Institute for Public Policy Research

FIXING THE FOUNDATIONS

THE CASE FOR INVESTING IN CHILDREN'S HEALTH

Amy Gandon and
Jamie O'Halloran

May 2025

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This paper was first published in May 2025.

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ACKNOWLEDGEMENTS

The authors would like to thank Impact on Urban Health who generously funded this project.

The authors would also like to thank Will Cook, Abi Hynes, Richard Maclean, David Wastell, Liam Evans, Sebastian Rees, Avnee Morjaria and Ashwin Kumar for their contributions to this work.

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Citation
If you are using this document in your own writing, our preferred citation is:
Gandon A and O'Halloran J (2025) *Fixing the foundations: The case for investing in children's health*, IPPR.
http://www.ippr.org/articles/fixing-the-foundations

SUMMARY

For decades, governments of all stripes have promised to give children a better, healthier start to life. But despite this – and some notable policy successes – the UK continues to fall short on childhood health outcomes.

One in four children in England are obese by the end of primary school. One in five have a probable mental health disorder. Infant mortality rates are climbing, while childhood immunisation rates have now fallen below international targets. Ultimately, the UK now ranks in the bottom half of high income nations for overall child wellbeing, and in the bottom third for mental health.

Improving children's health is not just morally right – it is a social and economic necessity. Drawing on extensive research, including new analysis of the 1970 British Cohort Study, this report shows that poor childhood health has long-lasting consequences. For example, children who had severe emotional or behavioural problems at age 10 are nearly twice as likely to experience depressive symptoms at age 51 compared to those who had no problems. Other research also shows that poor childhood health can reduce educational attainment, limit employment prospects, and ultimately hold back national prosperity.

A healthier generation of children is essential to delivering this government's core missions: improving the nation's health, spreading opportunity, and securing sustainable economic growth.

This evidence is not new; it will be familiar to many politicians and policymakers. But too often, action has been deferred or deprioritised on the basis that its rewards lie too far in the future. This report not only restates the long-term case but underlines the near-term benefits. Effective interventions to improve children's health can help to improve their life chances within this Parliament, by increasing their school attendance and enhancing their career prospects. And the right action can also deliver near-term fiscal returns, easing pressure on NHS services and enabling more parents to stay in work.

Despite this, progress has been repeatedly undermined by political short-termism, policy churn, and difficulties justifying investment in a fiscally constrained environment. Promising initiatives have been launched but not sustained. And responsibility for outcomes remains fragmented across departments, with limited national accountability.

This report is the first in a longer-term programme of work by IPPR this year, aimed at setting out a bold, practical and long-lasting plan to improve children's health and wellbeing. With the upcoming spending review in mind, this is an important moment to fix the foundations – and create the conditions to invest in the nation's children, once and for all. We recommend:

- **reframing child health as a nation-building mission**, on a par with net zero or major infrastructure projects
- **introducing a children's investment standard** to safeguard spending on children and 'hardwire' preventative spending in the NHS and other public services
- **strengthening internal and external accountability for delivery**, giving a single person oversight of children's wellbeing, creating a single, coherent view of spending and expanding the role of the children's commissioner

- **adopting a phased prevention strategy**, targeting the 'quick wins' needed first to reduce acute demand and release resources to unlock longer-term reform
- **taking bold regulatory action**, including through levies that tackle health harms while raising additional revenue.

While this report sets out the case for change and high-level recommendations on leadership, strategy and governance, forthcoming IPPR research will set out a more detailed plan to deliver for children and young people.

1. THE HEALTH OF THE UK'S CHILDREN: RHETORIC VS REALITY

Every government in recent memory has sought to give children a better start. From "every child matters" under New Labour to "the best start for life" under the last Conservative government, politicians of all stripes have put children at the heart of a vision where services intervene earlier and prevent more illness than they treat (HM Treasury 2003; Department of Health and Social Care 2021). The current Labour government has continued this trend, pledging to create "the healthiest and happiest generation of children ever" (Labour 2024) as a key pillar in the shift to prevention.

The arguments for prioritising children's health have remained remarkably consistent in that time. Ill health in childhood leaves a long shadow, with strong and enduring associations with lower educational attainment, worse labour market outcomes, and reduced physical and mental wellbeing across the life course. When children from disadvantaged backgrounds are far more likely to experience poor health early in life, intervention is a question of fairness: an opportunity to prevent disadvantage from becoming destiny.

But there is also a highly practical case to make. Tackling ill health early is simultaneously the most effective and the least expensive point of intervention. And conversely, the costs of addressing a poor start in life increase significantly as children grow older, with later interventions needing to be more intensive, more expensive and often across multiple agencies and services to shift the dial (Heckman 2006). Healthier children are also more likely to become healthier, more productive adults, contributing not only to their own earnings potential, but to the growth prospects of the nation. By this token, investment in children's health is common sense: delivering better value for money, relieving pressure on public services and promoting long-term economic growth.

