

The False Economy of Big Food

September 2026 update

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Executive Summary

In November 2024, the Food, Farming and Countryside Commission's report on *The False Economy of Big Food* asked two questions: how much does the UK's current food system cost the nation through diet-related ill health; and how much additional household expenditure would be required to ensure access to a healthy diet for everyone?

This report revisits these questions using updated evidence and statistics. It also takes into consideration new insights and research, published since the earlier work, that are important context for our analysis.

THE UPDATED CONTEXT

The evidence that diet-related ill health causes economic harm has increased. It has been estimated that 2.8 million working-age people are now outside the labour market because of long-term sickness. The burden is unequally distributed, with poorer households and more deprived places experiencing substantially higher rates of illness.

The unequal burden of illness is compounded by a profound inequality in the ability to afford a healthy diet. The Food Foundation have estimated that a family with children in the lowest income quintile would need to spend approximately 85% of disposable income after housing costs to afford a diet compliant with the government's Eatwell Guide on healthy eating.

These impacts are framed by market conditions. Evidence of the 'commercial determinants of health' has gained increasing prominence since our original report. This evidence has established how commercial actors influence health and health equity. It has revealed how diets are shaped by product formulation, pricing, availability, marketing and retail environments. And it has exposed the way corporate power exerts influence over research, public narratives and policymaking.

In short, as health conditions decline and food inequality increases, commercial drivers are still pitted against public health and undermining social and economic well-being.

THE UPDATED FINDINGS

The calculations in this report show that the 'hidden' health-related costs of our food system have increased since the 2024 report was published, while the additional household spending needed to achieve healthy diets for all has narrowed slightly. Specifically, we find that:

- The estimated health-related costs attributable to unhealthy diets have risen to £298 billion a year at mid-2026 prices.
- Direct healthcare, social care and welfare costs amount to approximately £104 billion (up £12 billion from 2024). Indirect productivity and quality-of-life losses add a further £194 billion (£18 billion higher than in 2024).
- The incremental expenditure needed to bring household food budgets up to the cost of achieving the Eatwell Guide across the nation has fallen from £57 billion to £51 billion a year. Households are spending more on food, but not necessarily more on healthy food.
- The hidden costs of unhealthy diets are therefore almost six times the household expenditure gap. Direct costs alone are more than twice the estimated uplift.
- On this illustrative accounting framework, the overall cost of current household food spending – including the hidden cost – amounts to more than £414 billion a year, compared with just under £167 billion for an Eatwell-compliant diet – an annual difference of almost £248 billion.

The updated evidence leaves the fundamental argument from *The False Economy of Big Food* unchanged. The UK spends vast sums managing chronic illness while maintaining a food economy that makes healthy eating difficult and, for many households, unaffordable.

THE POLICY CONCLUSIONS

These findings do not change the policy conclusions from the earlier report. On the contrary they underline the importance of our previous analysis. In particular, they point towards a clear set of policy principles:

1. Treat food and health policy as economic policy
2. Establish affordable healthy food as a practical right
3. Reshape the food environment with enforceable standards and product transparency
4. Redirect financial flows to align commercial returns with public value
5. Build a cross-government food and health mission

Ensuring access to nutritious food is an ethical and public health imperative. The updated analysis confirms that it is also an economic necessity.

Aim of this report

In our 2024 report, *The False Economy of Big Food*ⁱ, we found that unhealthy diets imposed annual health-related costs of approximately £268 billion, comprising £92 billion in direct healthcare, social care and welfare costs and £176 billion in lost productivity and diminished quality of life. By comparison, the estimated expenditure required to raise every household's food spending to the cost of a diet consistent with the government's Eatwell Guideⁱⁱ was £57 billion. The central conclusion of the *False Economy* was that the cost of managing the consequences of unhealthy diets in the UK substantially exceeds the cost of enabling people to eat well.

This report updates those calculations to a mid-2026 price and data basis. It incorporates newer evidence on healthcare and long-term-care expenditure, health and disability benefits, diet-attributable disease burden, obesity-related quality-of-life losses, household food expenditure and the cost of following the Eatwell Guide. It also considers important research published since November 2024, including work by the Health Foundation, the Food Foundation, Nesta and Frontier Economics, the Office for National Statistics (ONS) and the World Health Organization (WHO).

