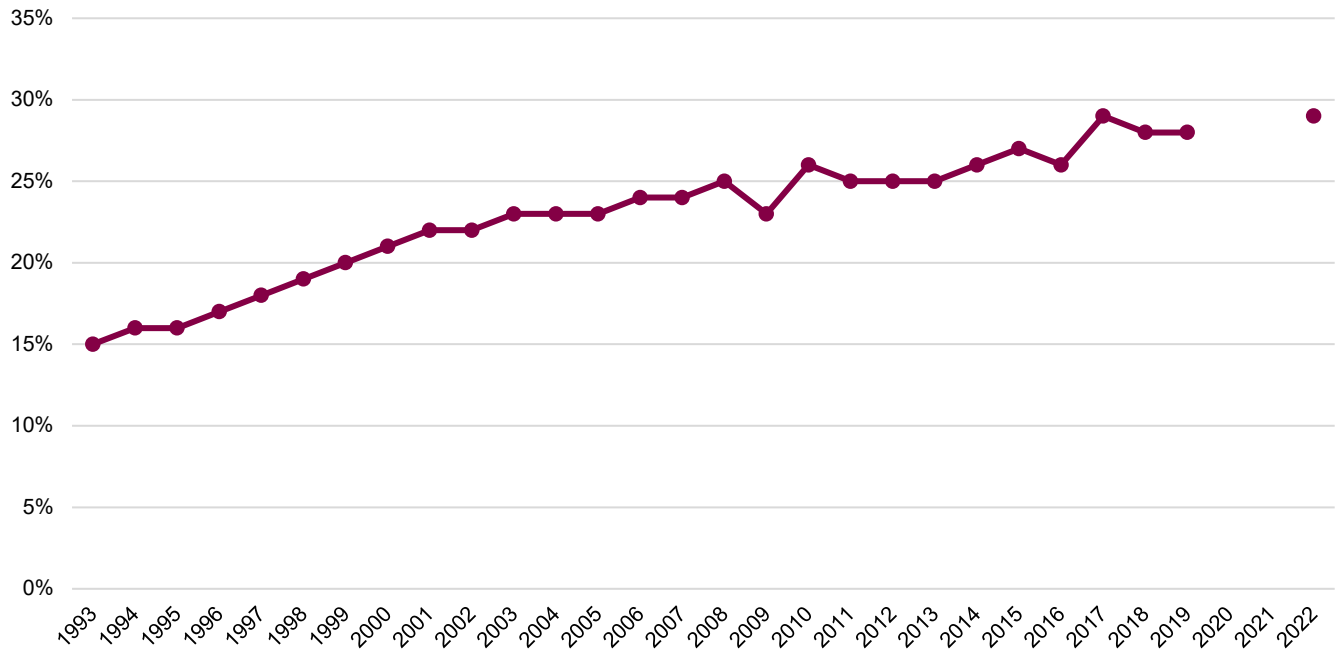
More broadly, waiting lists for diagnostic tests have steadily increased since 2009, with 1.8 million patients waiting for one of 15 key tests in January 2026 compared with 418,000 in January 2009.[35]

Stage at diagnosis is also an important consideration, data for which is available.[36]

[34] CRUK (2026). *Cancer waiting times: Latest updates and analysis.* https://news.cancerresearchuk.org/2026/06/12/cancer-waiting-times-latest-updates-and-analysis/
[35] QualityWatch (2026). *Diagnostic test waiting times.* https://www.nuffieldtrust.org.uk/resource/diagnostic-test-waiting-times
[36] ONS (2025). *Cancer diagnosis at stage 1 and 2.* https://www.ons.gov.uk/explore-local-statistics/indicators/cancer-diagnosis-stage-1-and-2

Figure 8: Trend in adults living with obesity in England, 1993 to 2022

Source: DHSC



NHS England's Health Survey for England 2022 found that *'the proportion of adults living with obesity has risen since the early 1990s'*. Data was not collected in 2020. It also found that *'nearly 1 in 10 reception-aged children were living with obesity in 2023 to 2024. The proportion of children living with obesity is greater in the most deprived compared with least deprived areas, with the difference increasing from reception age to year 6'*. The data also shows differences by ethnicity and gender.

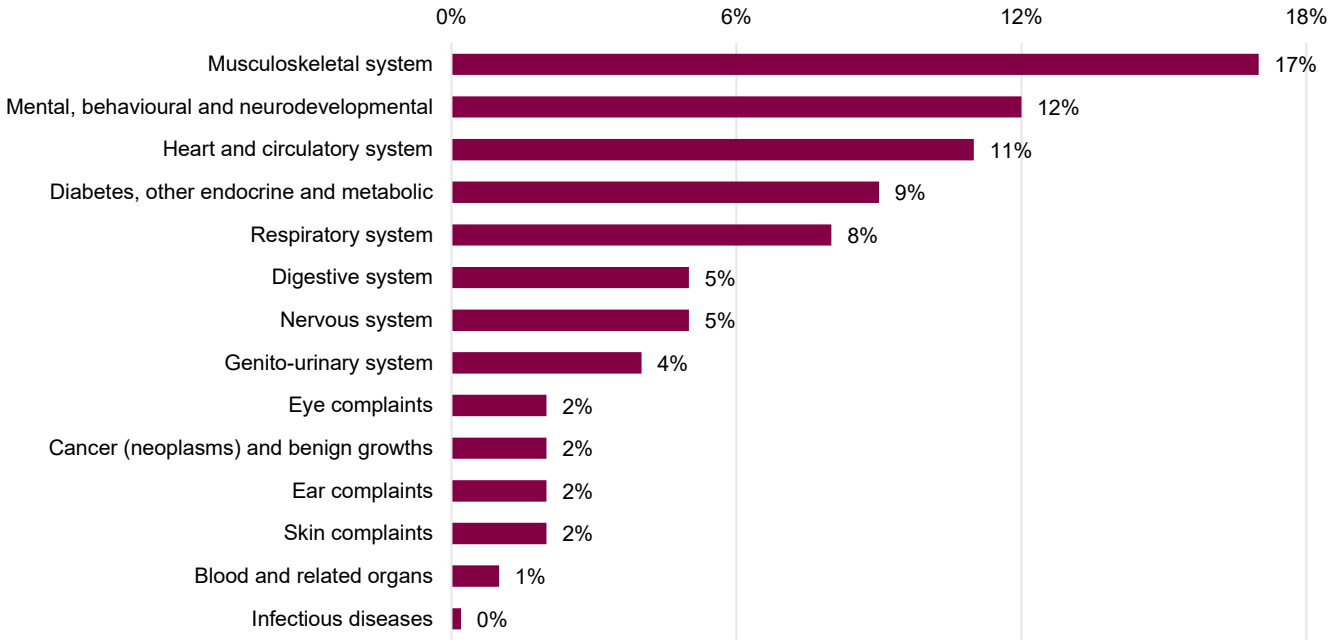
Obesity increases the risk of other health conditions.[37] The Academy has undertaken research on early years interventions to tackle childhood obesity, finding that obesity in childhood *'typically persists into adulthood and increases the risks of a wider range of […] health problems that limit both health span and lifespan'*. The report describes childhood obesity as an *'urgent public health challenge'*.[38]

[37] NHS England (2022). *National Obesity Audit (NOA) dashboards.* https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-obesity-audit/dashboards

[38] Academy of Medical Sciences (2025). *Child's weight for life shaped by first 1,000 days, report health experts.*

Figure 9: Prevalence of adult long-standing conditions in England, 2024

Source: NHS England

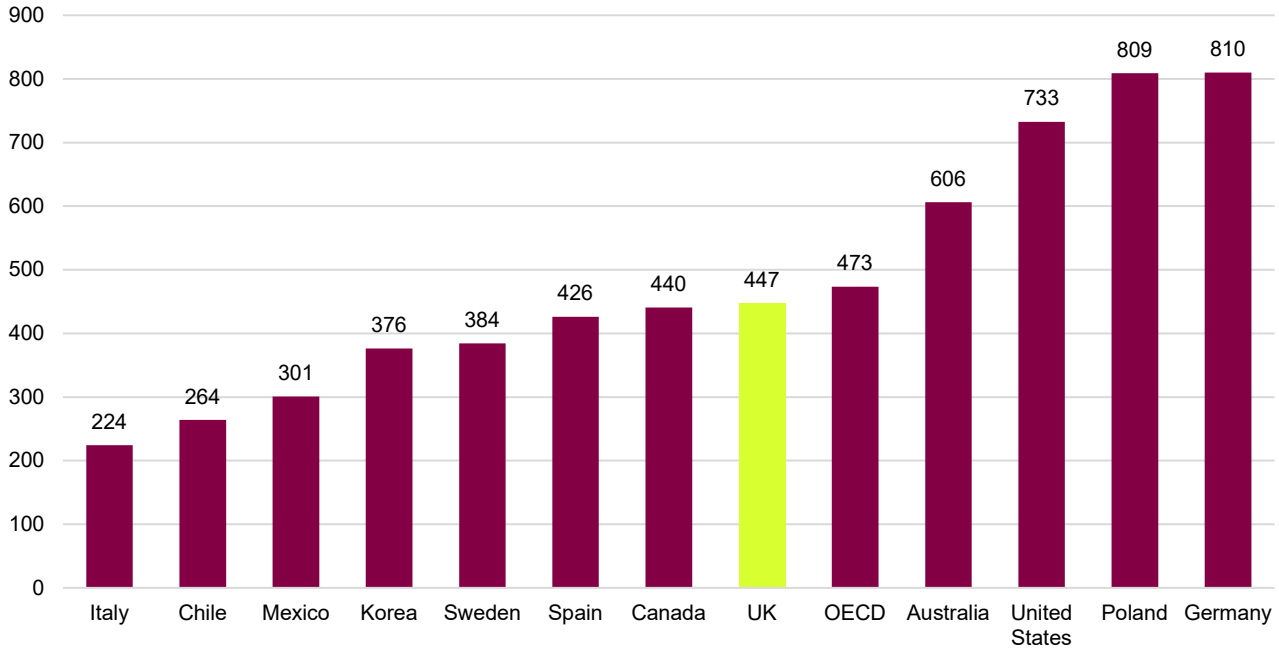


NHS England's Health Survey for England found that, in 2024, *'46% of adults aged 16 and over had at least one longstanding illness or condition'*. Women were *also 'more likely than men to have one or more longstanding conditions'*.

From 2012 to 2016, there was a *'gradual increase in the prevalence of longstanding conditions among men',* from 35% to 40%. Between 2016 and 2022, *'prevalence fluctuated between 39% and 41%'*. Among women, *'prevalence was stable at 41% between 2012 and 2015, then fluctuated between 43% and 45% between 2016 and 2022'*.

Figure 10: Avoidable hospital admissions per 100,000 population, OECD comparisons, 2023

Source: OECD



A core part of medical science is to help prevent avoidable admissions. In the chart above, 'Avoidable hospital admissions' includes asthma or chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and diabetes. In 2023, in the UK, there were 447 avoidable hospital admissions per 100,000 population, which is less than the OECD average of 473.

The Local Government Association notes that there are knock-on effects of preventable admissions, including additional health challenges, increased health service demand and costs of follow-on care.[39]

[39] LGA (N.D.). *High Impact Change Model: reducing preventable admissions*. https://www.local.gov.uk/our-support/partners-care-and-health/better-care-fund-support-programme-2025-26/high-impact-change

Domain 3: Delivering world-class health research

What we want to see

High-quality research and sustainable institutions underpin discovery and the implementation of effective and efficient interventions.

How we can measure it

Health research activities result in strong outputs and impact, and there is evidence of sustainable investment in R&D activities.

Indicative metrics

Quality and impact of health research

Figure 11: UK Activity Index across six research areas, 2022

Figure 12: Average UK overall quality profile and sub-profiles, 2021 (FTE, weighted), Main Panel A

Figure 13: G7 country positions amongst comparator countries (in terms of quartiles) for research environment metrics, latest year available

Investment in health research

Figure 14: Gross domestic spend on medical and health sciences R&D performed by the Government as a percentage of GDP, 2023 (or latest year available)

Figure 15: Targeted UK investment in Industrial Strategy growth sectors across priority buckets, Spending Review period (combined investment, £ millions)

Figure 16: Estimates for the total UK health-relevant R&D expenditure, 2018 and 2022

Sustainability of institutions

Figure 17: Full economic cost recovery (fEC) of UK higher education institutions by sponsor type, 2023/24

Trajectory assessment

Metric	Assessment
Quality and impact of health research	**Strong**: The UK's health research is high quality and a national strength, and performs well amongst comparator countries when it comes to research environment metrics.
Investment in health research	**Developing**: It is encouraging to see the life sciences highlighted as a growth sector and the broad increase in R&D spend. However, targeted investment in health R&D is below many other nations.
Sustainability of institutions	**Concerning**: Universities' costs for research activities means that they have to cross-subsidise activities from other sources, at a time when the sector is faced with financial challenges.