The consistency of these arguments – including across the political spectrum – speaks to the strength and stability of the evidence supporting them. Research from multiple disciplines – replicated across different cohorts, countries and methodological approaches – has repeatedly shown the critical role of early health in later life. This report adds to the evidence base in this area, harnessing new analysis of the latest wave of the British Cohort Study – which has followed children born in 1970 to the present day – to show how different forms of poor health at age 10 predict the likelihood of serious health problems by age 51.

And yet, despite both commitment and consensus – as well as some notable policy successes – sustained improvements in many children's health outcomes have remained elusive.

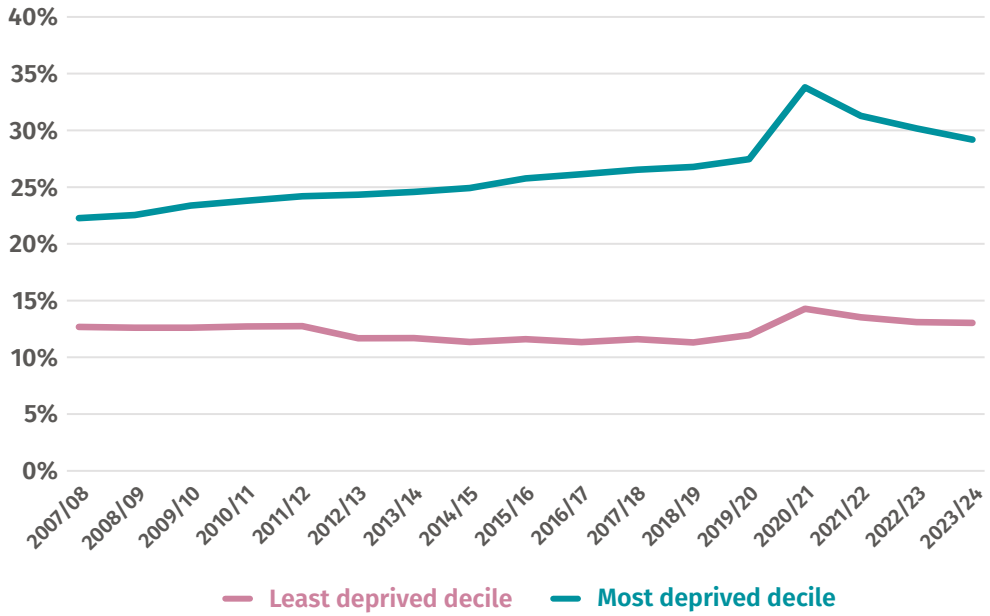
THE STATE OF CHILDREN'S HEALTH IN THE UK

Too many children in the UK are growing up in poor health. Nearly one in four children in England are obese by the time they leave primary school, with the figure rising to one in three in the most deprived areas (figure 1.1; NHS Digital 2023a). National surveys of British children's diets consistently show excess intake of sugar and saturated fat, but insufficient fibre, and fruits and vegetables. These dietary patterns are not simply the result of individual choices but reflect wider food environments that make healthy options less accessible, particularly for low-income families. Micronutrient deficiencies are widespread: in the latest data, 27 per cent of children aged 11–18 had vitamin A intakes below the lower reference nutrient intake (a minimum threshold), 19 per cent had low vitamin D status, and over one in 10 had inadequate folate levels (Public Health England 2020). Nearly a quarter (23.7 per cent) of five-year-olds have tooth decay – now the leading cause of hospital admissions among young children (OHID 2024) – and UK children experience some of the worst asthma outcomes in Europe (Asthma + Lung UK 2023).

FIGURE 1.1

The proportion of children living with obesity is growing, especially those in the most deprived areas

The proportion of children in England who are obese in year 6, 2007/8–2023/24 (least deprived decile vs most deprived decile)



Source: NHS Digital (2023a)

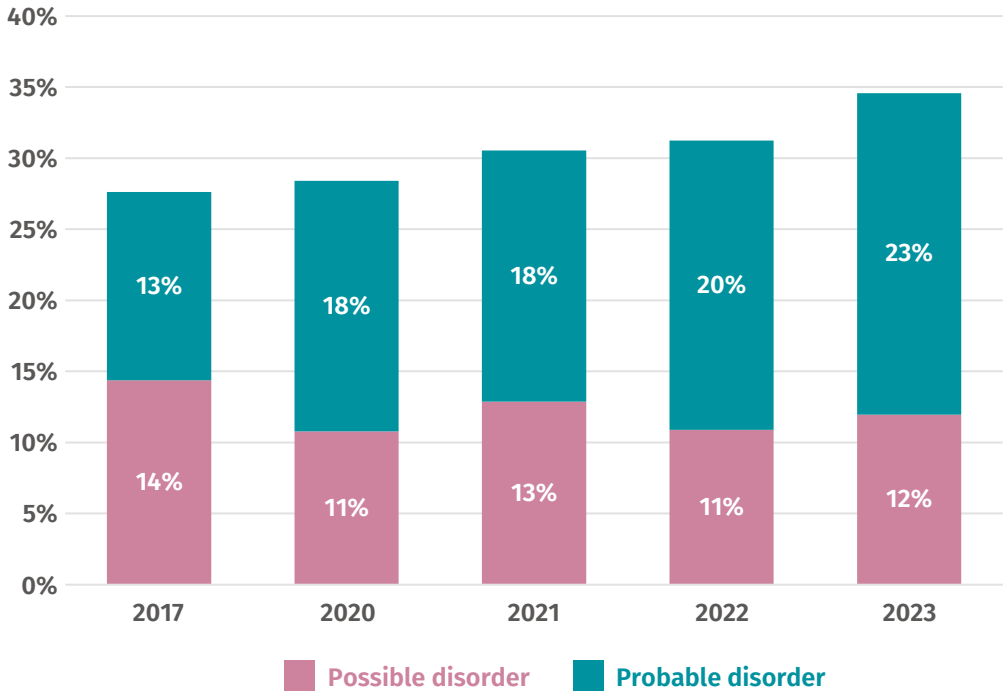
Areas where there had previously been steady progress – for example, the prevention of infectious diseases or infant mortality rates – have now stalled or gone into reverse. Uptake of key immunisations has declined in recent years: in 2022/23, coverage of the 6-in-1 vaccine by age one fell to 91.5 per cent, the lowest level since 2008, while MMR coverage at age five dropped to 84.5 per cent – well below the WHO's 95 per cent target for herd immunity (UKHSA 2023). In England and Wales, the infant mortality rate increased from 3.6 deaths per 1,000 live births in 2020 to 3.9 in 2022 – the third consecutive annual increase after steady decline until the mid-2010s (ONS 2023).