The updated estimates are not intended as a complete cost-benefit analysis of any particular intervention. They are designed to test whether the central proposition of the original study remains credible in the light of newer evidence and to reassess the relevance of these findings for policy.

Background

The case for revisiting the original calculation is not simply that prices and public expenditure have changed. Since 2024, the evidence that poor health represents a structural economic constraint has strengthened, the question of the affordability of food has become more pronounced and the realisation that health is being affected by commercial practices has received increasing attention. We summarise these factors briefly here.

A WORSENING HEALTH AND ECONOMIC CHALLENGE

The Health Foundation's 2026 report *Health as an economic asset* finds that 15.7 million working-age adults now live with a long-term health

condition, compared with 11.7 million in 2014.ⁱⁱⁱ Healthy life expectancy fell by approximately two years over the decade to 2024, while almost 2.8 million working-age people are now outside the labour market because of long-term sickness. The burden is unequally distributed, with poorer households and more deprived places experiencing substantially higher rates of illness.

The report estimates that restoring working-age health to its 2014 level could generate approximately £57 billion in additional annual output, increase tax and National Insurance revenues by £40 billion, reduce welfare expenditure by £18 billion, lower morbidity-related NHS spending by £15 billion and produce quality-of-life improvements valued at £47 billion a year.^{iv} These figures are not directly additive to the estimates in this report: they cover all working-age long-term illness, use a different counterfactual and present several complementary economic and fiscal perspectives. They nevertheless reinforce the central argument that health is not merely a cost to be managed by the NHS. It is a productive asset and a foundation of economic capacity.

Research commissioned by Nesta and undertaken by Frontier Economics reaches a similar conclusion from a narrower focus on obesity and overweight.^v It estimates their total annual cost to UK society at around £126 billion, including approximately £31 billion in lost productivity. Its broader treatment of reduced participation, absence, lower effectiveness at work and premature mortality produces productivity costs more than twice as high as some earlier estimates. The Frontier Economics analysis is also valuable because it provides an updated monetary estimate of the quality-of-life burden (human cost) in this report (see Figure 1).

A CONTINUING AFFORDABILITY PROBLEM

It has become clearer over the last two years that every person and every household in the land should have access to affordable, healthy and sustainable food. But the economic climate for achieving that aim has worsened.

The Office for National Statistics reports that household expenditure on food has risen from £109 billion a year to £116 billion a year since the original report.^{vi} This rise is in large part due to an increase in the price of foodstuffs. The ONS consumer price index for food and non-alcoholic drinks rose 7 index points from 137 to 144 between November 2024 and June 2026, indicating a 5% increase in the price of food since our earlier

report was published.^{vii} This increase inevitably has a more profound effect on poorer households who spend a greater proportion of their income on food than richer households.

At the same time, the food environment remains strongly tilted away from health.^{viii} The Food Foundation's report *The Broken Plate 2025* found that healthier foods were more than twice as expensive per calorie as less healthy foods and that healthier options were also less widely available.^{ix} *The Broken Plate 2026* estimates that a family with children in the lowest income quintile would need to spend approximately 85% of disposable income after housing costs to afford a diet compliant with the government's Eatwell Guide on healthy eating.^x Although the income methodology differs from that used in the present update, the finding demonstrates that the affordability problem remains acute and highly unequal.

The Food Foundation's work is particularly useful here in providing an up-to-date estimate of the potential cost of a healthy diet. Using prices for 18,441 food and drink products collected in May 2022, *The Broken Plate 2023* reported the cost of an Eatwell-compliant diet as £7.48 per adult per day.^{xi} *The Broken Plate 2026* adjusted this basket for food-price inflation and found that the cost had risen to £9.53 per adult per day by October 2025.^{xii} The latest estimate is an inflation update rather than an entirely new optimisation of the Eatwell basket, but it is the most recent suitable benchmark.