Data assessment

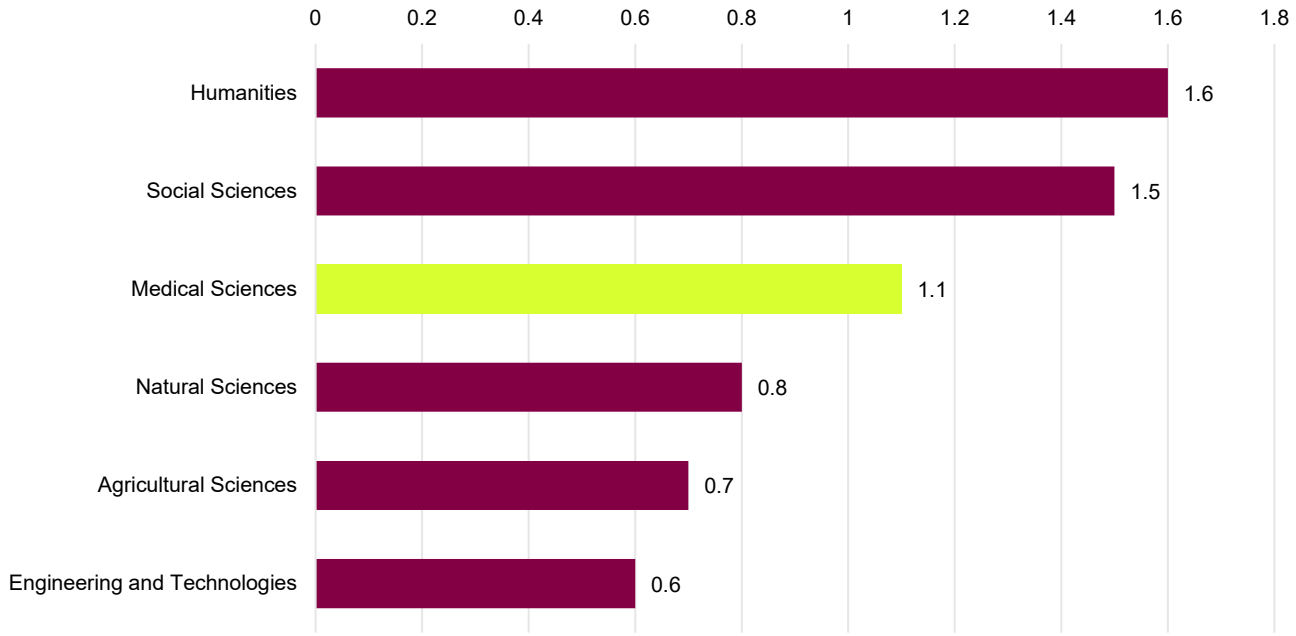
- The data helps us to examine current rates and distribution of investment in health research, and how the UK performs in terms of research impact and output.
- We should use this data to maximise the UK's life sciences strengths and ensure we can convert research into innovative outputs that support population health.

Policy assessment

- The UK's health research system benefits from many world-leading academic research institutions, coupled with a diverse funding system including public, private and charitable organisations. Collectively, these contribute to the life sciences being recognised as a UK 'growth' sector.
- The strength and financial sustainability of these institutions underpin both the training of research talent and their ability to contribute to the health and wealth of the UK. As the data shows, we should not take this for granted, especially given the financial challenges faced by universities (and other sectors).

Figure 11: UK Activity Index across six research areas, 2022

Source: DSIT



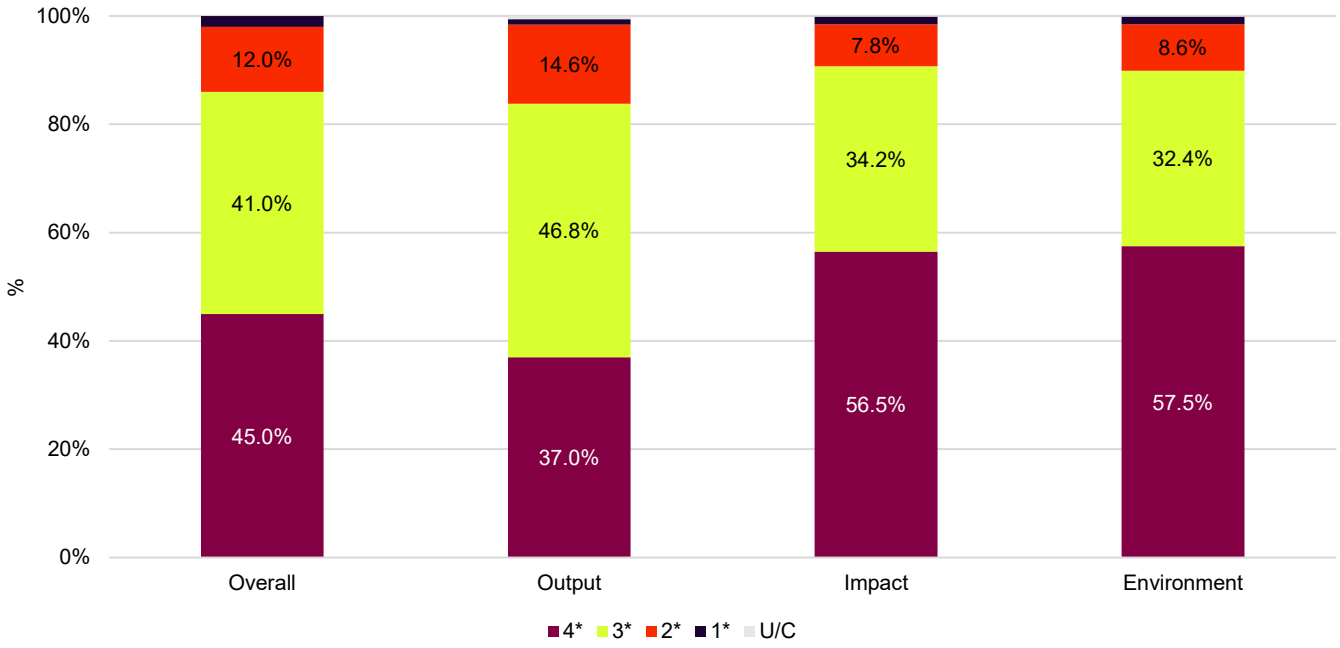
DSIT publishes international comparisons of the UK research base. Using bibliometric data from SciVal, their analysis shows that, in 2022, the UK's 'Activity Index' for medical sciences was 1.14 (2 d.p.); a higher-than-average publications share. This has increased incrementally, from 1.11 in 2014 and 1.12 in 2018. The data shows that medical science is a national research strength.

The Activity Index is described by DSIT as *'a means of showing the relative importance of different subjects within a country with respect to the world'*. It is defined as *'the ratio of the country's subject share of all country publications to the World's subject share of all world publications'*. A value higher than 1 implies the country's share of the subject or discipline is higher than the world's share.

It is useful to have publications data as an indicator of performance; however, we need to develop a broader evidence base for assessing research activities.[40]

Figure 12: Average UK overall quality profile and sub-profiles, 2021 (FTE, weighted), Main Panel A

Source: REF 2021



UK universities' health research is high quality. For the 2021 REF, the quality of submissions to Main Panel A (medicine, health and life sciences) was judged, on average, to be 45% world-leading (4*) and 41% internationally excellent (3*) (FTE weighted). This compares with a Main Panel average of 41% world-leading and 43% internationally excellent.

This is a useful data source for showing universities' research impact and performance, however this data is only collected as part of the REF cycle. We should consider how best to maximise the use of this data between cycles, particularly as the collection includes a suite of case studies on societal and economic impact, beyond academia.

[40] Curry, S, Gadd, E & Wilsdon, J (2022). *Harnessing the Metric Tide: indicators, infrastructures & priorities for UK responsible research assessment.* https://doi.org/10.6084/m9.figshare.21701624

Figure 13: G7 country positions amongst comparator countries (in terms of quartiles) for research environment metrics, latest year available

Source: OLS

Green = top quartile; Orange = middle quartiles; Red = bottom quartile; Blank = Not available

1= Canada; 2 = France; 3 = Germany; 4 = Italy; 5 = Japan; 6 = USA

	UK	1	2	3	4	5	6
Government budget allocations for health R&D (2024)							
Health R&D performed by government (2023)							
Health R&D performed by private non-profit sector (2024)							
Health R&D performed by the higher education sector (2023)							
Pharmaceutical R&D performed by business enterprises (2023)							
% share of patients recruited to commercial global studies (2023)							
Time from clinical trial application to a regulatory authority and patient first dose (2023)							
Share of medical sciences academic citations (2024)							
Share of most highly cited medical sciences publications (2024)							
Life sciences patents per thousand population (2022)							

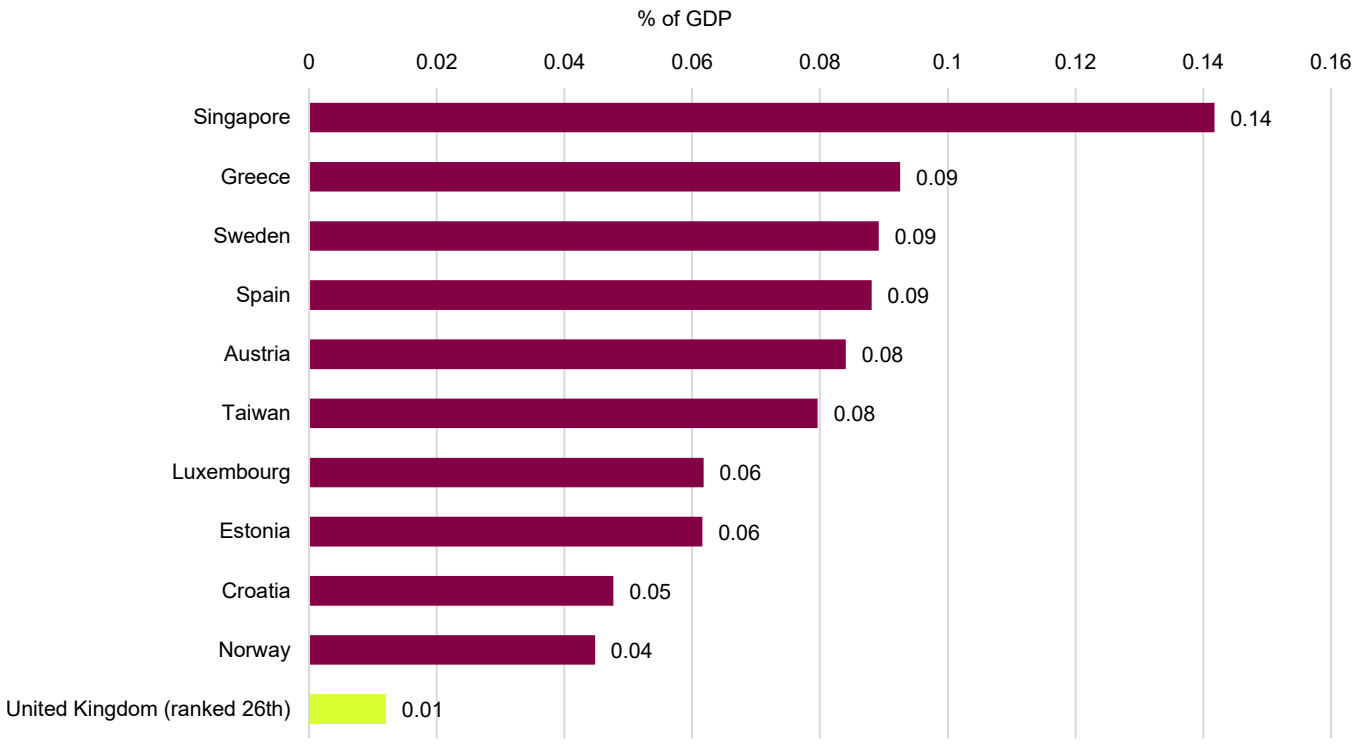
The OLS collects data on the international comparative performance of the UK's life sciences sector. It is helpful to have a snapshot of performance across these indicators. In most metrics, the UK is performing in the top quartile compared with other G7 countries. It also shows a comparative strength in health R&D performed by the private non-profit sector, and an interdependency of different sectors.

However, there is room to further reduce the time taken from clinical trial application to a regulatory authority and patient first dose. We need to streamline the pathway from discovery to adoption; the Government recognises this and the Academy also has a dedicated priority to mobilise the health system to turn discovery into practice.[41]

[41] DHSC (2025). *Introducing new medicines in the NHS in the UK - pathway.* https://www.gov.uk/government/publications/introducing-new-medicines-in-the-nhs-in-the-uk/introducing-new-medicines-in-the-nhs-in-the-uk-pathway

Figure 14: **Gross domestic spend on medical and health sciences R&D performed by the Government as a percentage of GDP**, 2023 (or latest year available), UK and comparator countries

Source: OLS



OLS analysis shows that UK Government institutions performed £327 million of medical and health sciences R&D, which was equivalent to 0.01% of GDP. This was lower than most countries with available data.

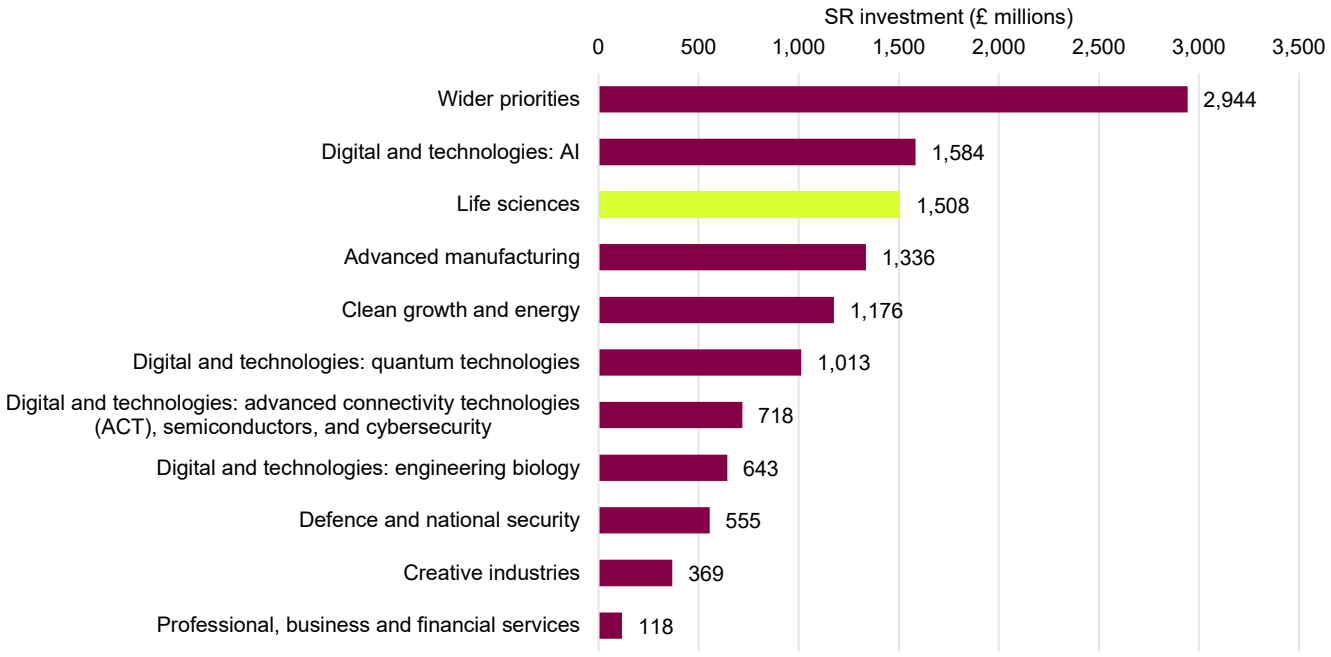
The analysis also shows that value of expenditure on R&D performed by the UK private non-profit sector was £1.1 billion (0.04% as a percentage of GDP), which placed the UK sixth in comparator rankings.