Alongside poor physical health, the UK faces a growing crisis in children and young people's mental health. Rates of anxiety, depression, and other common mental health conditions have risen sharply over the last decade. Figure 1.2 shows the proportion of children aged 11 to 16 with a probable or possible mental health problem has been growing, with the increase being driven by increases in the number of probable cases.

FIGURE 1.2

The mental health of children has been worsening since 2017

Proportion of children aged 11 to 16 who have possible or probable mental health disorder



Source: Authors' analysis of NHS Digital (2023b)

These challenges are not experienced equally. Children from low-income families are significantly more likely to experience asthma, tooth decay and food-related ill health such as obesity than their more affluent peers (NHS Digital 2023a). Mental health need is also patterned by deprivation, with children from low-income families more likely to experience difficulties and less likely to access timely support (ibid; Grimm et al 2022). Inequalities are visible across geography – with worse outcomes in parts of the North and the Midlands (ibid) – and across ethnicity, with, for example, Black children being disproportionately referred to mental health services via crisis pathways (NHS Race and Health Observatory 2022).

The UK lags behind its peers on multiple measures of child wellbeing, including life satisfaction, healthy behaviours (such as diet, exercise and smoking), and self-reported mental health. In UNICEF's most recent report card on overall child wellbeing, the UK placed 21st out of 36 high-income nations – as well as 22nd for physical health and 27th for mental health – with a significant decline in adolescent life satisfaction since the last ranking (UNICEF 2025).

BREAKING THE CYCLE: THE CASE FOR DECISIVE ACTION

As the government approaches the next spending review, there is a critical window in which to decide and deliver on the policies needed to build "the healthiest generation of children ever". This report brings longstanding arguments about the need to invest in children's health back into focus.

Chapter 2 draws on new and existing evidence to show the relationship between children's health and later health, opportunity and national prosperity, with potential to deliver returns not only in the distant future, but within this Parliament. Chapter 3 examines the barriers to past governments' ability to make significant progress, and outlines a series of recommendations to help this government overcome them, once and for all.

The following chapters lay the groundwork for a new policy agenda – one that puts children's health at the centre of national renewal. But this is just the beginning. Future IPPR work will examine the most pressing health challenges affecting children in detail and develop fuller policy proposals to guide action over the rest of the parliament.

2. THE LONG SHADOW: CHILD HEALTH, LIFE CHANCES AND NATIONAL PROSPERITY

Poor childhood health casts a 'long shadow'. Children who grow up in poor health are likely to experience worse health outcomes in adulthood, achieve less at school, earn less and rely more heavily on public services throughout their lives. This chapter brings together the extensive evidence for these links and adds to the literature with new findings from the 1970 British Cohort Study. This new analysis forms part of a longer-term programme of work by IPPR to understand the full costs of poor child health – and the economic and social returns to early intervention – across key conditions and stages of life.

Importantly, however, this chapter also offsets the risk that the benefits of early investment are relegated to the distant future, highlighting the near-term fiscal and economic benefits that improved child health could realise within this parliament. When child health is so central to the government's missions to improve health, spread opportunity and boost growth, the political dividends – and risks – are immediate too.

MEASURING THE ASSOCIATIONS BETWEEN CHILDHOOD HEALTH AND FUTURE OUTCOMES

Cohort studies are among the most valuable sources of evidence for understanding the long-term effects of childhood health. By following the same individuals from birth into adulthood, they allow researchers to track how early life experiences shape outcomes across education, employment, health and wellbeing over time.

In this report, we present new and original analysis using the most recent wave of the 1970 British Cohort Study (BCS70), one of the UK's key longitudinal studies, which follows individuals born in a single week in 1970. This is among the first published uses of newly released data collected in 2021 – and released in February 2025 – when participants were aged 51. This allows us to estimate the correlation between health in childhood with outcomes more than four decades later.