THE COMMERCIAL DETERMINANTS OF HEALTH

A further strand of evidence that has gained increasing prominence since our original report concerns the 'commercial determinants of health': the systems, practices and pathways through which commercial actors influence health and health equity. This perspective shifts attention beyond individual behaviour towards the way diets are shaped by product formulation, pricing, availability, marketing and retail environments, as well as by corporate influence over research, public narratives and policymaking.^{xiii}

A major report from WHO Europe, published shortly before our original study, estimated that commercial products and practices – including tobacco, alcohol and processed food – contribute to around a quarter of all deaths in the European region. It documented how commercial actors systematically pursue profit-making strategies which undermine health. It

also showed how these actors obstruct effective public-health policy through lobbying, conflicts of interest, the strategic production and use of evidence and the framing of ill health as a matter of personal responsibility.^{xiv} The report's policy conclusions emphasise transparency, stronger management of conflicts of interest, financial and legal reform and the effective regulation of industry power.

Subsequent work has extended this analysis and applied it more directly to contemporary food systems. The WHO's 2025 *World Report on Social Determinants of Health Equity* places health inequalities within the distribution of power, money and resources, reinforcing the case for coordinated action across government rather than relying principally on health services or consumer education.^{xv} A UK study by Lambie-Mumford and Kennedy applies the commercial-determinants framework to partnerships between food corporations and food charities.^{xvi} It argues that corporate donations may relieve immediate hardship while also enhancing corporate legitimacy and leaving intact the commercial structures that help produce food insecurity. Most recently, a 2025 Lancet series on ultra-processed foods has explicitly connected their global expansion to commercial determinants and corporate power, calling for coordinated measures addressing products, marketing, food environments, supply chains and corporate influence over policy.^{xvii}

Together, this recent work strengthens the case for moving towards regulation, fiscal intervention, transparent governance and clear safeguards against conflicts of interest. It also reinforces the central argument of the *False Economy* report: commercial actors may capture the financial returns from unhealthy food, but the resulting cost is transferred to households, the health and care system, the state and the wider economy.

Updating the hidden, health-related costs of the UK diet

This update is intended as a limited methodological review and price refresh of the earlier FFCC report, rather than a complete re-estimation of the costs attributable to unhealthy diets. All expenditure estimates, costs and losses are expressed on an annualised mid-2026 current-price basis. Where the evidence base or underlying statistical data have changed, these changes are reflected in the updated estimates. Otherwise, the calculation retains the broad architecture and attribution assumptions of

the original analysis. Once again, the costs are divided between what we call ‘direct costs’ – where spending is clearly visible in monetary and financial accounts for the calendar year – and ‘indirect costs’ which are estimated on the basis of lost productivity and losses in people’s quality of life.^{xviii}

Direct costs include healthcare and social spending and the welfare payments associated with disability and sickness. Healthcare and social care expenditure are derived from the UK Health Accounts (UKHA)^{xix} and updated to mid-2026.^{xx} To retain comparability with the original analysis the elements of ‘long-term care’ included in UKHA have been separated out of overall healthcare spending and are included instead in our category ‘social care’. Welfare payments for disability and sickness are drawn from the Department for Work and Pensions benefit expenditure and caseload tables 2026.^{xxi}

The proportion of direct payments associated with the management of chronic disease is assumed here (as in the 2024 study) to be 70%.^{xxii} The fraction (33%) of those costs attributable to diet is (as before) calculated using risk factors drawn from the Global Burden of Disease (GBD) study.^{xxiii} The combined impact of these factors means that we include just 23% of total health-related spending as direct costs. It remains likely that this is a conservative underestimate.^{xxiv}

When it comes to indirect costs, the productivity loss component has been revised using the same Food and Agriculture Organization (FAO) methodology used in the earlier report while incorporating updated evidence on disability-adjusted life years (DALYs) from the most recent GBD study, published in 2025.^{xxv} The human-cost component is calculated by taking the loss of quality of life component in the updated Nesta/Frontier Economics study on the costs of overweight and obesity and adjusting it for mid-2026 prices. This estimate remains a partial measure of the human cost of a dysfunctional food system. Diet-related ill health extends beyond excess weight and includes cardiovascular disease, diabetes, cancers and other chronic conditions. For now, this component remains a conservative proxy of quality of life losses rather than a comprehensive valuation of human suffering.^{xxvi}

The results from the updated calculations are shown in Figure 1. The overall hidden costs of food patterns in the UK in 2026 come to a total of £298 billion. Direct costs amount to £104 billion. These costs comprise healthcare costs (excluding long-term care^{xxvii}) of £67 billion, social care

(long-term care) costs of £20 billion and welfare payments for health and disability of £18 billion. Indirect costs comprise £194 billion of the total and include productivity losses of £119 billion and human costs (loss of quality of life) of £75 billion.