Further, medical and health sciences R&D as a share of GDP performed by the Government and the private non-profit sector remained broadly consistent in the UK between 2015 and 2023.

To continue undertaking world-leading research, we need to build investment in these activities.

Figure 15: Targeted UK investment in Industrial Strategy growth sectors across priority buckets, Spending Review period (combined investment, £ millions)

Source: UKRI



In the UK, the life sciences are considered a growth sector, and there is a dedicated sector plan as part of the UK's Industrial Strategy.[42] UKRI's investment in life sciences is ranked third in their priority 'buckets'. It is useful to see a breakdown of allocations from the UK's largest public investor in research and innovation, which has a targeted investment of £1.5 billion in life sciences over the spending review period.

We hope that clarity on the priority buckets continues to emerge, and that UKRI and the MRC continue to work with the medical sciences community to share developments and identify areas for targeted investment.[43]

[42] UK Government (2025). *Life Sciences Sector Plan.* https://assets.publishing.service.gov.uk/media/688c90a8e8ba9507fc1b090c/Life_Sciences_Sector_Plan.pdf
[43] MRC (2026). *Improving MRC funding through continued community engagement*. https://www.ukri.org/blog/improving-mrc-funding-through-continued-community-engagement/

Figure 16: Estimates for the total UK health-relevant R&D expenditure, 2018 and 2022

Source: UK Health Research Analysis

	2018 Estimate		2022 Estimate		Difference	
Performing sector	**Spend (real terms)**	**% of total**	**Spend**	**% of total**	**Spend**	**% of total**
Business	£4.69bn	50.0%	£5.01bn	49.5%	£0.33bn	-0.6%
University	£3.41bn	36.3%	£3.64bn	35.9%	£0.23bn	-0.4%
Public Sector Research Institutes	£0.66bn	7.0%	£0.83bn	8.2%	£0.18bn	1.2%
Private non-profit	£0.62bn	6.7%	£0.65bn	6.4%	£0.03bn	-0.2%
TOTAL	**£9.38bn**	**100%**	**£10.13bn**	**100%**	**£0.76bn**	**-**

Note: Figures may not sum due to rounding

The UK Health Research Analysis reports provide estimates for the total health related research and development expenditure by UK public, charitable and private sector institutions.

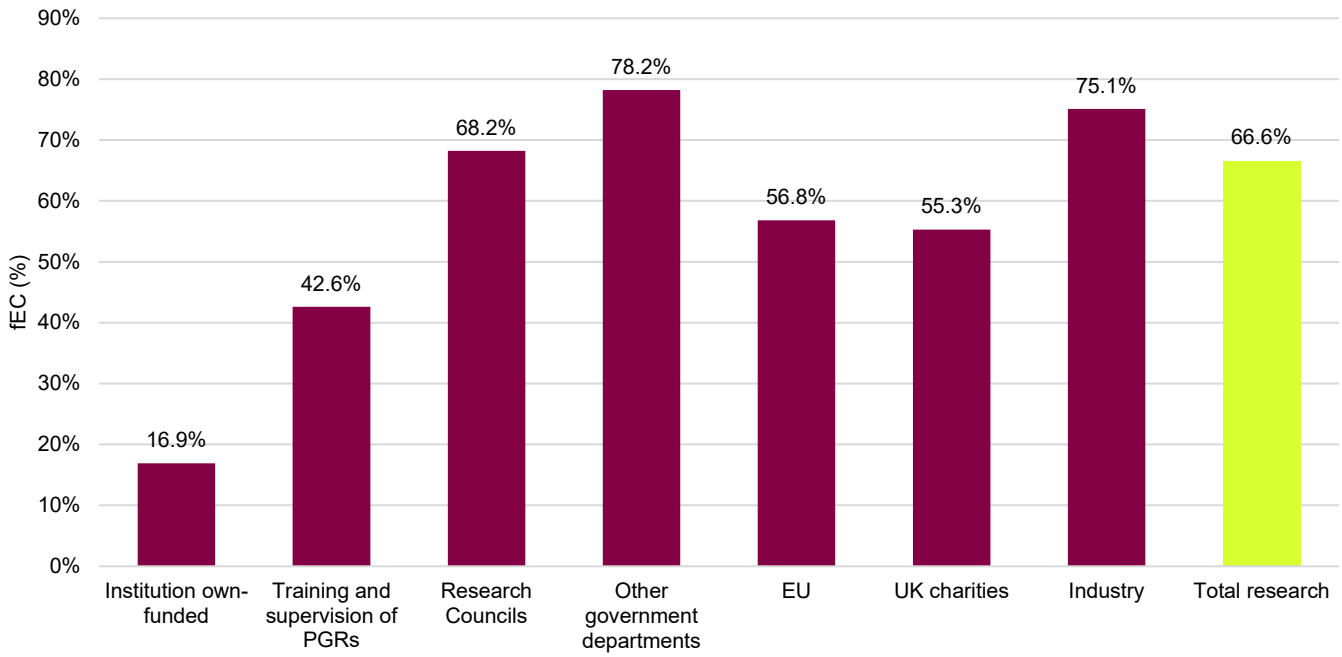
In 2022, the combined total expenditure for research performed in the business, private not-for-profit, university and public research institute sectors was £10.13bn. Of this expenditure, £5.01bn was from the pharmaceutical private sector and £5.12bn was from public/charitable sectors.

It is helpful to have a periodic, consistent and publicly available analysis of the UK health research landscape. The report notes that the analysis has been used to support high level strategy discussions and funding initiatives; it also suggests that there is room for improvement in terms of finding ways to share information on health research funding, without which *'decisions on how the UK funds health research will continue at its current slow pace'*.[44]

[44] UKCRC (2023). *UK Health Research Analysis 2022*. https://hrcsonline.net/wp-content/uploads/2024/09/UK_Health_Research_Analysis_Report_2022_web_v1-2-postpub.pdf

Figure 17: Full economic cost recovery (fEC) of UK higher education institutions by sponsor type, 2023/24

Source: OfS



Data from the OfS shows that the gap between costs of research and the income for research is widening in academic institutions and that in 2023–24, fEC for research was 66.6%, and within this, fEC from UK charities was 55.3%.

The lack of cost recovery for research is making health (and other) research increasingly reliant on cross-subsidisation, including income from international students' tuition fees.[45] This is at a time when the sector has broader financial challenges and is considering how it can specialise and collaborate.[46]

[45] UKRI (2025). *Research Financial Sustainability: insights 2025.* https://www.ukri.org/publications/research-financial-sustainability-insights-2025/
[46] DfE (2025). *Post-16 education and skills white paper.* https://www.gov.uk/government/publications/post-16-education-and-skills-white-paper/post-16-education-and-skills-white-paper

Domain 4: Building capacity to accelerate the development of new treatments

What we want to see

The speed of, and ability to translate research from, clinical trials is key to developing timely solutions.

How we can measure it

Clinical trials delivered in growing numbers, more quickly and readiness of the system to adopt innovations of proven worth.

Indicative metrics

Clinical trial set-up times

Figure 18: UK Clinical Research Delivery key performance indicators, March 2026

Volume of and engagement in clinical trials

Figure 19: Average number of participants recruited per month to commercial and non-commercial clinical trials in the UK, 2016 to 2025

Figure 20: Diversity and inclusion of participants in clinical trials in the UK, 2024

Trajectory assessment

Metric	Assessment
Clinical trial set-up times	**Developing**: The latest figures show progress on clinical trials set-up times. However, there are differences between commercial and non-commercial trials, and we need to continue progress to ensure the UK remains a leader in clinical research.
Volume of and engagement in clinical trials	**Developing**: Recruitment to trials and transparency of outcomes need to improve; initiatives to address these are in place.

Data assessment

- It is helpful to see data showing progress on clinical research delivery against targets set by the Government last year. There is also published transparency data which can help to outline how we can better engage with research participants. Through having these published performance metrics, we can identify where further progress needs to be made, and where we can showcase the UK as a leading environment for health innovation.

Policy assessment

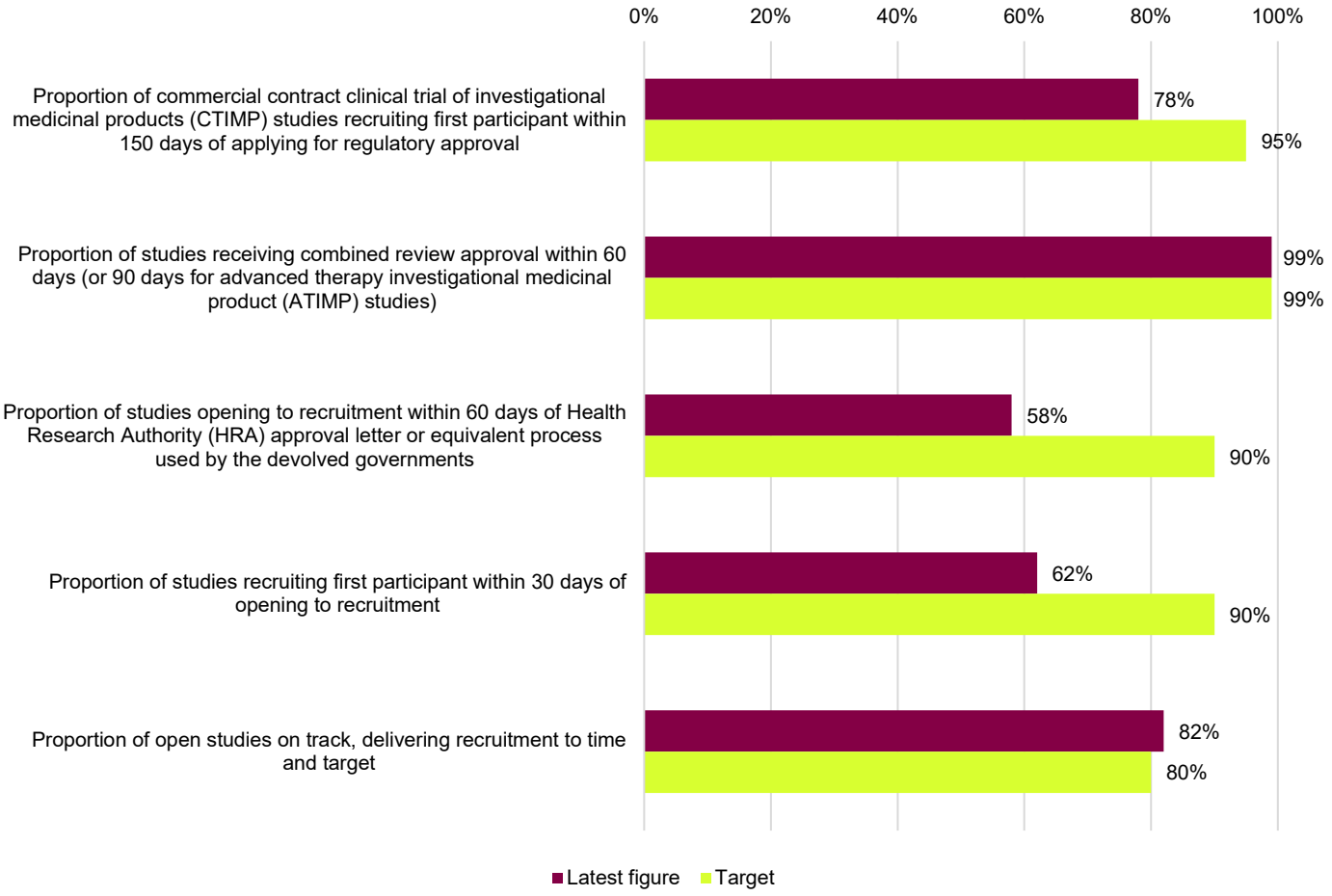
- A 2023 review of the UK clinical trial environment identified several factors behind the challenges to attracting clinical trials. These include slow and bureaucratic set-up processes, a lack of transparency and data on commercial clinical trial activity, research not being

systematically prioritised by the NHS, a lack of incentives for staff to participate in trials and poor data infrastructure and disconnected primary care participation.[47]

- Sustaining and building on progress will require continued focus from system partners, particularly in reducing variation between sites and embedding best practice.