Our approach draws on well-established and validated measures within the BCS70 dataset: emotional and behavioural problems were assessed at age 10 using the Rutter Scale, a questionnaire designed to assess emotional and behavioural difficulties in children, based on parental reports (Rutter et al 1970). Outcomes in mid-life were measured by asking participants whether they had a long-term health condition that impacted either the type or amount of work they could do and using the malaise inventory, a questionnaire designed to measure psychological distress, particularly symptoms of depression and anxiety (ibid).

We used logistic regressions to estimate the association between health in early life and mid-life. A common challenge in cohort studies is participant attrition over time, which can lead to a sample that is no longer representative of the original population. To address this problem, we applied inverse probability weighting, a method which assigns greater weight to individuals who are underrepresented in

the final sample, based on their likelihood of remaining in the study. This helps correct for potential bias and improves the representativeness of the analysis. For a detailed description of the indicators and methodology, please see O'Halloran (2025).

POOR CHILDHOOD HEALTH IS CORRELATED WITH WORSE HEALTH OUTCOMES IN LATER LIFE

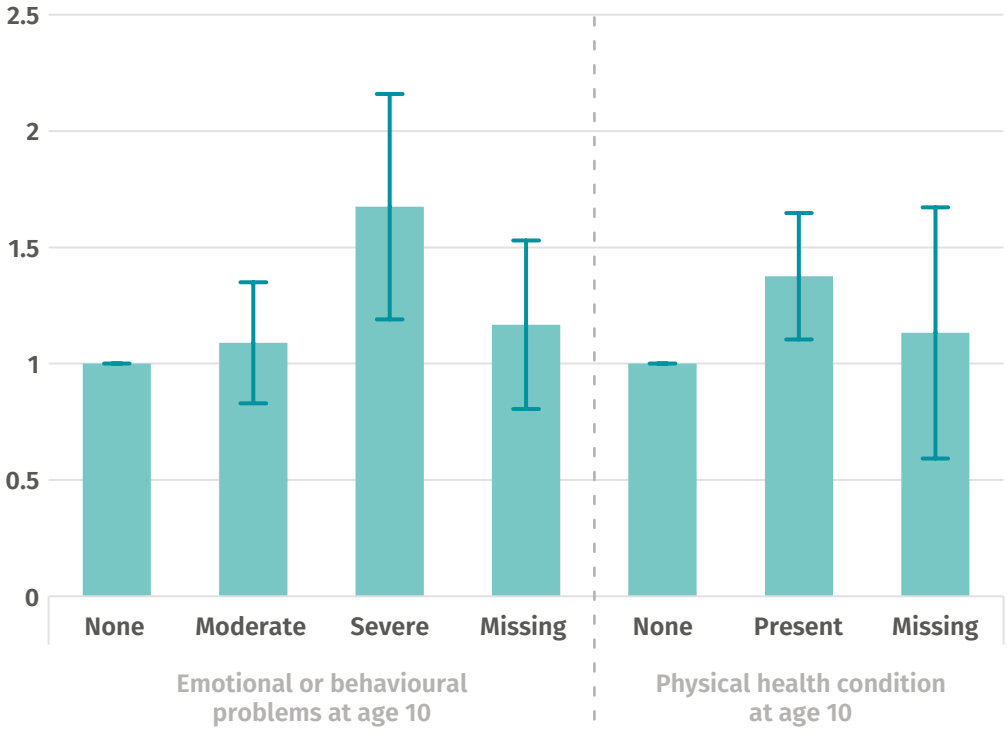
The findings of our cohort analysis are striking. As illustrated in figure 2.1, emotional and behavioural problems at age 10 are strongly correlated with depressive symptoms at age 51. We estimate that children who experienced severe difficulties at age 10 had an 85 per cent higher likelihood of reporting depressive symptoms at age 51, compared to peers who did not experience mental health difficulties at age 10. For those with moderate difficulties, the likelihood was 25 per cent higher, although this is only statistically significant at a lower confidence level.

These findings have important implications. Given that a person's mental health in adulthood is predicted by poor mental health in childhood (Fryers and Brugha 2013), intervening early to prevent the emergence of poor mental health can pay dividends across the life course.

FIGURE 2.1

Mental or behavioural problems in childhood are correlated with experiencing depressive symptoms in adulthood

Relative risk ratios measuring the association between emotional or behavioural problems at age 10 and physical health conditions at age 10 with the Malaise Scale at age 51



Source: Adapted from O'Halloran (2025)

Note: Estimates are derived from O'Halloran (2025), based on relative risk ratios from logistic regressions controlling for parental socio-economic indicators and educational outcomes of the child at age five and 10. The results show there is a relative increase in the probability of experiencing depressive symptoms in adulthood, when comparing individuals with emotional problems at age 10 to those without, and individuals with a physical health condition at age 10 to those without.