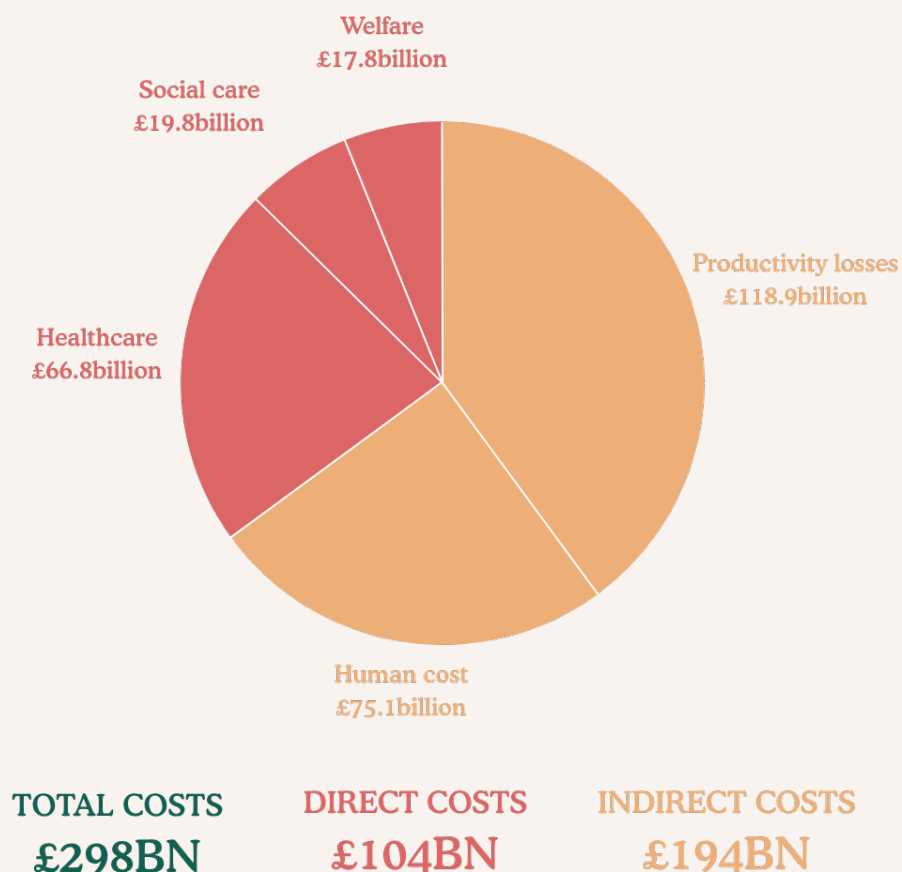


Figure 1: The hidden health-related costs of the UK diet: 2026 update.
Source: summary of calculations as detailed in this update.

The total is approximately £30 billion higher than the £268 billion reported in 2024^{xxviii}. Direct costs have increased from £92 billion to £104 billion, while indirect costs have increased from £176 billion to £194 billion.

The distinction between direct and indirect costs remains important. The £104 billion direct component represents financial expenditure incurred through healthcare, social care and welfare support. These are direct costs incurred by Treasury, by the taxpayer and by private citizens. The £194 billion indirect component represents lost economic output and diminished length or quality of life. These losses are not entirely sums that could immediately be recovered by the Treasury, even if diets improved. Lost economic output does translate partially to lost revenue for the

Treasury through lower tax revenues, although unlike direct annual costs, these are harder to quantify and unfold over many years. The human costs of diminished length or quality of life do not impact on Treasury directly. But this does not make them less important. They represent genuine social and economic losses to society.

The increase in total costs visible in Figure 1 reflects a combination of newer expenditure data, inflation adjustments, more up-to-date forecasts of expenditure, revised burden-of-disease information and improved valuation sources.

Updating the cost of eating well

The second aim of this report is to update the data on household expenditure on food and recalculate the uplift in cost implied by a shift to a healthier diet based on the Eatwell Guide.