Figure 18: UK Clinical Research Delivery key performance indicators, March 2026

Source: DHSC



Note: Latest available data varies by indicator

- Average monthly recruitment to clinical studies: 86,151 participants
- Number of new studies added to the National Institute for Health and Care Research (NIHR) Research Delivery Network portfolio: 154 studies

[47] DHSC, DSIT (2023). *Commercial clinical trials in the UK: the Lord O'Shaughnessy review - final report.* https://www.gov.uk/government/publications/commercial-clinical-trials-in-the-uk-the-lord-oshaughnessy-review/commercial-clinical-trials-in-the-uk-the-lord-oshaughnessy-review-final-report

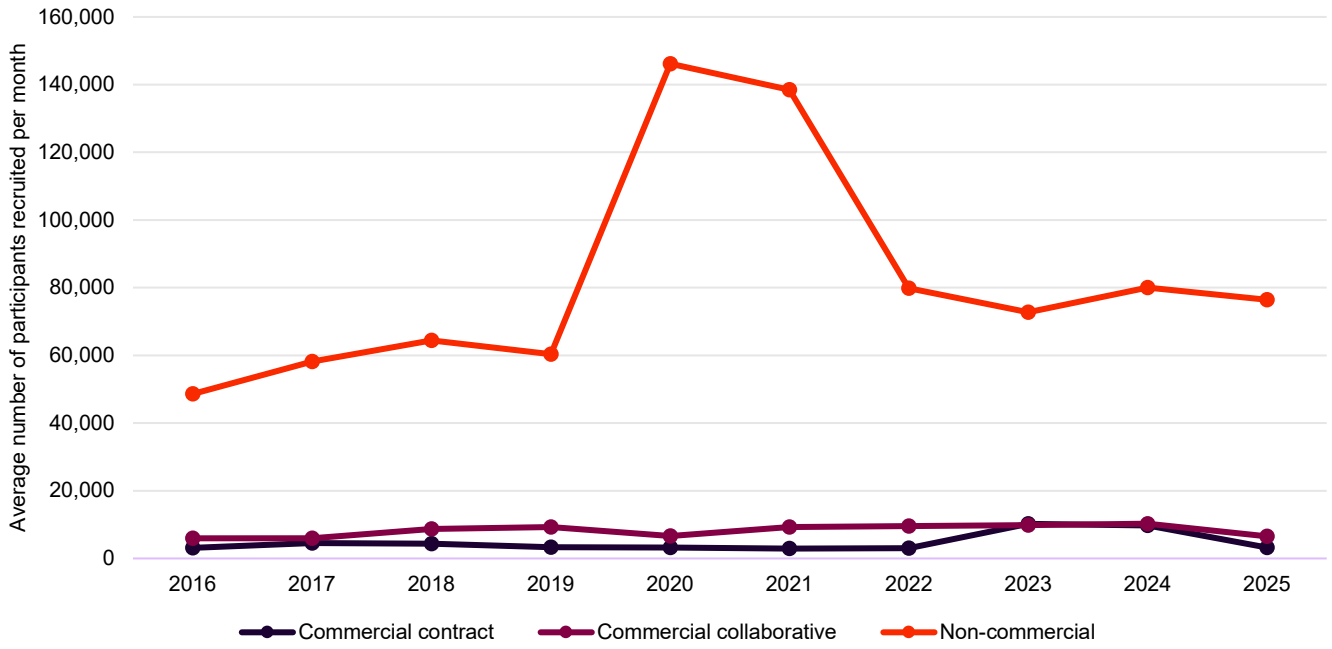
A faster and more consistent trials landscape mean patients can access promising new treatments sooner and the UK becomes a more attractive environment for life sciences investment. The latest figures from DHSC show progress towards meeting targets, and it is important that this continues.

In particular, good progress has been made in terms of combined review approval targets, but there is room to speed up the opening of studies to recruitment. The Health Research Authority (HRA) has outlined a range of activities to further enhance the UK's clinical research environment.[48]

From a data perspective, we welcome the availability of regular progress updates relating to performance targets.

Figure 19: Average number of participants recruited per month to commercial and non-commercial clinical trials in the UK, 2016 to 2025

Source: DHSC



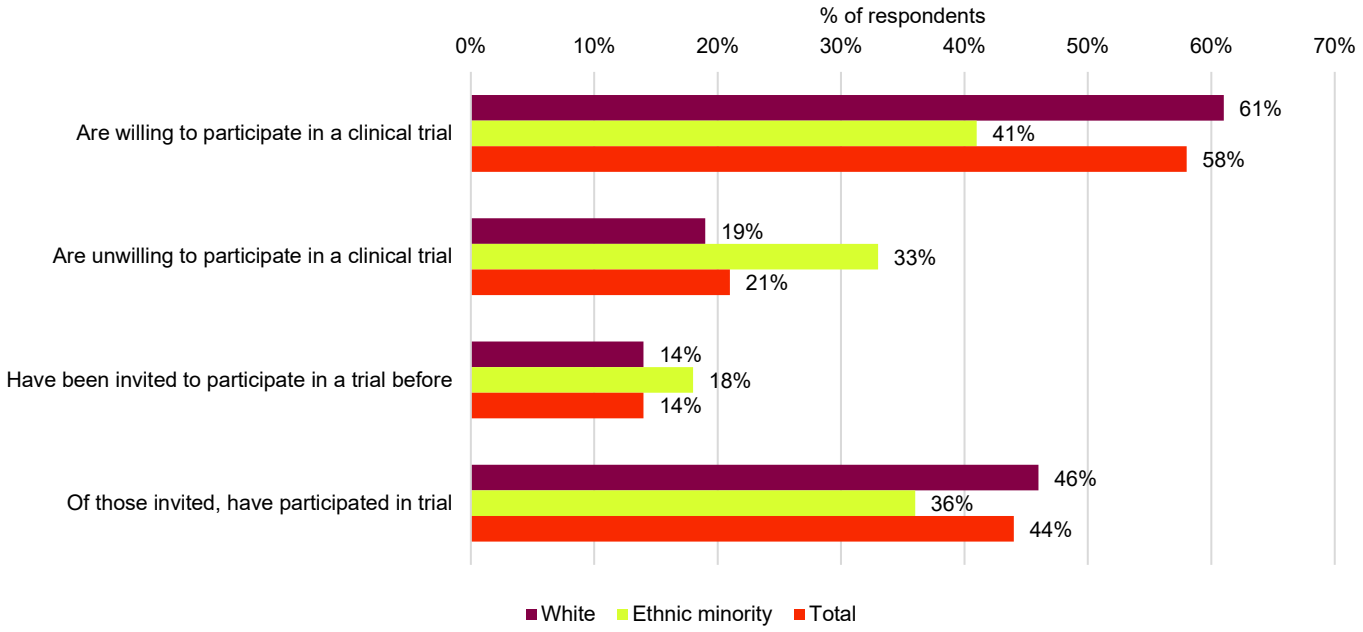
This indicator measures the average (mean) number of participants recruited per month over the last 12 months to all studies in the UK that are held on the NIHR Research Delivery Network's Central Portfolio Management System. It is designed to track the volume of clinical research activity taking place in the UK.

Since 2022, the average number of participants recruited per month has been steady. Research from the Association of the British Pharmaceutical Industry (ABPI) suggests that trends in clinical trials have been driven by consistently slow and variable study set-up timelines.[49]

[48] HRA (2025). *Making the UK a great place to do clinical trials – our response to the ABPI report.* https://www.hra.nhs.uk/about-us/news-updates/making-the-uk-a-great-place-to-do-clinical-trials-our-response-to-the-abpi-report/
[49] ABPI (2025). *UK industry clinical trials: Translating actions into impact.* https://www.abpi.org.uk/publications/uk-industry-clinical-trials-translating-actions-into-impact/

Figure 20: Diversity and inclusion of participants in clinical trials in the UK, 2024

Source: Ipsos



Ipsos conducted a survey to understand awareness, participation and barriers to participation in clinical trials. Ipsos notes that *'clinical trials are critical to the development of medicines and devices to improve the health and wellbeing of people around the world'*. Their research also notes that 'trials have historically failed to engage a diverse group of participants from different ethnic and racial backgrounds'. In 2025, the Academy, ABPI and the NIHR Research Delivery Network jointly organised a FORUM workshop focusing on decentralised methods of clinical trial delivery, finding that such trials can lead to *'improved participant recruitment, trial accessibility, inclusion and diversity'*.[50]

The HRA publishes transparency data on UK clinical trials, including registration and reporting data.[51] The findings show that there has been an increase in studies registered or in the process of being registered, but more than 40% did not have published results. Transparency is in an important way to encourage participation in studies and the HRA has committed to further improve this.

[50] Academy of Medical Sciences (2026). *Innovative clinical research: delivering trials in the community.*
[51] HRA (2026). *New research transparency data on UK clinical trials published.* https://www.hra.nhs.uk/about-us/news-updates/new-research-transparency-data-on-uk-clinical-trials-published/

Domain 5: Increasing public trust and engagement in medical science

What we want to see

The quality of, and trust in, medical research and science are improved by patient and public involvement throughout.

How we can measure it

Positive public sentiment in science and active patient and public participation in health research activities.

Indicative metrics

Public attitudes to medical science

Figure 21: Public attitudes to science in the UK, 2025

Figure 22: Public attitudes to R&D in the UK, 2025

Patient and public involvement in health research

Figure 23: Percentage of applicants reporting public involvement in health and social care research (HRA sample selection), 2023 to 2024

Trajectory assessment

Metric	Assessment
Public attitudes to medical science	**Developing**: It is encouraging to see that the public values science and understands the importance of R&D in improving the NHS and developing new treatments. However, uncertainties and mistrust around AI and '*profit-driven motivations*' of business R&D need to be addressed.
Patient and public involvement in health research	**Developing**: It is encouraging to see that the interest and involvement of patients and the public in research have increased. However, we need to continue activities that improve engagement in clinical trials and commercial studies.

Data assessment

- Survey data allows us to monitor public sentiment, which in turn helps to identify how we can work with the public to outline the value of medical science, discuss concerns and build trust in the process from people of all backgrounds.

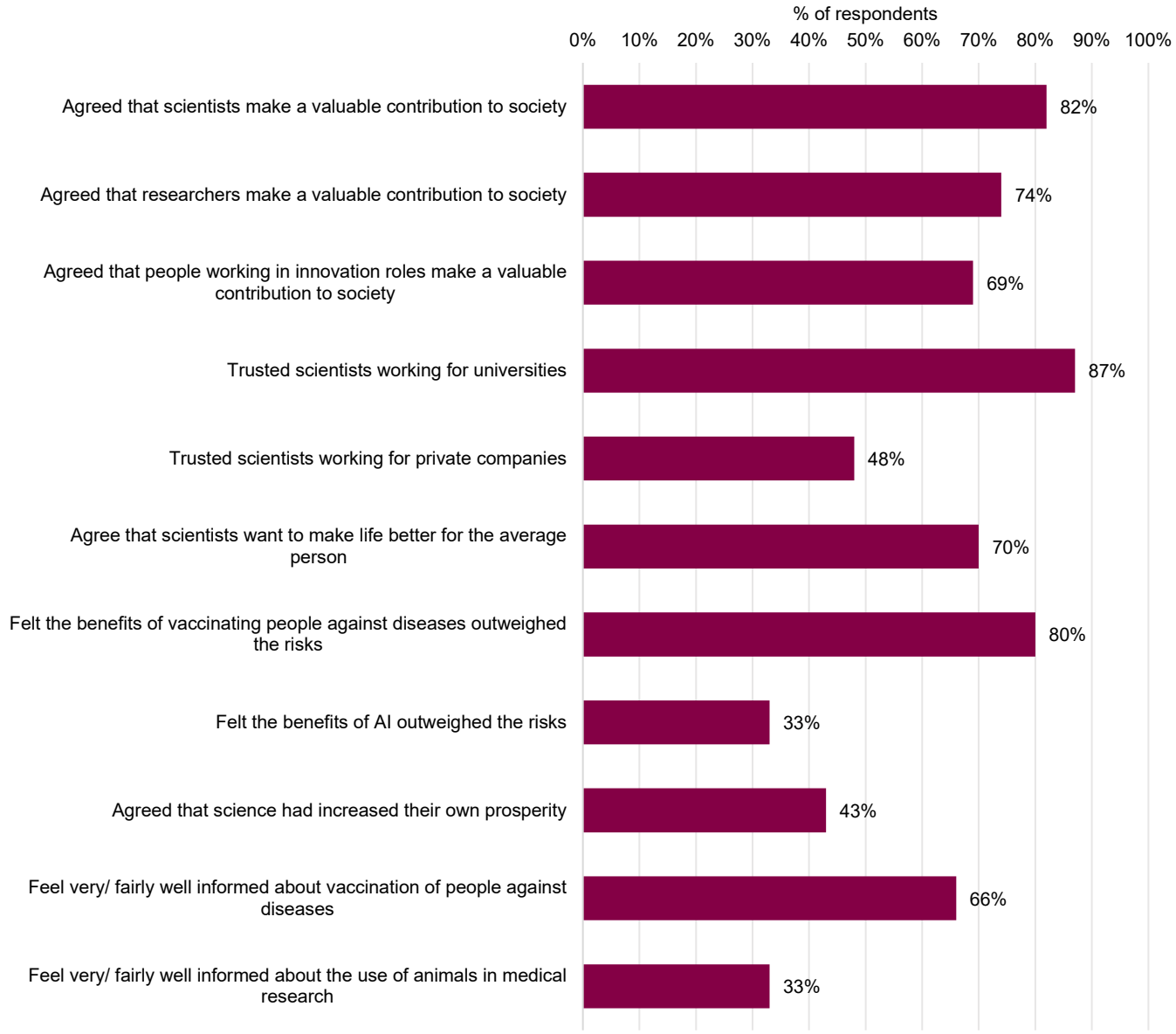
Policy assessment

- We need to make sure we maintain and build trust in medical science, particularly as we find ways to adopt emerging technologies such as AI. And to achieve health equity, we need to create more supportive environments for a diverse range of individuals to participate in medical science, including clinical trials.
- Research from CaSE has suggested that there are challenges in designing regulatory frameworks that are responsive to technological change, while still providing sufficient

safeguards and maintaining public trust where scientific technologies are complex and uncertain.[52]

Figure 21: Public attitudes to science in the UK, 2025

Source: British Science Association (BSA), Ipsos, UKRI



The findings of the Public Attitudes to Science Survey *'reveal a public that values science and scientists, where more people are discussing science with those around them than before. However, the greater numbers engaging have not necessarily led to deeper engagement. And despite greater access to information on science, fewer people feel informed'*.