While the persistence of poor health over four decades later is notable, it is consistent with findings from decades of previous research. Seminal work by Case et al (2005) using the 1958 National Child Development Study showed that poor general health in childhood predicted worse health in adulthood, both through a direct, biological pathway (ie the lasting effects of early illness) and through indirect, socioeconomic mechanisms (ie where poor health leads to weaker engagement with education and employment, making good health harder to maintain later in life).

This study and another from 2021 – which also used the BCS70 – similarly found that emotional and behavioural problems in childhood were among the most powerful predictors of living with long-term health conditions in mid-life (ibid; Gondek et al 2021), alongside low birthweight, obesity and serious chronic conditions (such as asthma, epilepsy or a heart condition). This is consistent with wider work that demonstrates the importance of good nutrition – access to enough healthy food – in early life (Barker 1997).

BEYOND CLINICAL OUTCOMES: THE ASSOCIATION BETWEEN CHILDHOOD HEALTH AND ECONOMIC PERFORMANCE

Previous IPPR research has consistently shown that health has broad implications beyond immediate wellbeing (Thomas et al 2024). It is therefore plausible that childhood health has wider economic consequences later in life. Using this novel analytical approach, we find evidence to support this, which we further contextualise with findings from the wider literature.

Specifically, we find that adults aged 51 who experienced emotional or behavioural problems or physical health issues at age 10 are more likely to report having a long-term condition that limits either the type or amount of work they are able to do.

As illustrated in figure 2.2, we estimate that adults at age 51 have a 68 per cent higher likelihood of having a long-term condition that impacts their work if they had severe emotional or behavioural problems at age 10, compared to those no problems. We also find evidence of physical health problems at age 10 being correlated with having a long-term condition that impacts people's work – with those with a physical condition at 10 being 38 per cent more likely to have one.

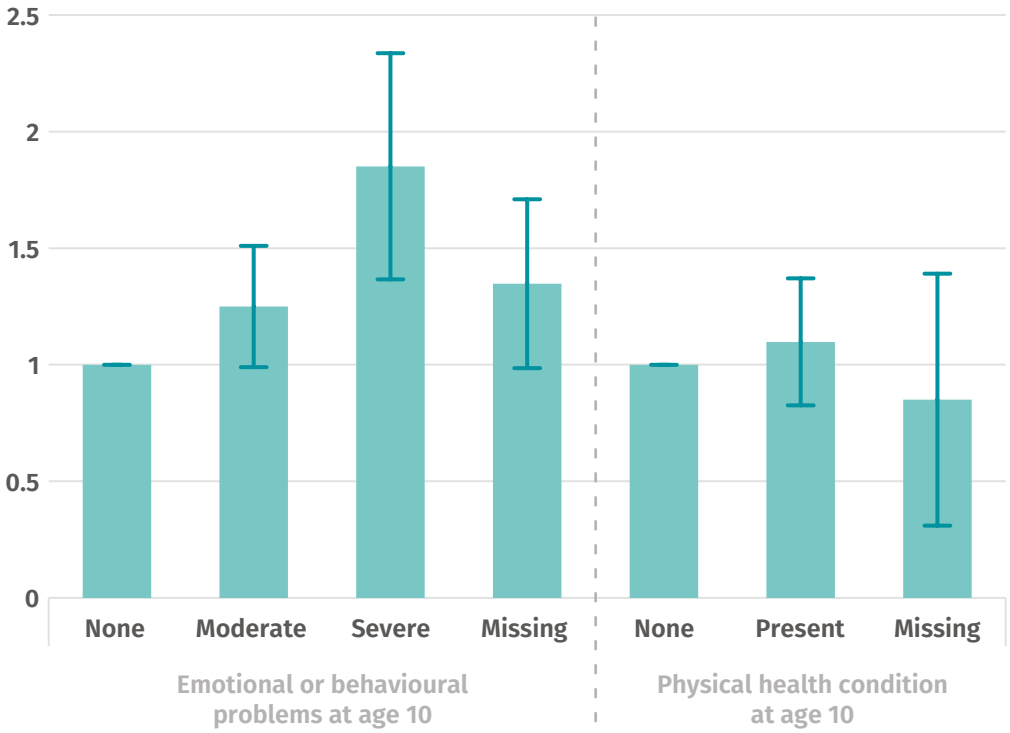
These findings may have serious economic implications. Research has shown that presenteeism – when individuals attend work despite being unwell – is more prevalent in the UK than in many comparable countries (Kwon 2020). This can lead to significant costs for the UK economy due to reduced workplace productivity (O'Halloran and Thomas 2024). Preventing the development of health conditions that impair individuals' ability to work could therefore deliver substantial productivity gains.

Boosting productivity is particularly important for the UK. Since the global financial crisis, productivity growth has slowed markedly – more so than in many peer economies. With an ageing population, improving productivity will be essential for sustaining long-term economic growth (André et al 2024), another key mission of this government.

FIGURE 2.2

Children with poor mental health or physical health problems at age 10 have a higher risk of a long-term condition that impacts their work at age 51

Relative risk ratios measuring the association between emotional or behavioural problems and physical health conditions of children at age 10 and the presence of a long-term condition that affects either the amount or type of work they can do at 51



Source: Adapted from O'Halloran (2025)

Note: The results show the relative increase in the probability of having a long-term condition that impacts either the amount or type of work an individual can do when comparing individuals with emotional problems at age 10 to those without, and individuals with a physical health condition at age 10 to those without.