As with the hidden costs of the current diet, the analysis preserves the broad architecture and methodological assumptions of the earlier work.^{xxix} Current household expenditure on food was drawn from the most recent ONS data, adjusted to 2026 prices using the consumer food price inflator.^{xxx} Costs associated with the Eatwell diet were taken from the Food Foundation's most recent estimate. Broken Plate 2026 estimated the cost per adult per day of an Eatwell-compliant diet at £9.53. We have adjusted this cost to mid-2026 prices using the same price inflator.^{xxxi}

The results of the updated analysis show that the average household spends around £78 a week on food in the UK, but there is still substantial variation between the poorest household decile (£44 a week) and the richest (£112 a week). Despite spending less money in absolute terms, poorer households spend significantly more on food as a percentage of their income (20%) than rich households do (4%). Poorer households are self-evidently less able to absorb the increased costs of a healthier diet.

A surprising conclusion follows from our analysis. Current household expenditure on food and non-alcoholic drinks in the UK has increased to £116 billion, compared to £109 billion in our previous assessment. The estimated cost associated with an Eatwell-compliant diet at the national level has risen from £159 billion to £167 billion. As a result, the expenditure *gap* between the current diet and an Eatwell-compliant diet has *fallen* from £57 billion to £51 billion since our original report. The

corresponding weekly gap for the average household has fallen from around £38 to approximately £33.

This counterintuitive result arises because household food expenditure has risen more rapidly than the inflation-updated cost of the Eatwell basket. It does not demonstrate that diets have become healthier nor that healthy food is now less expensive. Increased household expenditure may reflect food prices, larger quantities, different products, changes in quality, retailer choice or shifts in household purchasing. The ONS expenditure data do not directly measure nutritional adequacy.

It is also worth noting here that the £51 billion ‘uplift’ required to meet the costs of the Eatwell diet should not be interpreted as the cost of a proposed universal cash subsidy. It is a thought experiment to measure the size of the aggregate market expenditure gap. A workable policy could close this gap through a combination of lower prices, improved incomes, targeted support, changes in product formulation and availability, public procurement, producer assistance and regulatory reform. An alternative and complementary approach is to reduce other components of the cost of living, particularly for lower income households, such as utilities, council tax, transport costs and rent. Any sets of policies would need, in particular, to address the needs of the poorest households, which are least able to afford to spend more on food.

The economic comparison

The updated comparison strengthens rather than weakens the central conclusion of the 2024 report. When the estimated health and social burden associated with current diets is added to current household spending on food, the total amounts to just over £414 billion a year (Figure 2). This compares with estimated food expenditure of just under £167 billion for an Eatwell-compliant diet.

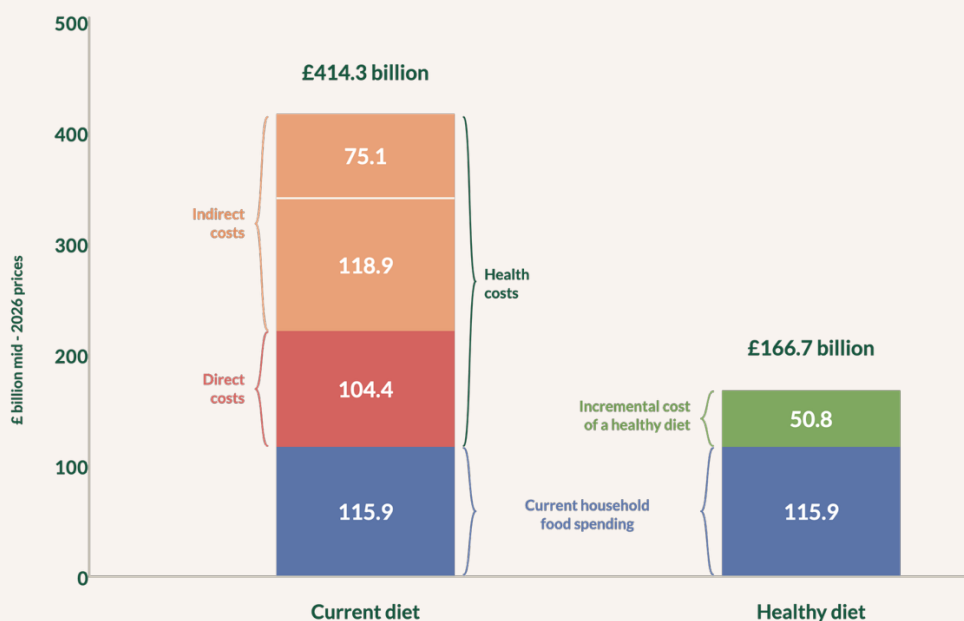


Figure 2 Current food expenditure and diet-related losses compared with estimated Eatwell expenditure