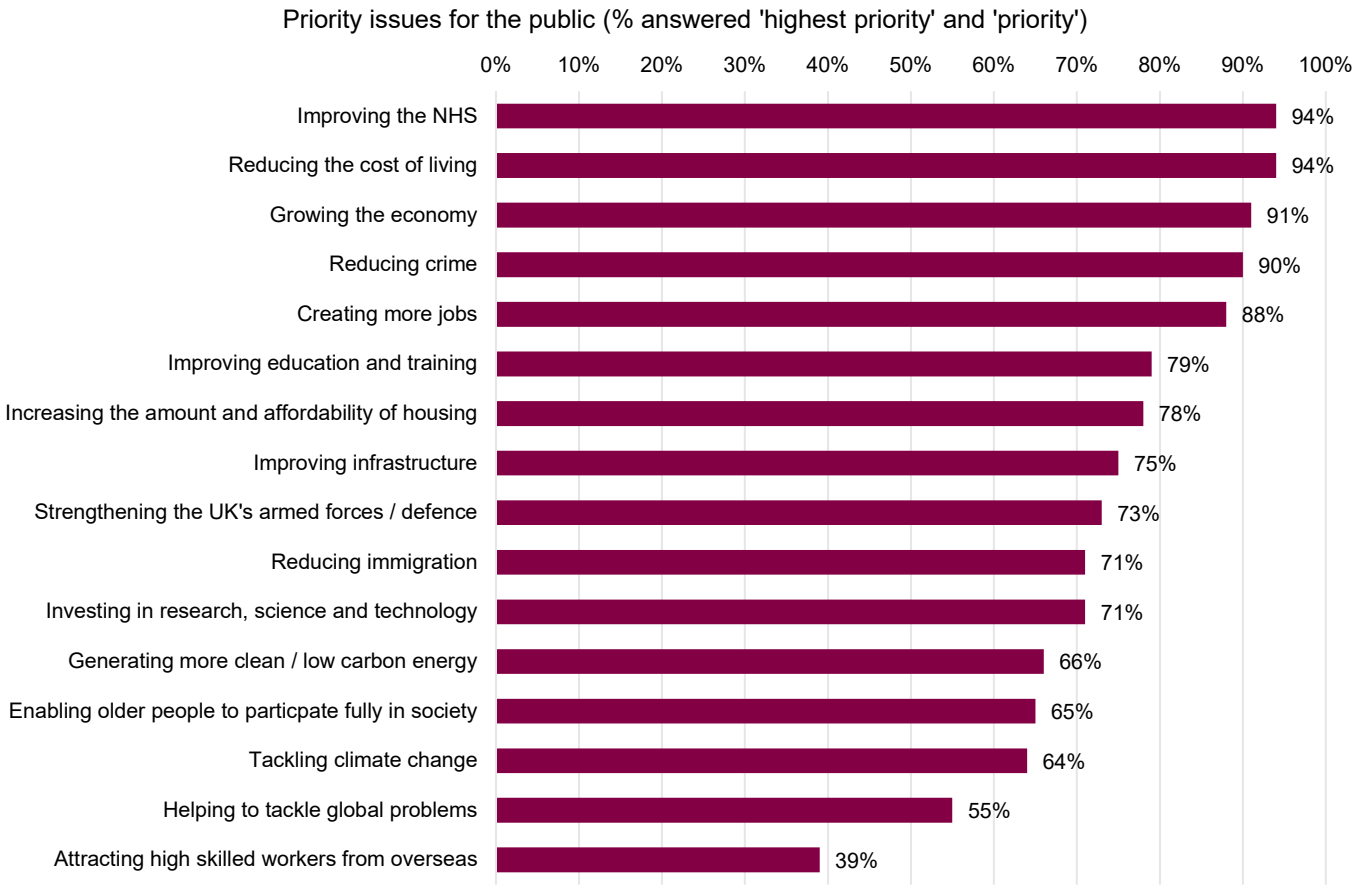
[52] CaSE (2026). *Reimagining R&D: What future does the sector want for UK R&D?* https://www.sciencecampaign.org.uk/analysis-and-publications/detail/reimagining-rd-what-future-does-the-sector-want-for-uk-rd/

The findings also suggest that *'trust and certainty have eroded since the pandemic, with responses showing more neutral or uncertain views – especially among young people – and divisive attitudes toward AI'*.

Further, the findings highlight *'an urgent need to involve and represent the public in decisions on science, to better understand the factors behind increasing uncertainty, and to give people a sense of personal connectedness to science at multiple touchpoints across their daily lives'*.

Figure 22: Public attitudes to R&D in the UK, 2025

Source: Campaign for Science and Engineering (CaSE)



CaSE has developed a formal tracker survey of public attitudes to R&D, which will be repeated every three years. The study comprised a nationally representative survey of 8,000 UK adults, alongside focus groups and interviews. There were a range of findings relating to medical science, including the following:

- The public's top UK priorities were *'improving the NHS'* (selected by 94% as either *'highest priority'* or *'a priority'*) and reducing the cost of living (94%), followed by '*growing the economy'* (91%).

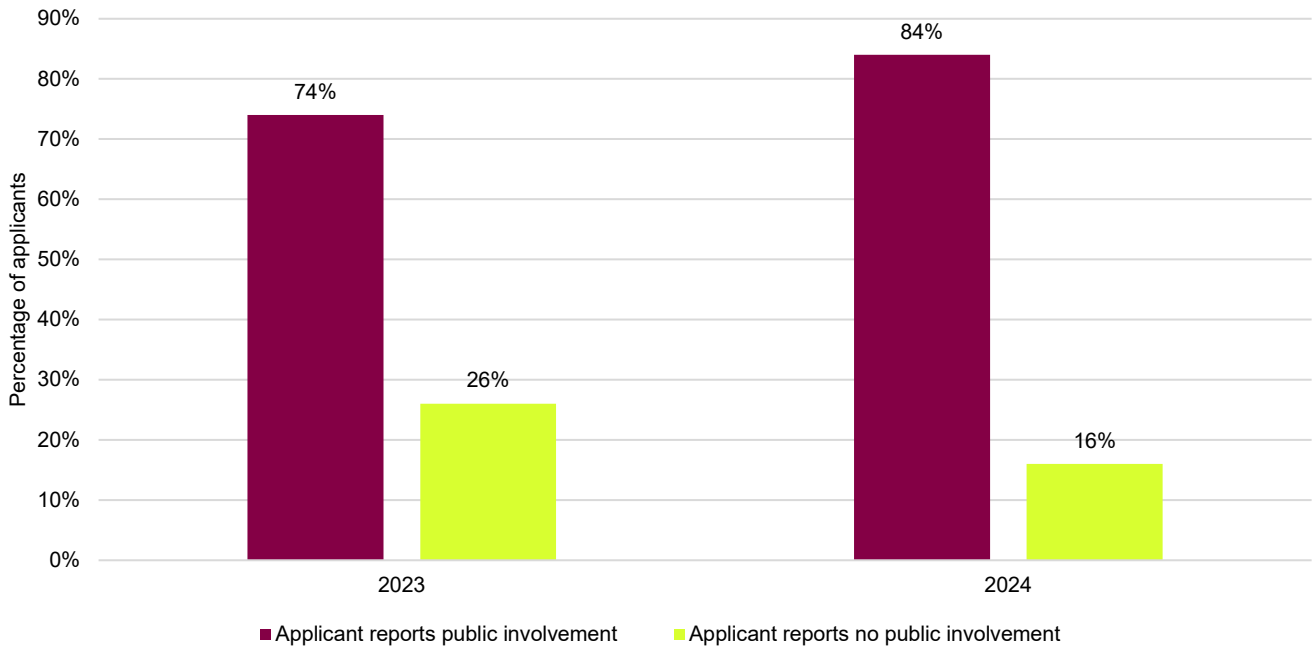
- 79% of respondents believed that R&D has an important or essential role to play in improving the NHS.
- There was strong association between R&D and new medicines and treatments.
- If there was extra money to invest in R&D, 86% said that new medicines and treatments should be a priority.
- As with the previous figure, the most commonly cited concern about R&D was AI (although only 9% of respondents).

Many of the priority issues included in the chart are influenced by medical science.

More broadly, while 71% agreed that the private sector has an important role to play in UK R&D, some focus group participants demonstrated concerns about the *'profit-driven motivations'* of business R&D. We may need to consider how to demonstrate the alignment of health and economic policy and articulate the important role of industry, alongside other key stakeholders such as medical research charities, in advancing medical science.

Figure 23: Percentage of applicants reporting public involvement in health and social care research (HRA sample selection), 2023 to 2024

Source: HRA



The HRA noted that public involvement is essential to improving the quality and impact of health and social care research. The percentage of applicants reporting that they had, or would, actively involve the public in their research, increased from 2023 to 2024. However, public involvement was less common in commercial studies and in clinical trials.

Domain 6: Developing a workforce fit for the future

What we want to see

A thriving, empowered medical science workforce with the right skills, leadership and cross-sector engagement.

How we can measure it

Increasing numbers of medical scientists and accessible opportunities across different career stages.

Indicative metrics

Trajectory and diversity of the workforce

Figure 24: UK medical science student enrolments, 2020/21 to 2024/25

Figure 25: UK staffing levels of medical clinical academics, 2004 to 2025

Cross-sector activities of the health research and innovation workforce

Figure 26: Cross-sector activities of the UK's research and innovation workforce (current main sector: NHS), 2024

Trajectory assessment

Metric	Assessment
Diversity of the clinical academic workforce	**Concerning**: There have been worrying trends in the clinical academic workforce, both in absolute numbers and as a proportion of the expanding NHS workforce. While there has been progress in the diversity in the workforce, men still hold a high proportion of senior roles. The workforce is also ageing, which is a concern for the future of research activity.
Cross-sector activities of the R&I workforce	**Developing**: Mobility has long been identified as an issue in medical science, particularly a lack of formal and structured mobility opportunities to work across academia, industry and the NHS.

Data assessment

- The MSC analysis is helpful for understanding workforce trends, but data needs to be embedded more strongly in national collection.
- The Academy was pleased to see information on the prevalence, drivers and barriers to cross-sector mobility included in DSIT's R&D workforce survey.

Policy assessment

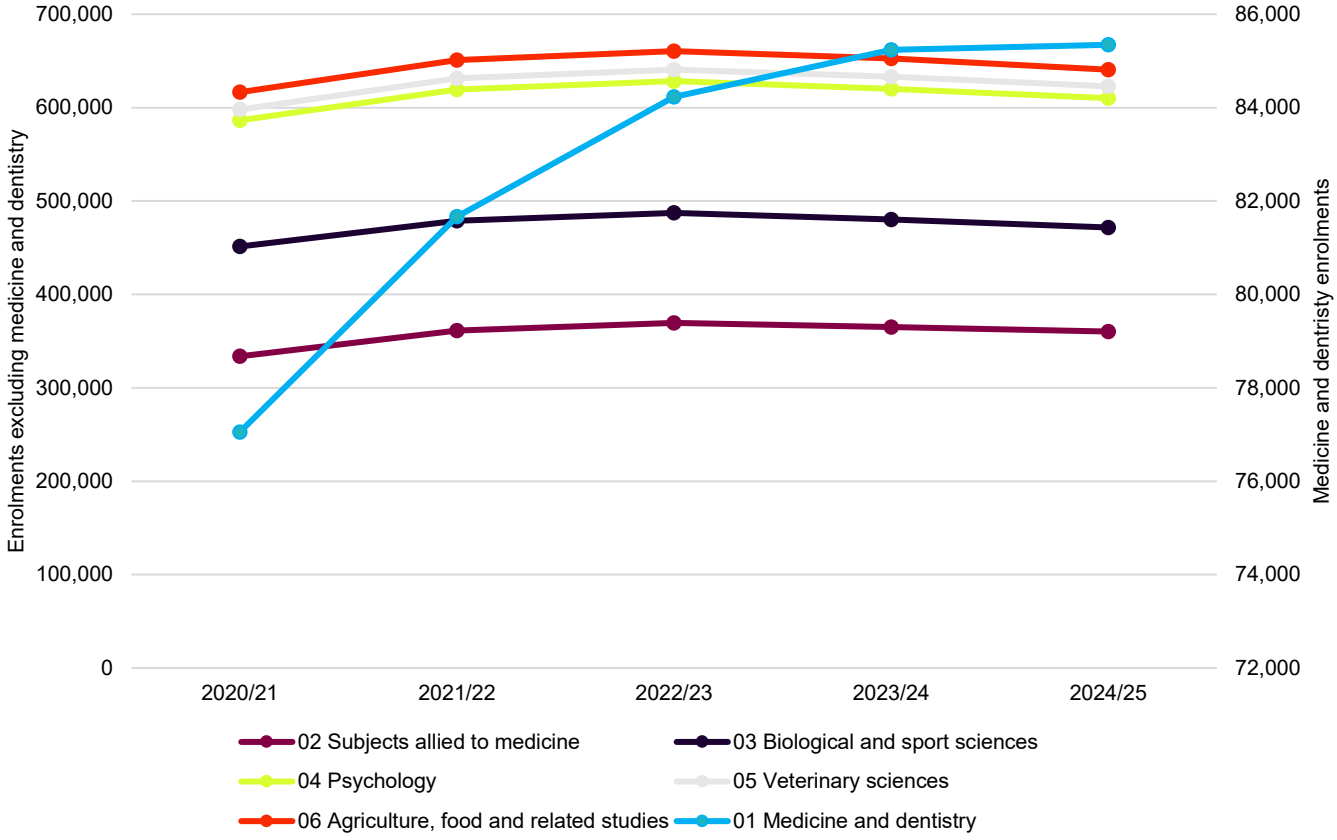
- A range of deliverables have already been identified to support clinical academics, through reports commissioned by OSCHR.[53] A key solution is the need to establish a clearer national career framework, which supports flexible training pathways, backed by support for leaders and mentors, with appropriate pay and funding.