While our analysis focuses on how future health conditions may have wider economic implications, the previous literature in this area finds more evidence of how health and economic outcomes are interlinked. The evidence points to a positive association between health and economic growth and results primarily from the association between good health, educational attainment and productivity. Businesses may also be more attracted to investing in areas with more productive and resilient workforces (see systematic review by Fumagalli et al 2024).

While the previous evidence points to childhood health having longer-term impacts on the economy, it can have more immediate impacts. For example, children experiencing physical and mental ill-health are more likely to miss school. Recent work has found a strong link between mental health difficulties and persistent school absence (Finning et al 2020), while a recent literature review by Lindblad et al (2024) finds that mental health issues, whether mild or severe, significantly heighten the risk of adverse education and employment outcomes in early adulthood. When we think about the number of young people leaving school over this parliament, the near-term economic value of addressing the current mental health crisis becomes ever clearer.

Children's wellbeing has effects beyond the individual, too. Parents of children with long-term health conditions – especially mothers – are more likely to reduce their working hours or leave work altogether. Hope et al (2017) estimate that for every four children developing a long-term health condition, one of their mothers is likely to leave the workforce altogether. Eriksen et al (2021) find a persistent reduction in maternal earnings of 4 to 5 per cent when their child is diagnosed with even a relatively manageable condition like type 1 diabetes. When over 25 per cent of children are estimated to have a long-term illness or disability (Hulbert et al 2023), these employment effects are likely to amount to significant losses to the national tax base.

POOR CHILDHOOD HEALTH MAY UNDERMINE LIFE CHANCES

The impacts of poor health in childhood are not confined to clinical outcomes. Longitudinal studies mapping the relationship between health and later educational and labour market outcomes find that poor health in childhood is strongly associated with lower educational attainment, reduced employment prospects and lower earnings in adulthood (Case et al 2005; Goodman 2011; Smith 2009), associations which persist, despite controlling for family background and cognitive ability. As with later health, emotional disorders were more influential on educational and employment outcomes than physical conditions, a finding corroborated by the wider literature (see systematic review by Hale et al 2015). Other studies also point to the particular effects of neurodevelopmental conditions such as ADHD (O'Nions et al 2024) and serious chronic conditions (Hu et al 2022) on life chances. To give a sense of the scale and durability of these effects, Case et al (2005) estimated that each childhood health condition at age seven correlates with a nearly 6 per cent reduction in earnings at age 42.

These studies highlight the independent role that ill-health can play in shaping economic outcomes. However, children from poorer families are more likely to be unwell (Yang et al 2023, Apouey and Geoffard 2013) and have less resources to deal with the implications, reflecting unequal exposure to health risks – such as poor-quality housing, food insecurity or air pollution – and barriers to information and services. Early life intervention is therefore a critical means of disrupting the otherwise self-reinforcing cycle between poor health and socioeconomic disadvantage.

LONG SHADOW, QUICK WINS

This chapter has shown how poor childhood health casts a long shadow, shaping individual life chances and collective prosperity. But too often, this evidence is deployed in ways that suggest a false binary – either we invest early to prevent these issues from materialising, or we condemn children to a life of disadvantage. We should not be so defeatist. Many of the most pressing health problems facing children today – such as tooth decay, poor management of asthma and epilepsy, and low vaccination uptake – are highly tractable with the right policies. And even conditions that are more complex, like mental ill-health and neurodevelopmental disorders, can be significantly improved through earlier, smarter and better-coordinated support (Hudson et al 2023; Daniolou et al 2022).

The political opportunity is equally clear, with the evidence in this chapter showing the centrality of child health to Labour's stated missions on health, opportunity and growth. The question – as we explore in the final chapter – is how Labour can resist the political traps that have plagued previous governments and take the bold action necessary to deliver lasting change.

3. BREAKING THE CYCLE: DELIVERING ON THE PROMISE OF BETTER CHILD HEALTH

The long-term harms of poor childhood health – discussed in the previous chapter – are striking but they are not new, nor should they be revelatory to policymakers. Yet when we set this evidence against the specific plight of UK children today, it becomes clear what profound challenges are in store for the nation's immediate and long-term future. As chapter 1 showed, health outcomes for UK children are not only poor but in many cases are stalling or deteriorating.

Government is already aware of these arguments. The pre-election announcement of a child health action plan, manifesto pledges on junk food advertising, supervised toothbrushing and mental health support, and the inclusion of early childhood development as one of the six milestones in the Plan for Change (UK Government 2024), mark welcome first steps to improving outcomes for children and young people.

The question now is whether ambitious commitments will survive contact with the reality of governing. Delivery feels especially at risk given the challenging fiscal inheritance and weaker-than-expected prospects for growth. This chapter examines the barriers to delivery that have delayed or diluted progress under previous governments and sets out practical and political steps to overcome them.