Source: summary of calculations as detailed in this update

On this basis, the costs associated with the present food economy exceed the costs of a healthy diet by almost £248 billion a year. That difference is far from insignificant in terms of public finance. In fact, it is higher than the planned 2026-27 expenditure limit (£225 billion) allocated to the Department of Health and Social Care in the latest Treasury spending review.^{xxxii}

Evidently, this accounting difference of £248 billion should not be interpreted as an immediately recoverable fiscal saving. Health improvements would take time to materialise and lower disease prevalence would not instantaneously remove the associated healthcare or welfare expenditure. Equally obviously, the Eatwell Guide is not a cure-all for the levels of food-related metabolic dysfunction that are known to exist across the population.^{xxxiii} Restorative diets capable of achieving clinical remission from chronic disease across such a wide population may well carry a higher price tag.^{xxxiv}

What is clear from Figure 2 is that the £298 billion annual health-related burden of current dietary patterns is almost six times the estimated £51 billion expenditure gap between current household spending on food and the cost of achieving the Eatwell diet. Even the direct costs of £104 billion associated with healthcare, social care and welfare payments are more than twice the estimated additional expenditure needed for an Eatwell-

compliant diet. The scale of the difference is too large to dismiss as a product of reasonable uncertainty. The existing food system remains a profound false economy.

Conclusions

The updated evidence leaves the fundamental argument from *The False Economy of Big Food* unchanged. The UK spends vast sums managing chronic illness while maintaining a food economy that makes healthy eating difficult and, for many households, unaffordable. Newer studies of working-age health, obesity, productivity and food affordability support rather than undermine the original diagnosis.

The precise figures remain subject to methodological and statistical uncertainty. But the imbalance is unmistakable: an estimated £298 billion in annual health-related costs stands against an estimated £51 billion expenditure gap required to bring household food budgets up to the cost of a healthy diet.

The findings from this updated analysis accentuate the need for a robust policy response. It is beyond the scope of this update to specify that response in detail. However, it is clear that it must proceed from a clear set of policy principles – all of which are commensurate with our previous report:

1. TREAT FOOD AND HEALTH POLICY AS ECONOMIC POLICY

Prevention should be regarded as productive investment rather than discretionary social expenditure. Decisions about food, public health and agriculture affect labour-force participation, productivity, tax revenues, welfare budgets and the sustainability of health and care services. Fiscal appraisal should recognise benefits arising outside the departmental budget that funds an intervention.

2. ESTABLISH AFFORDABLE HEALTHY FOOD AS A PRACTICAL RIGHT

The objective should be universal access to sufficient, nutritious and culturally appropriate food, with particular attention to households facing low incomes, high housing costs or additional needs. Targeted support – including stronger Healthy Start provision, improved school food and

adequate social-security incomes – will be necessary, but income support alone cannot overcome a food environment designed around the sale of cheap, heavily marketed unhealthy products. Public procurement should use the state’s purchasing power to expand regional markets for healthy and sustainably produced food rather than reinforcing the existing system.

3. RESHAPE THE FOOD ENVIRONMENT

Policy must address the commercial determinants of disease. In particular, it must reduce the commercial incentives to produce, promote and sell food that contributes to chronic disease. Voluntary commitments have repeatedly proved insufficient where corporate profitability depends on maximising sales of high-margin products. To be effective, policy must include enforceable standards for product composition, restrictions on the marketing and placement of unhealthy food, transparent reporting by manufacturers and retailers and effective penalties for non-compliance.

4. REDIRECT FINANCIAL FLOWS

Effective regulation is needed to curtail the power of financialised food markets and to support the emergence of a healthy and sustainable food system. The principle that those creating social harm should pay for that harm has a clear application to food policy. Taxes or levies on damaging products and practices can discourage harm while generating revenue to increase access to healthy food, to fund preventative healthcare, to finance local food infrastructure and to provide support for farmers producing nutritious and sustainable food.