[53] OSCHR (2025). *Clinical researchers in the UK: reversing the decline.* https://www.ukri.org/publications/clinical-researchers-in-the-uk-reversing-the-decline/

- We also need to improve the porosity between academia, industry and the NHS so that research and innovation activities are maximised for medical science. This includes mobility opportunities as well as incentives to share R&I infrastructure.

Figure 24: UK medical science student enrolments, 2020/21 to 2024/25

Source: Analysis of HESA Student Record



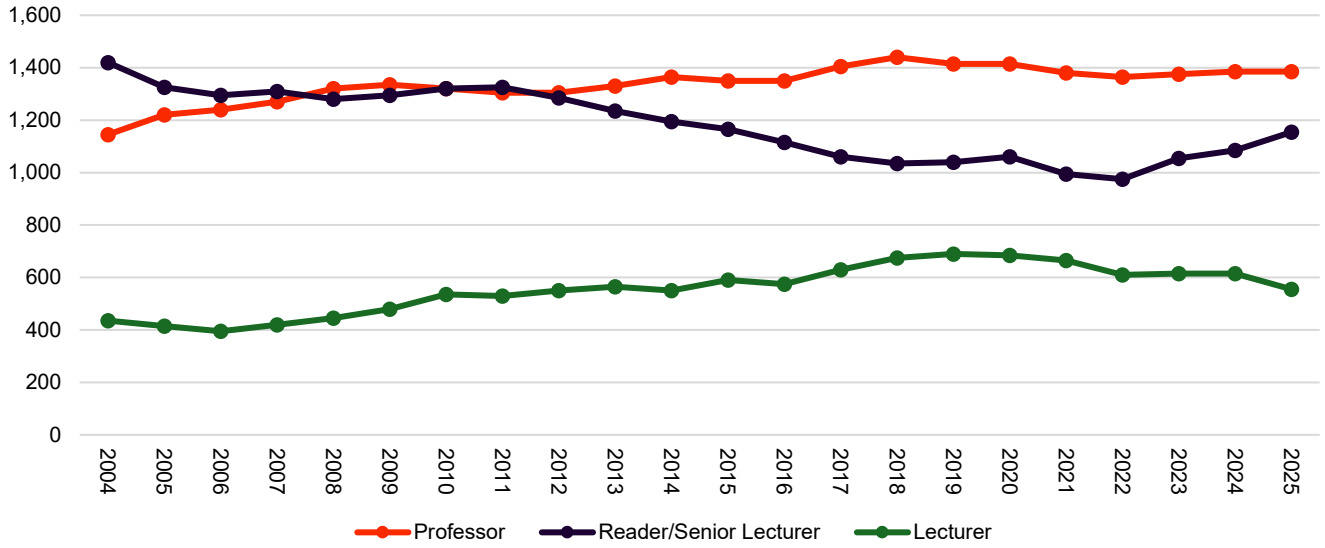
In June 2023, the NHS published a workforce plan for England, which committed to doubling the number of medical school training places to 15,000 a year by 2031/32 and expanding dentistry training places by 40%.[54] We expect to see an updated workforce plan soon. However, we also need parallel increases in employment opportunity in the NHS, and incentives for clinicians to take up research roles.

The OfS confirmed that the total intake of medical and dental students at UK medical and dental schools during the academic year 2024/25 was 10,333 (medical) and 1,118 (dental).[55]

[54] NHS England (2023). *NHS Long Term Workforce Plan*. https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/
[55] OfS (N.D.). *Funding for medicine and dentistry.* https://www.officeforstudents.org.uk/for-providers/finance-and-funding/medicine-and-dentistry-funding/data-on-medical-and-dental-intakes/

Figure 25: UK staffing levels of medical clinical academics, 2004 to 2025

Source: MSC



Analysis from the MSC shows that, in 2025, there were 3,105 full-time equivalent (FTE) clinical academics in medicine. This represents a slight increase on 2024 numbers, and we recognise efforts across the medical science community to address the long-term decline. However, only 3.2% of consultants held clinical academic posts, down from 4.7% in 2009. Further, more than a third of staff were aged over 55, and there has been a 25% fall in those aged under 36 compared with 2024.[56]

Clinical research delivers better health in part through the discovery of new ways to prevent and treat illness and deliver care. It also drives innovation and economic growth. However, these societal benefits are under threat due to the trajectory of the clinical academic workforce. In 2025, the Academy convened health leaders to share national and regional examples of new models for creating clinical academic posts, and to consider how to do this more effectively at scale. Key themes identified during the summit were used to produce a statement of ambition and intent for creating new UK clinical academic posts.[57]

While the proportion of women in senior academic roles is increasing, we need to continue this trajectory and provide opportunities for progression. The Academy's SUSTAIN programme supports women in research to develop leadership and career potential.[58]

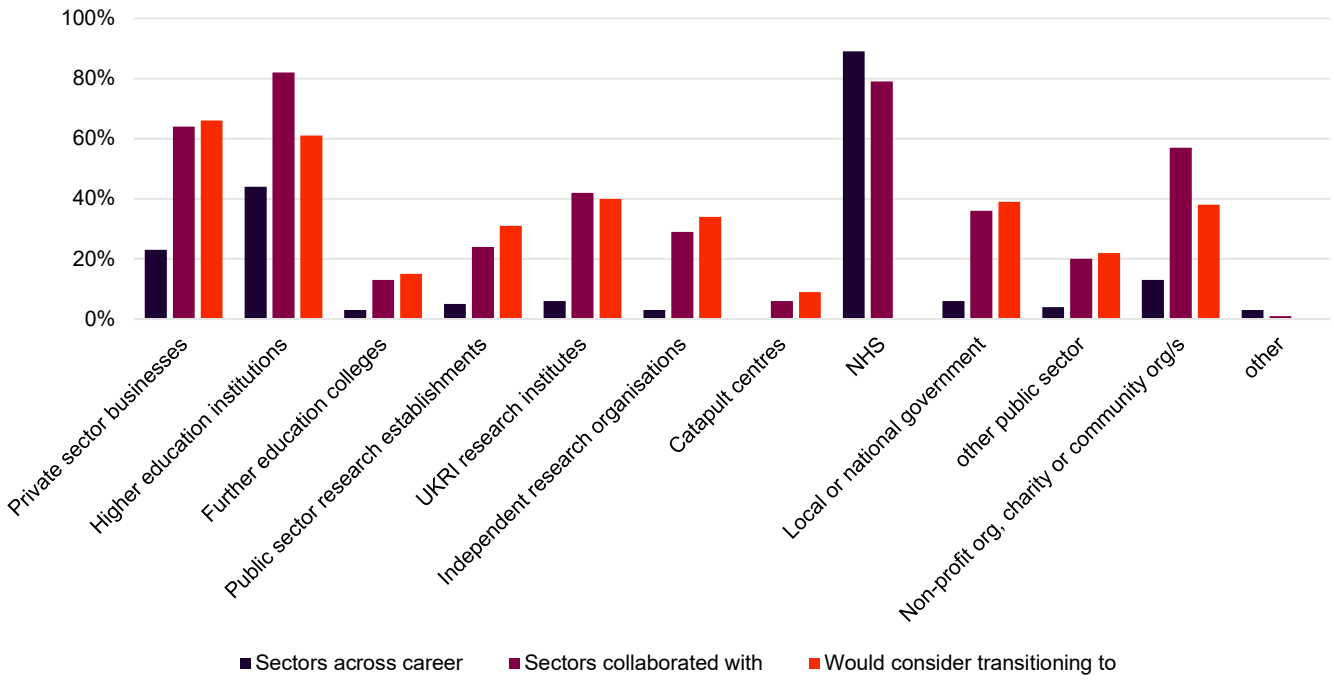
The MSC's data collection is helpful for understanding workforce trends, but data needs to be embedded more strongly in national collection. Following the OSCHR-commissioned reports on clinical academics,[59] we hope that improvements to data collection in the HESA record are being considered. Funders have also been coordinating to help create a more common and visible national

[56] MSC (2026). *Early-career clinical academic numbers fall sharply as workforce pipeline faces mounting challenges.* https://www.medschools.ac.uk/latest/news/early-career-clinical-academic-numbers-fall-sharply-as-workforce-pipeline-faces-mounting-challenges/
[57] Academy of Medical Sciences (2025). *Creating new clinical academic posts to support the UK's health and economic growth.*
[58] Academy of Medical Sciences (N.D.). *SUSTAIN - women in research.*
[59] OSCHR (2025). *Clinical researchers in the UK: reversing the decline.* https://www.ukri.org/publications/clinical-researchers-in-the-uk-reversing-the-decline/

clinical research pathway, by mapping out funding opportunities across different career stages. This map is available on the Clinical Academic Training and Careers Hub (CATCH).[60]

Figure 26: Cross-sector activities of the UK's research and innovation workforce (current main sector: NHS), 2024

Source: DSIT



Note: DSIT's survey excludes respondents who answered 'No' to the question, 'Does your work involve research or innovation?' Data on sector transition relates to respondents who said they would consider transitioning sectors.

DSIT's 2024 R&I workforce survey shows trends in cross-sector movement and collaboration. The figure above shows whether people working in the NHS (in roles involving research and innovation) have worked, collaborated or would consider transitioning to other sectors. The survey also found a recurring suggestion for how the Government could support them better in their R&I career: *'increased investment in clinical academics within the NHS to support healthcare innovation'*. Following a recommendation in our Future-proofing UK Health Research report, the Academy was pleased to see the survey's addition of information on the prevalence, drivers and barriers to cross-sector mobility.[61]

Academia, industry, the NHS, policymakers, patients and the public need to work together to solve the major challenges facing healthcare. Innovation happens at the intersection of sectors. This is why the Academy launched a Cross-Sector Programme in 2022.[62] Collectively, we need to incentivise and reduce barriers to collaboration.

[60] CATCH (2025). *National clinical research career pathway.* https://www.catch.ac.uk/national-clinical-research-career-pathway/
[61] Academy of Medical Sciences (2025). *Future-proofing UK Health Research: 2025 update report.*
[62] Academy of Medical Sciences (N.D.). *Cross-Sector Programme - network, connect, collaborate.*

Domain 7: Supporting economic growth through medical science

What we want to see

Medical science is used to enhance productivity, create jobs and leverage investment.

How we can measure it

Productivity gains from improving population health, along with job creation and private investment leveraged from medical science activities.

Indicative metrics

Productivity gains from improving population health

Figure 27: The UK's cost of working age ill-health and disability that prevents work, 2022

Employment from life sciences activity

Figure 28: Employment at UK life sciences companies by subsector, 2008/09 to 2023/24

Turnover generated from life sciences activity

Figure 29: Turnover generated from UK life sciences companies by subsector (£ billions), 2008/09 to 2023/24

Figure 30: UK life sciences inward foreign direct investment (FDI) (£ millions), 2014 to 2024

Trajectory assessment

Metric	Assessment
Productivity gains from improving population health	**Concerning**: There has been a substantial rise in people deemed economically inactive since 2019, which will only increase if action is not taken. This is leading to significant additional costs to the NHS.
Employment from life sciences activity	**Strong**: The number of people employed by businesses in the life sciences industry has increased, with medical technology accounting for the largest subsector in terms of employment.
Turnover generated from life sciences activity	**Strong**: The figures show that while the number of businesses operating has decreased, the increase in turnover generated by the UK life sciences industry has outweighed this. Following a period of decline, there has also been a recent uplift in estimated inward foreign direct investment into the UK, in the life sciences.

Data assessment

- Turnover and employment data help to underline the life sciences as a key growth sector. Data also shows the benefits of investing in medical science, in terms of how a healthy population improves economic performance.

Policy assessment

- In the Industrial Strategy, there are ambitions for UK to be, by 2035, *'the third most important Life Sciences economy globally, after the US and China'*.[63] To meet these ambitions, we need the policy landscape to recognise medical science as a core UK strength, which will improve the consistency of relevant decision-making and its ability to attract clinical research investment.

Figure 27: The UK's cost of working age ill-health and disability that prevents work, 2022

Source: The Department for Work and Pensions (DWP)

Cost element	Description	Lower Bound	Upper Bound	Single/ Mid-Point
Economic inactivity	Lost output due to working-age ill-health which prevents work	£127bn	£188bn	£132bn
Sickness absence	Lost output due to sickness absence	£38bn	£56bn	£47bn
Informal care giving	Lost output due to working age carers caring for working age sick	£37bn	£37bn	£37bn
NHS cost	The additional costs to the NHS when someone with a health problem is economically inactive rather than economically active	£2bn	£2bn	£2bn
Benefits payments	Cost of social security benefits related to health conditions that prevent people from working	£36bn	£47bn	£41bn
Total	**Total expenditure in 2022**	**£240bn**	**£330bn**	**£259bn**
of which: Exchequer flowbacks	*Tax and National Insurance foregone due to health-related worklessness*	*£57bn*	*£57bn*	*£57bn*

The DWP calculated that when an individual with health problems moves from activity to inactivity, the additional NHS cost per year is £910. When multiplied by the number of people who are inactive due to sickness, this amounts to approximately £2 billion. They estimated that the total cost of working age ill-health and disability that prevented work was between £240 billion and £330 billion in 2022.