UNDERSTANDING THE DELIVERY GAP

Chapter 1 highlighted the broad and long-standing consensus on the need to improve children's health. Successive governments have introduced a range of policies – many well-intentioned – but without delivering the transformative shift in outcomes that was hoped for. In this chapter we explore why. Some of the barriers are familiar across social policy; others are specific to the politics and policymaking surrounding childhood.

The long-term interests of children do not align with the short-term rhythms of politics

While this report has argued that short-term gains are often underplayed, early intervention in children's health faces a particularly acute challenge. Many of the benefits – from reduced chronic illness to improved workforce participation – typically emerge decades after action is taken. Sure Start, for example, delivered reductions in hospital admissions and school absenteeism, but these only became clear a decade later (Cattan et al 2021; Johnson and Cattan 2023).

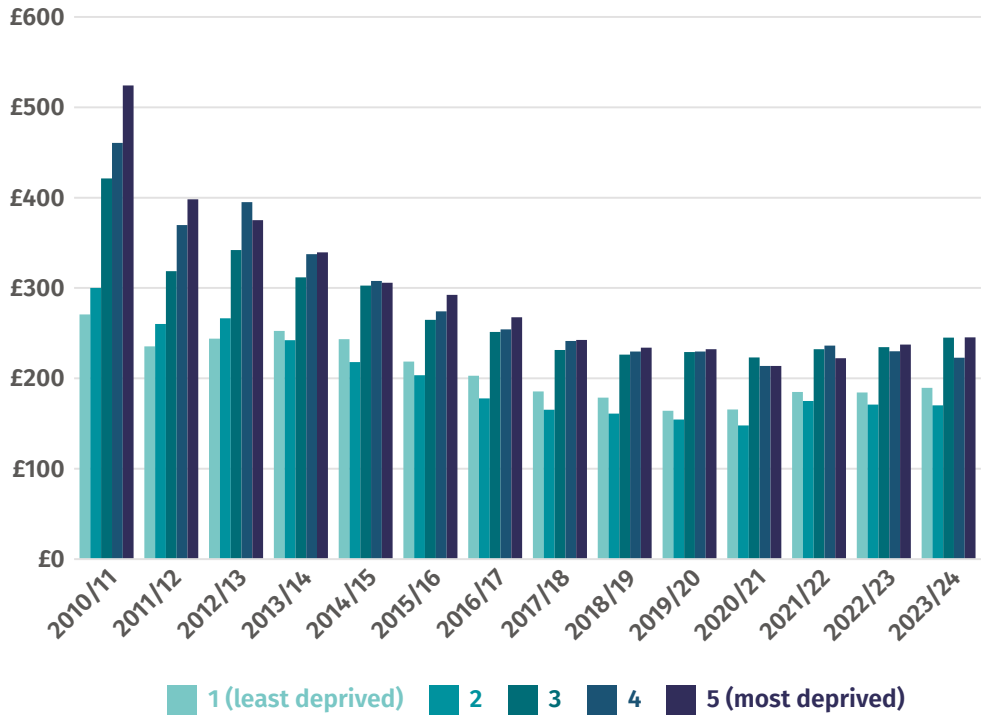
Unlike adult healthcare, where services respond to visible crises with vocal constituencies, preventative action in childhood health often lacks immediate payoff and direct democratic accountability when children do not yet vote. This political time-lag has made it easier for governments to defund long-term services like Sure Start while protecting acute care, pensions or defence.

As figure 3.1 shows, local authority spending on early intervention services for children has fallen significantly since 2010. If children's health is to be treated as infrastructure for the future, we need mechanisms that protect investment through political cycles – and ensure that today's decisions reflect the rights and interests of future generations.

FIGURE 3.1

Spending on early intervention services for children has fallen over the past decade and fallen fast for children in most deprived areas

Real-terms spending per child (0–19) on early intervention services by local authorities in England, by deprivation quintile (2010/11, 2020/21 and 2023/24)



Source: Recreated from Larkham and Ren (2025)

Everyone's responsibility – and no-one's

Policy around children's health cannot be readily contained within the health system alone. While it can be said that all health – at any age – is shaped by people's wider environment, for children this is uniquely the case. Children's wellbeing is especially vulnerable to external factors: their relationship with their parents and caregivers and those caregivers' own health, and access to nutrition, stimulation and a safe home environment. Healthy development in the early years – physical, emotional and cognitive – is not so easily categorised as 'health' or 'education'. And unlike adults, children interact with a greater array of services by necessity: health visitors, early years providers, social workers, teachers and more.

As a result, responsibility for children's wellbeing is dispersed across multiple departments and ministerial briefs – health, education, welfare, and local government – with no clear national accountability for overall outcomes. Cross-government structures – such as the Inter-ministerial Group on Early Years Family Support, chaired by Andrea Leadsom in 2018/19 – or strategies can help to cohere activities but rarely deliver the sustained focus or authority needed to shift the dial.

This fragmentation makes it difficult to track progress in a joined-up way or to assess the level and impact of investment, with spending spread across multiple departments, programme budgets and tiers of government. Accountability for the decline in spending highlighted above is near impossible without a clear, shared sense of the baseline.