5. BUILD A CROSS-GOVERNMENT FOOD AND HEALTH MISSION

The causes and consequences of unhealthy diets span health, welfare, education, agriculture, planning, trade, defence, local government and fiscal policy. Responsibility cannot be left solely to the NHS or to individual consumers.^{xxxv} A credible strategy requires long-term goals, clear accountability across departments and independent monitoring of diet, health, affordability, corporate conduct and distributional outcomes. The Good Food Cycle gives ministers the vehicle to act across government, with its ten recommendations that span departmental responsibilities.^{xxxvi}

In summary, ensuring access to nutritious food is an ethical and public-health imperative. The updated analysis confirms that it is also an economic necessity.

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- i Jackson, T (2024) *The False Economy of Big Food*, London: Food, Farming and Countryside Commission. Available at: <https://ffcc.co.uk/publications/the-false-economy-of-big-food>.
 - ii HMG (2016) *The Eatwell Guide*. London: Office for Health Improvement and Disparities. Available at: <https://www.gov.uk/government/publications/the-eatwell-guide>.
 - iii Health Foundation (2026) *Health as an economic asset – unlocking the economic potential of the UK’s working age population*. London: Health Foundation, p 5. Available at: <https://www.health.org.uk/reports-and-analysis/reports/health-as-an-economic-asset>.
 - iv Health Foundation (2026), note 3, p 5-6.
 - v Frontier Economics (2025) *The economic and productivity costs of obesity and excess weight in the UK*. London: Frontier Economics and Nesta, p 6. Available at: <https://www.nesta.org.uk/report/the-economic-and-productivity-costs-of-obesity-and-overweight-in-the-uk/>.
 - vi ONS (2026a). *Family Spending Workbook 1: detailed expenditure and trends*. Newport: Office for National Statistics. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/expenditure/datasets/familyspendingworkbook1detailedexpenditureandtrends>.
 - vii ONS (2026b) *Consumer Price Index: food and non-alcoholic beverages*. Available at: <https://www.ons.gov.uk/economy/inflationandpriceindices/timeseries/d7bu/mm23>.
 - viii Food Foundation (2026a) *The Broken Plate – 2026: the state of the nation’s food system*. Available at: <https://foodfoundation.org.uk/publication/broken-plate-2026>
 - ix Food Foundation (2025) *The Broken Plate – 2025*, p28. London: The Food Foundation. Available at: <https://foodfoundation.org.uk/publication/broken-plate-2025>.
 - x Food Foundation (2026a), note 8, p14-15.
 - xi Food Foundation (2023) *The Broken Plate 2023 – Technical Report*, p2. Available at: <https://foodfoundation.org.uk/sites/default/files/2023-06/Broken%20Plate%202023%20-%20Technical%20Report.pdf>
 - xii Food Foundation (2026b) *The Broken Plate 2026: Technical Report*, p 3. Available at: [https://foodfoundation.org.uk/sites/default/files/2026-06/Broken Plate Technical Report v.2.pdf](https://foodfoundation.org.uk/sites/default/files/2026-06/Broken%20Plate%202026%20-%20Technical%20Report.pdf)
 - xiii Gilmore, A.B., Fabbri, A., Baum, F. et al. (2023), Defining and conceptualising the commercial determinants of health, *The Lancet* 401(10383), p1194–1213. Available at: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(23\)00013-2/abstract](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)00013-2/abstract).
 - xiv WHO Europe (2024) *Commercial Determinants of Noncommunicable Diseases in the WHO European Region*. Copenhagen: World Health Organization Regional Office for Europe. Available at: <https://www.who.int/europe/publications/i/item/9789289061162>.
 - xv WHO (2025) *World Report on Social Determinants of Health Equity*. Geneva: World Health Organization. Available at: <https://www.who.int/publications/i/item/9789240107588>.
 - xvi Lambie-Mumford, H. and Kennedy, K. (2025) Commercial determinants of health: a new framework for studying relationships between food corporations and food charities in the UK, *Social Science & Medicine* 366, 117590. Available at: <https://www.sciencedirect.com/science/article/pii/S027795362401044X>.
 - xvii Monteiro, C.A., Louzada, M.L.C., Steele-Martinez, E. et al. (2025) ‘Ultra-processed foods and human health: the main thesis and the evidence’, *The Lancet* 406 (10520) pp. 2667-2684. Available at: <https://www.thelancet.com/series-do/ultra-processed-food/>
 - xviii We call this component lost quality of life the ‘human cost’ in Figure 1 for purposes of comparability with the previous report.
 - xix ONS (2026) *UK Health Accounts Reference Tables: 2025*. See in particular Tables 1a & 7a. Newport: Office for National Statistics. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/datasets/healthaccountsreferencetables>.
 - xx Government-financed healthcare is projected from 2025 to 2026 using the planned increase in Department of Health and Social Care spending from HMT’s 2025 Spending Review: Table B.2 on ‘Resource Departmental Expenditure Limits excluding depreciation’ (available at: <https://www.gov.uk/government/publications/spending-review-2025-document/spending-review-2025->