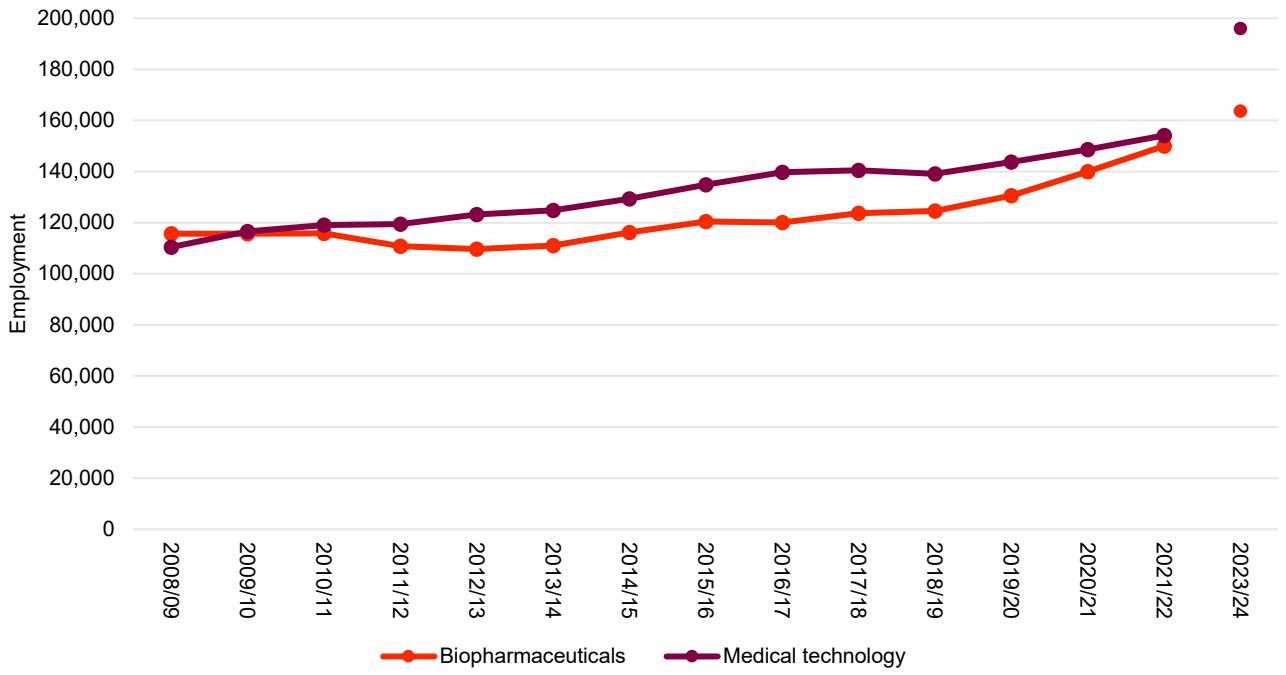
Poor health is a significant driver of the UK's poor economic performance. A joint DWP/DBT report found that 2.8 million working-age people were economically inactive for health reasons, an increase of over 40% since 2019. If no further action is taken, it is estimated that this will increase by 600,000 people by 2030.[64]

[63] DBT (2025). *The UK's Modern Industrial Strategy 2025.* https://www.gov.uk/government/collections/the-uks-modern-industrial-strategy-2025

[64] DWP, DBT (2026). *Keep Britain Working: Final report.* https://www.gov.uk/government/publications/keep-britain-working-review-final-report/keep-britain-working-final-report

Figure 28: Employment at UK life sciences companies by subsector, 2008/09 to 2023/24

Source: OLS



Note: No data for 2022/23; methodology change from 2023/24 onwards

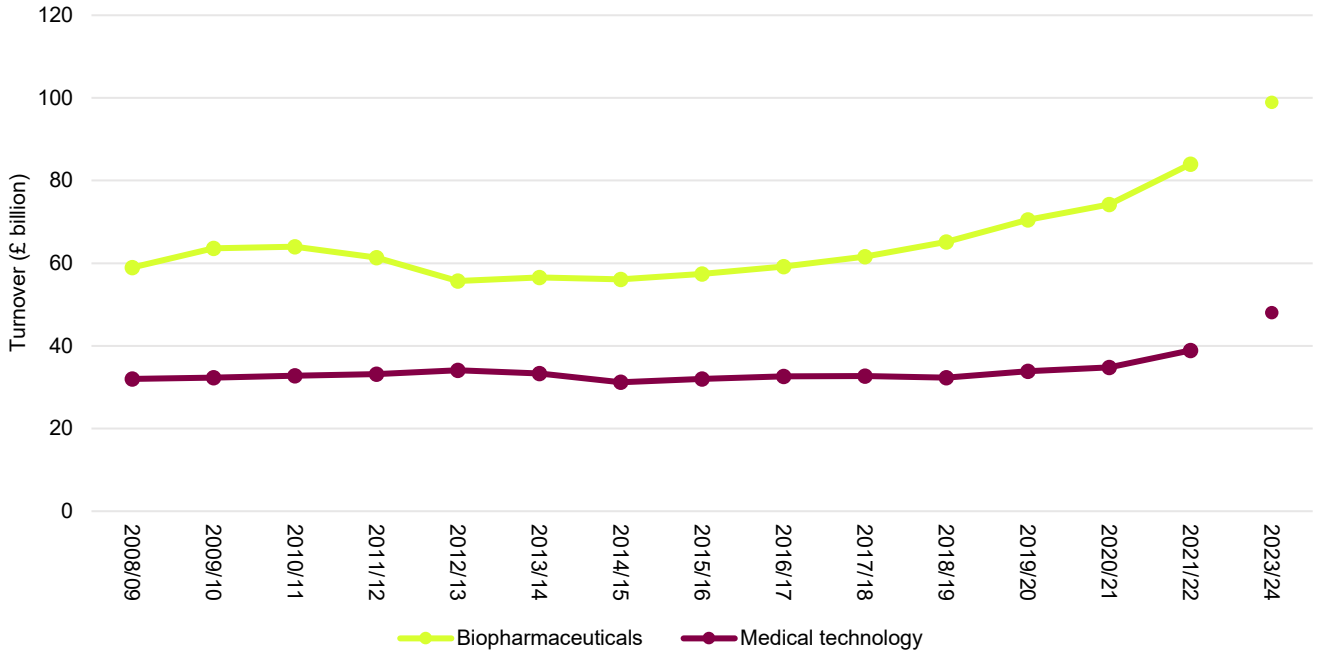
The Academy's input to the Industrial Strategy noted that the UK has historically been one of the best places in the world for life sciences and medical research. This has consistently attracted highly skilled and committed international and domestic research talent to work in the UK life sciences industry, and this is now a major driver of employment and growth. Data from the OLS shows that, in 2023/24, there were 6,170 businesses operating in the UK life sciences industry across 7,320 companies.[65] These businesses employed 359,600 people.

There were 1,400 life sciences companies in 2023/24 across the UK that had R&D as their primary activity. This was 19% of the total number of life sciences companies in the OLS data.

[65] Businesses here are defined as entities that are legal owners of one or more companies.

Figure 29: Turnover generated from UK life sciences companies by subsector (£ billions), 2008/09 to 2023/24

Source: OLS

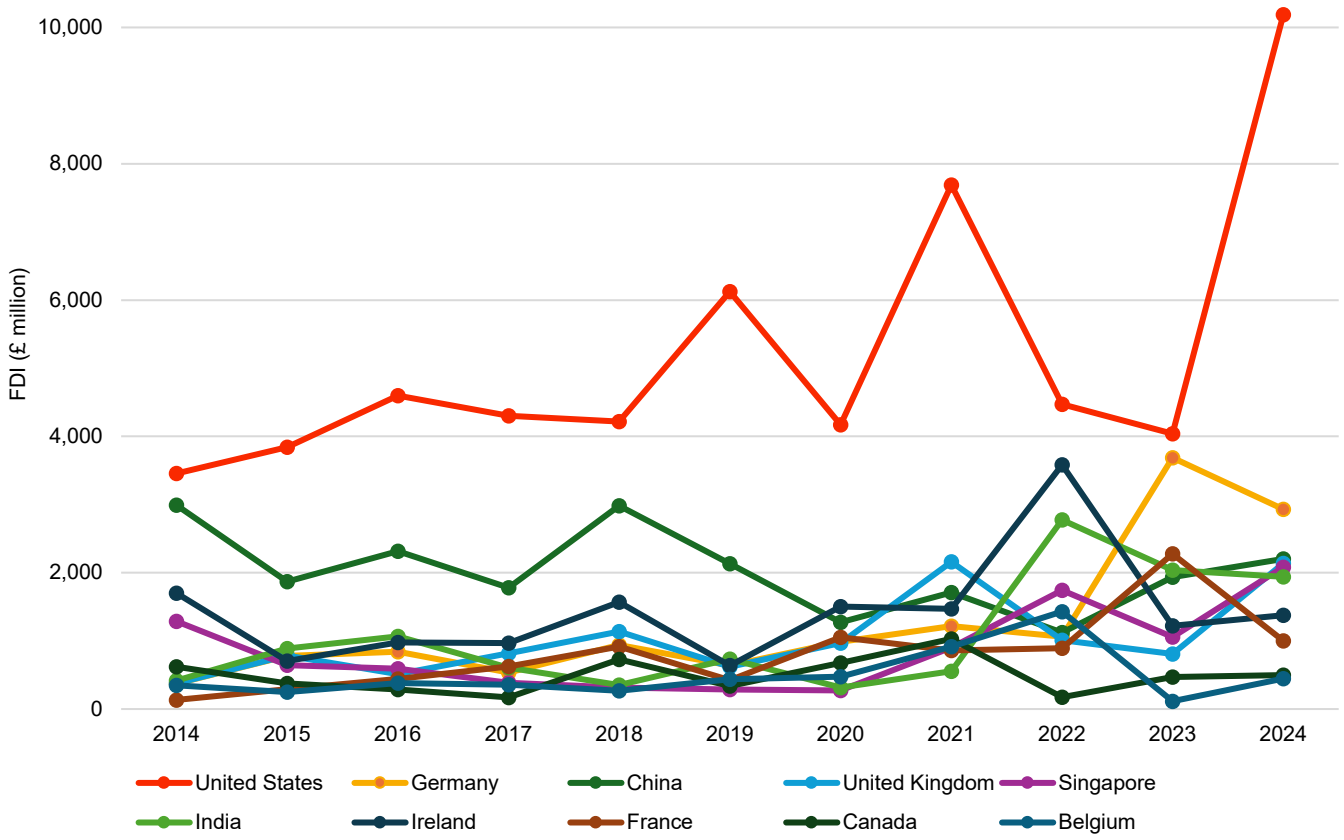


Note: No data for 2022/23; methodology change from 2023/24 onwards

Data from the OLS shows that, in 2023/24, businesses operating in the UK life sciences industry, generated £146.9 billion in turnover. The subsector that generated the highest turnover was the biopharmaceutical subsector, accounting for 67% of turnover across the life sciences industry.

Figure 30: UK life sciences inward foreign direct investment (FDI) (£ millions), 2014 to 2024

Source: OLS



The OLS has estimated that in 2024, the value of inward FDI into the UK was £2.1 billion. This was an increase of £1.3 billion, or 164%, compared with 2023, which moved the UK's ranking from eighth to fourth amongst 18 comparators.

Successful life sciences companies and individual researchers need access to global markets and international linkages. To maintain and enhance the UK's place in life sciences on the global stage, we must consider how to remain a research partner of choice.[66]

[66] Academy of Medical Sciences (2024). *Academy of Medical Sciences response to Invest 2035: the UK's modern industrial strategy.*

Concluding remarks

There is a broad range of invaluable datasets that can help us to understand and enhance medical science, improve health and grow the economy. This report highlights just a small number of these, and provides a starting framework for how they could be collated in ways that can help us to understand trajectory, evidence gaps and policy implications.

We want to build on this framework and data collection, and work with the medical science community to make sure we are valuing and assessing the right domains and evidence. Through this, we can make the right interventions to ensure the UK continues to be one of the best places in the world for medical science and deliver on our policy ambitions.

Annex 1: Table of Figures and Sources

Domain 1: Creating a healthier population and reducing health inequalities

No.	Figure	Source
1	Healthy life expectancy at birth by sex, UK, 2011-13 to 2022-24	ONS (2026). *Healthy life expectancy, UK: between 2011 to 2013 and 2022 to 2024.* https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/between2011to2013and2022to2024
2	Age-standardised mortality rates for deaths from avoidable causes, England and Wales, registered between 2001 and 2024	ONS (2026). *Avoidable mortality in England and Wales: 2024.* https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2024
3	All-Cause Mortality in England by Index of Multiple Deprivation Decile, 21 March 2021 to 31 January 2023	ONS (2023). *Inequalities in mortality involving common physical health conditions, England: 21 March 2021 to 31 January 2023.* https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/inequalitiesinmortalityinvolvingcommonphysicalhealthconditionsengland/21march2021to31january2023
4	OECD comparisons of health status and risk factors, 2025 statistics	OECD (2025). *Health at a Glance 2025.* OECD Publishing, Paris, https://doi.org/10.1787/8f9e3f98-en

Domain 2: Detecting and preventing health issues at an earlier stage

No.	Figure	Source
5	Difference in uptake of national immunisation programmes between the least deprived and most deprived Upper Tier Local Authorities (UTLA) Index of Multiple Deprivation (IMD) deciles in 2024/25	UKHSA (2026). *National Immunisation Programme Health Equity Audit 2025.* https://www.gov.uk/government/publications/national-immunisation-programme-health-equity-audit-2025/national-immunisation-programme-health-equity-audit-2025
6	Children vaccinated in England by their first or second birthday, 2006/07 to 2024/25	QualityWatch (2026). *Vaccination coverage for children and mothers.* https://www.nuffieldtrust.org.uk/resource/vaccination-coverage-for-children-and-mothers-1
7	Cancer waiting times, 2021/22 to 2025/26	NHS England (2026). *Cancer Waiting Times Data Collection.* https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
8	Trend in adults living with obesity in England, 1993 to 2022	DHSC (2025). *Health trends and variation in England, 2025.* https://www.gov.uk/government/publications/health-trends-and-variation-in-england-2025-a-chief-medical-officer-report/health-trends-and-variation-in-england-2025-accessible-version#chapter-4-risk-factors-and-wider-determinants
9	Prevalence of adult long-standing conditions in England, 2024	NHS England (2026). *Health Survey for England, 2024.* https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2024/adults-health
10	Avoidable hospital admissions per 100,000 population, OECD comparisons, 2023	OECD (2025). *Health at a Glance 2025.* OECD Publishing, Paris, https://doi.org/10.1787/8f9e3f98-en

Domain 3: Delivering world-class health research

No.	Figure	Source
11	UK Activity Index across six research areas, 2022	DSIT (2025). *International comparison of the UK research base, 2025.* https://www.gov.uk/government/publications/international-comparison-of-the-uk-research-base-2025/international-comparison-of-the-uk-research-base-2025
12	Average UK overall quality profile and sub-profiles, 2021 (FTE, weighted), Main Panel A	REF 2021 (N.D.). *Sector and main panel average results.* https://2021.ref.ac.uk/results-analysis/sector-and-main-panel-average-results/index.html
13	G7 country positions amongst comparator countries (in terms of quartiles) for research environment metrics, latest year available	OLS (2026). *Life sciences competitiveness indicators 2026.* https://www.gov.uk/government/publications/life-sciences-competitiveness-indicators-2026/life-sciences-competitiveness-indicators-2026-summary
14	Gross domestic spend on medical and health sciences R&D performed by the Government as a percentage of GDP, 2023 (or latest year available), UK and comparator countries	OLS (2026). *Life sciences competitiveness indicators 2026.* https://www.gov.uk/government/publications/life-sciences-competitiveness-indicators-2026/life-sciences-competitiveness-indicators-2026-summary
15	Targeted UK investment in Industrial Strategy growth sectors across priority buckets, Spending Review period (combined investment, £ millions)	UKRI (2025). *Budget allocations for UK Research and Innovation.* https://www.ukri.org/publications/explainer-ukri-budget-allocations/budget-allocations-for-uk-research-and-innovation/
16	Estimates for the total UK health-relevant R&D expenditure, 2018 and 2022	UKCRC (2023). *UK Health Research Analysis 2022.* https://hrcsonline.net/wp-content/uploads/2024/09/UK_Health_Research_Analysis_Report_2022_web_v1-2-postpub.pdf
17	Full economic cost recovery (fEC) of UK higher education institutions by sponsor type, 2023/24	OfS (2025). *Annual TRAC 2023-24: Sector summary and analysis by TRAC peer group.* https://www.officeforstudents.org.uk/media/zntnyj2n/annual-trac-2023-24.pdf

Domain 4: Building capacity to accelerate the development of new treatments

No.	Figure	Source
18	UK Clinical Research Delivery key performance indicators, March 2026	DHSC (2026). *UK Clinical Research Delivery key performance indicators: data to March 2026.* https://www.gov.uk/government/statistics/uk-clinical-research-delivery-key-performance-indicators-data-to-march-2026/uk-clinical-research-delivery-key-performance-indicators-data-to-march-2026
19	Average number of participants recruited per month to commercial and non-commercial clinical trials in the UK, 2016 to 2025	DHSC (2026). *UK Clinical Research Delivery key performance indicators: data to March 2026.* https://www.gov.uk/government/statistics/uk-clinical-research-delivery-key-performance-indicators-data-to-march-2026/uk-clinical-research-delivery-key-performance-indicators-data-to-march-2026
20	Diversity and inclusion of participants in clinical trials in the UK, 2024	Ipsos (2024). *Diversity and clinical trials in the UK.* https://www.ipsos.com/en-uk/bridging-ethnicity-gap-clinical-trial-participation-education-and-tailored-communications-needed

Domain 5: Increasing public trust and engagement in medical science

No.	Figure	Source
21	Public attitudes to science in the UK, 2025	BSA, Ipsos, UKRI (2026). *Public Attitudes to Science 2025.* https://pas.ipsos.com/
22	Public attitudes to R&D in the UK, 2025	CaSE (2025). *Public Attitudes to R&D 2025.* https://www.sciencecampaign.org.uk/what-we-do/public-opinion/research/case-public-attitudes-to-rd-2025/
23	Percentage of applicants reporting public involvement in health and social care research (HRA sample selection), 2023 to 2024	HRA (2025). *Public involvement IRAS data analysis report 2024.* https://www.hra.nhs.uk/planning-and-improving-research/best-practice/public-involvement/how-we-champion-public-involvement-in-research/public-involvement-iras-data-analysis-report-2024/

Domain 6: Developing a workforce fit for the future

No.	Figure	Source
24	UK medical science student enrolments, 2020/21 to 2024/25	Analysis of HESA Student record, 2020/21 to 2024/25. https://www.hesa.ac.uk/data-and-analysis/students/table-46
25	UK staffing levels of medical clinical academics, 2004 to 2025	MRC (2025). *Staffing levels of medical clinical academics.* https://www.medschools.ac.uk/what-we-do/championing-clinical-academia-and-research/clinical-academic-survey/
26	Cross-sector activities of the UK's research and innovation workforce (current main sector: NHS), 2024	DSIT (2025). *Research and Innovation workforce survey: 2024 insights.* https://www.gov.uk/government/publications/research-and-innovation-workforce-survey-2024-insights

Domain 7: Supporting economic growth through medical science

No.	Figure	Source
27	The UK's cost of working age ill-health and disability that prevents work, 2022	DWP (2025). *The cost of working age ill-health and disability that prevents work.* https://www.gov.uk/government/statistics/the-cost-of-working-age-ill-health-and-disability-that-prevents-work/the-cost-of-working-age-ill-health-and-disability-that-prevents-work
28	Employment at UK life sciences companies by subsector, 2008/09 to 2023/24	OLS (2025). *Bioscience and health technology sector statistics 2023 to 2024.* https://www.gov.uk/government/statistics/bioscience-and-health-technology-sector-statistics-2023-to-2024/bioscience-and-health-technology-sector-statistics-2023-to-2024
29	Turnover generated from UK life sciences companies by subsector (£ billions), 2008/09 to 2023/24	OLS (2025). *Bioscience and health technology sector statistics 2023 to 2024.* https://www.gov.uk/government/statistics/bioscience-and-health-technology-sector-statistics-2023-to-2024/bioscience-and-health-technology-sector-statistics-2023-to-2024
30	UK life sciences inward foreign direct investment (FDI) (£ millions), 2014 to 2024	OLS (2026). *Life sciences competitiveness indicators 2026.* https://www.gov.uk/government/publications/life-sciences-competitiveness-indicators-2026/life-sciences-competitiveness-indicators-2026-summary

Narrative sources

ABPI (2025). *UK industry clinical trials: Translating actions into impact*. https://www.abpi.org.uk/publications/uk-industry-clinical-trials-translating-actions-into-impact/

Academy of Medical Sciences (2024). *Academy of Medical Sciences response to Invest 2035: the UK's modern industrial strategy.*

Academy of Medical Sciences (2025). *Child's weight for life shaped by first 1,000 days, report health experts.*

Academy of Medical Sciences (2025). *Creating new clinical academic posts to support the UK's health and economic growth.*

Academy of Medical Sciences (N.D.). *Cross-Sector Programme - network, connect, collaborate.*

Academy of Medical Sciences (2023). *Future-proofing UK Health Research: a people-centred, coordinated approach.*

Academy of Medical Sciences (2025). *Future-proofing UK Health Research: 2025 update report.*

Academy of Medical Sciences (N.D.). *Health inequalities.*

Academy of Medical Sciences (2026). *Innovative clinical research: delivering trials in the community.*

Academy of Medical Sciences (2026). *New national taskforce to secure the future of UK medical science careers*

Academy of Medical Sciences (2026). *Shifting left to prevention: innovation for fairer health.*

Academy of Medical Sciences (N.D.). *SUSTAIN - women in research.*

Academy of Medical Sciences, IAP (2022). *Global Health Inequalities: Research for a fairer future.*

Academy of Medical Sciences, NHSA (2026). *Cross-Sector North of England: Future Proofing Northern Prevention Research.*

CaSE (2026). *Reimagining R&D: What future does the sector want for UK R&D?* https://www.sciencecampaign.org.uk/analysis-and-publications/detail/reimagining-rd-what-future-does-the-sector-want-for-uk-rd/

CRUK (2026). *Cancer waiting times: Latest updates and analysis.* https://news.cancerresearchuk.org/2026/06/12/cancer-waiting-times-latest-updates-and-analysis/

Curry, S, Gadd, E & Wilsdon, J (2022). *Harnessing the Metric Tide: indicators, infrastructures & priorities for UK responsible research assessment.* https://doi.org/10.6084/m9.figshare.21701624

DBT (2025). *The UK's Modern Industrial Strategy 2025.* https://www.gov.uk/government/collections/the-uks-modern-industrial-strategy-2025

DfE (2025). *Post-16 education and skills white paper.* https://www.gov.uk/government/publications/post-16-education-and-skills-white-paper/post-16-education-and-skills-white-paper

DHSC (2025). *10-Year Health Plan for England.* https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

DHSC (2026). *Government drives forward its 150-day clinical trial target.* https://www.gov.uk/government/news/government-drives-forward-its-150-day-clinical-trial-target

DHSC (2025). *Introducing new medicines in the NHS in the UK - pathway* https://www.gov.uk/government/publications/introducing-new-medicines-in-the-nhs-in-the-uk/introducing-new-medicines-in-the-nhs-in-the-uk-pathway

DHSC, DSIT (2023). *Commercial clinical trials in the UK: the Lord O'Shaughnessy review - final report.* https://www.gov.uk/government/publications/commercial-clinical-trials-in-the-uk-the-lord-oshaughnessy-review/commercial-clinical-trials-in-the-uk-the-lord-oshaughnessy-review-final-report

DWP, DBT (2026). *Keep Britain Working: Final report.* https://www.gov.uk/government/publications/keep-britain-working-review-final-report/keep-britain-working-final-report#fn:14

Government Actuary's Department (2024). *Healthy life expectancy - Mortality Insights* https://www.gov.uk/government/publications/mortality-insights-from-gad-december-2024/mortality-insights-from-gad-december-2024

HRA (2025). *Making the UK a great place to do clinical trials – our response to the ABPI report.* https://www.hra.nhs.uk/about-us/news-updates/making-the-uk-a-great-place-to-do-clinical-trials-our-response-to-the-abpi-report/

HRA (2026). *New research transparency data on UK clinical trials published.* https://www.hra.nhs.uk/about-us/news-updates/new-research-transparency-data-on-uk-clinical-trials-published/

LGA (N.D.). *High Impact Change Model: reducing preventable admissions.* https://www.local.gov.uk/our-support/partners-care-and-health/better-care-fund-support-programme-2025-26/high-impact-change

MRC (2026). *Improving MRC funding through continued community engagement.* https://www.ukri.org/blog/improving-mrc-funding-through-continued-community-engagement/

MSC (2026). *Early-career clinical academic numbers fall sharply as workforce pipeline faces mounting challenges.* https://www.medschools.ac.uk/latest/news/early-career-clinical-academic-numbers-fall-sharply-as-workforce-pipeline-faces-mounting-challenges/

NHS England (2022). *National Obesity Audit (NOA) dashboards.* https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-obesity-audit/dashboards

NHS England (N.D.). *NHS England public data gateway.* https://data.england.nhs.uk/

NHS England (2023). *NHS Long Term Workforce Plan.* https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/

OfS (N.D.). *Funding for medicine and dentistry.* https://www.officeforstudents.org.uk/for-providers/finance-and-funding/medicine-and-dentistry-funding/data-on-medical-and-dental-intakes/

OLS (2026). *Life Sciences Jobs Plan.* https://assets.publishing.service.gov.uk/media/6a4e701e559c26eacf438f53/life-sciences-jobs-plan.pdf

OLS (2025). *Life Sciences Sector Plan.* https://www.gov.uk/government/publications/life-sciences-sector-plan

OLS (2026). *Life Sciences Sector Plan: One Year On.* https://www.gov.uk/government/publications/life-sciences-sector-plan-one-year-on

ONS (2025). *Cancer diagnosis at stage 1 and 2.* https://www.ons.gov.uk/explore-local-statistics/indicators/cancer-diagnosis-stage-1-and-2

ONS (2025). *Economic inactivity due to long-term sick or disabled, by health condition and change over time, Scotland and UK, selected years.* https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/adhocs/3123economicinactivityduetolongtermsickordisabledbyhealthconditionandchangeovertimescotlandandukselectedyears

OSCHR (2025). *Clinical researchers in the UK: reversing the decline.* https://www.ukri.org/publications/clinical-researchers-in-the-uk-reversing-the-decline/

QualityWatch (2026). *Diagnostic test waiting times.* https://www.nuffieldtrust.org.uk/resource/diagnostic-test-waiting-times

QualityWatch (2026). *Vaccination coverage for children and mothers.* https://www.nuffieldtrust.org.uk/resource/vaccination-coverage-for-children-and-mothers-1

Raleigh, V. (2025). *Is the UK becoming the 'sicker man' of Europe?* https://www.kingsfund.org.uk/insight-and-analysis/blogs/uk-sicker-man-europe

UKCRC (2023). *UK Health Research Analysis 2022.* https://hrcsonline.net/wp-content/uploads/2024/09/UK_Health_Research_Analysis_Report_2022_web_v1-2-postpub.pdf

UK Government (2025). *Life Sciences Sector Plan.* https://assets.publishing.service.gov.uk/media/688c90a8e8ba9507fc1b090c/Life_Sciences_Sector_Plan.pdf

UK Government (2025). *Transformative £86 billion boost to science and tech to turbocharge economy, with regions backed to take cutting-edge research into own hands.* https://www.gov.uk/government/news/transformative-86-billion-boost-to-science-and-tech-to-turbocharge-economy-with-regions-backed-to-take-cutting-edge-research-into-own-hands

UKHSA (2026). *National Immunisation Programme Health Equity Audit 2025.* https://www.gov.uk/government/publications/national-immunisation-programme-health-equity-audit-2025/national-immunisation-programme-health-equity-audit-2025

UKRI (2025). *Research Financial Sustainability: insights 2025.* https://www.ukri.org/publications/research-financial-sustainability-insights-2025/

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