- [html#annex-b-statistical-annex](#).) Non-governmental healthcare is projected using the ONS CPIH health index (available at: <https://www.ons.gov.uk/economy/inflationandpriceindices/timeseries/l528/mm23>.)
- xxi DWP (2026) Benefit expenditure and caseload tables 2026. London: Department for Work and Pensions. See Table 4, 'Benefit expenditure to support disabled people and people with health conditions'. Available at: <https://www.gov.uk/government/publications/benefit-expenditure-and-caseload-tables-2026>.
- xxii The 70% figure is widely cited in the literature – see Jackson, (2024), note 1, p16. It originates from a 2010 report from the Department of Health (Ten things you need to know about long-term conditions. London: Department of Health. Available at: <https://webarchive.nationalarchives.gov.uk/ukgwa/+www.dh.gov.uk/en/Healthcare/Longtermconditions/ten-thingsyouneedtoknow/index.htm>).
- xxiii See IHME (2025) GBD Results Tool: Global Burden of Disease Study 2023. Seattle, WA: Institute for Health Metrics and Evaluation. Available at: <https://vizhub.healthdata.org/gbd-results/>; see Jackson (2024), note 1, p20-21, for further discussion.
- xxiv Some estimates of the relative weight of chronic disease management on the health system are considerably higher. For example, the US Center for Disease Control estimates that 90% of US healthcare expenditure is for people with chronic and mental health conditions: <https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html>. Moreover, the GBD methodology currently represents a lower bound for dietary risk and takes no account, for example, of the risks associated with ultra-processed food (UPF) – see Jackson (2024), note 1, p20-21. A case could be made for using the GBD risk factor of 33% directly to derive the proportion of healthcare costs attributable to diet. This would have raised our direct cost estimates by more than 40%.
- xxv FAO (2024) *The State of Food and Agriculture 2024: value-driven transformation of agrifood systems*. Rome: Food and Agriculture Organisation of the United Nations. Available at: <https://openknowledge.fao.org/items/65139780-d06c-4b7c-a2cd-3ed4256eaa1c>. The update proceeds by converting the FAO's figure for the UK of \$129 billion in 2020 values at purchasing power parity (PPP) to mid-2026 prices. This sum is then adjusted for the growth in productivity per worker in the UK and the increase in Disability Adjusted Life Years (DALYs) over the years between the FAO analysis and this update.
- xxvi Frontier Economics (2025), note 5, Table 1, p6. Its estimate of £71.4 billion in lost quality-adjusted life years is then rebased to mid-2026 prices for this report.
- xxvii For purposes of comparability with the previous report, the health costs associated with long-term care are separated out from the overall healthcare costs reported in the UK Health Accounts and reported together with the social costs of long-term care in one category which we call 'social care'.
- xxviii Around £12.8 billion of this increase is attributable to price inflation between the two reports; the remainder reflects a real-price increase.
- xxix Jackson, T (2024), note 1.
- xxx ONS (2026b), note 7.
- xxxi Food Foundation (2026b), note 12, p3.
- xxxii HMT (2025), Table B2, note 20.
- xxxiii NHS (2026) Adults Health – Summary. Available at: <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2024/adults-health>.
- xxxiv As an example of such an intervention see Xin, Y., Davies, A, McCombie, L. et al (2018) Within-trial cost and 1-year cost-effectiveness of the DiRECT/Counterweight-Plus weight-management programme to achieve remission of type 2 diabetes. *The Lancet Diabetes Endocrinology*. Available at: [http://dx.doi.org/10.1016/S2213-8587\(18\)30346-2](http://dx.doi.org/10.1016/S2213-8587(18)30346-2).
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