Children's policy has been vulnerable to policy churn and 'pilotitis'

Children need stability – consistent relationships, predictable care and services that reliably accompany them through critical stages of development. Yet policy in this area has been defined by a high degree of policy 'churn'.

In an environment of low growth and rising public debt, successive governments have often felt politically and fiscally unable to commit fully to this agenda. The result has been a pattern of 'pilotitis' – initiatives trialled but never taken to scale – and under-resourcing of effective programmes, preventing them from realising their full potential. Small-scale delivery also makes these policies feel more dispensable, while political volatility has created the conditions for incoming ministers to introduce new initiatives at the expense of continuity and cumulative progress.

Family hubs, for example, became government policy under the Johnson government and bear many similarities to Sure Start, with the important exception that the programme's budget stands at just £100 million a year across 75 local authorities and serves ages 0–19, compared to £1.8 billion (today's prices) at Sure Start's height in 2009/10, with a centre in nearly every community and focussed specifically on ages 0–5.

Meanwhile, children's mental health policy has been chequered by a proliferation of 'hubs', all with subtly different operating models and purposes: family hubs (including holistic family support) and youth services (including access to child and adult mental health) under Johnson; early support hubs (open access support with mental health, sexual health, education and housing) under Sunak; and now Young Futures hubs (mental health, crime prevention and career advice) under Labour.

Ideological views about the family and fears about reception

Significant improvements to children's health will require bold action, but many such policies have been dogged by fears about public and business backlash. Politicians may fear accusations of 'nanny state-ism' or intervention in the private sphere of the family. Chancellors focussed on growing the economy may fear appearing anti-business if regulations are imposed to tackle children's exposure to various health risks, from food marketing to online harms.

For example, planned restrictions on junk food advertising to children – announced by the Johnson government in 2020 – were delayed and diluted in response to heavy lobbying by the food and advertising industries (House of Lords 2024). This is to say nothing of the many evidence-based policy options discounted or left unexplored due to these concerns. Taken together, this has jeopardised the scale and ambition of government intervention in this space.

Fears about public backlash may be overstated. Polling conducted by IPPR and Public First (2025) found that the vast majority (72 per cent) of the public believe responsibility for child health should be shared between parents, schools and the government. Across a range of proposals – stricter advertising rules, higher nutritional standards in schools and smoking bans in public places – support consistently outweighed opposition. In focus groups, the policies most favourably discussed were those seen as bold and decisive, such as the sugar tax or plain packaging for cigarettes, and which limited the ability of corporations to profit at the expense of public health. These findings suggest that far from alienating the

public, governments that take ambitious action to protect children's health may well be supported in these efforts.

Growing demand in children's services makes preventative action ever harder

Whatever service improvements may have been made in this period, a decade of austerity, rising child poverty and a whole host of other shifts – from the rise of social media to worsening environmental conditions – have meant it is now even harder to keep children well. At the same time, these trends – as well as previous failure to intervene early – are driving up the pressures on 'late intervention' services (such as hospital care, mental health crisis services, and children's social care) and draining the resources and political bandwidth needed to build a more preventative and sustainable system.

This can test even the most committed advocates of prevention, presenting a perceived dilemma: either make the impossible choice between supporting future children or those currently in crisis, or find the fiscal headroom to fund both simultaneously. But this needn't be a binary choice. A phased and prioritised strategy – focussed initially on preventative measures most likely to deliver short-term reductions in acute demand and spending – can help unlock resources and capacity for deeper, longer-term reform.

The alternative – a 'doom loop' in which acute pressures continue to mount while the room to invest gets smaller – can no longer be tolerated, especially in the context of a falling birth rate and an ageing population generating further demand for services but a smaller working age population to fund those services through tax revenues. If there were ever a time to fix the foundations – and mark an end to the 'sticking-plaster politics' that has plagued this agenda for decades – it is now.

FIXING THE FOUNDATIONS: CREATING THE CONDITIONS FOR 'THE HEALTHIEST GENERATION OF CHILDREN EVER'

This final section sets out recommendations for how the government can succeed where others have fallen short, addressing the barriers above. With the spending review on the horizon, these focus on the high-level strategy, governance and spending approach needed to unlock lasting progress. More detailed policy proposals will follow later this year as part of IPPR's ongoing programme on children's health.

Recommendation 1: Make children's health a nation-building project

Labour should reframe investment in children's health as a defining act of national renewal – on a par with net zero or major infrastructure, or with previous, historic investments in the nation's social infrastructure (for example, in the post-war period).

Too often, spending on health is framed as a cost. However, investment in children should not only be seen as good economic policy, but as critical national infrastructure. To anchor this as a shared, national endeavour – creating the momentum for decisive action and insulating it from political churn – the government should foster a sense of collective purpose and long-term stewardship. Parliament should be a central forum for this effort.

The government should:

- introduce **statutory, independent annual reporting to Parliament** on child health – and wider childhood – outcomes, modelled on the Climate Change Committee's reports on climate progress. This reporting could be part of an extended role for the children's commissioner (see recommendation 3).

Recommendation 2: Introduce a children's investment standard, framed as a "downpayment on national prosperity"

As with the mental health investment standard (MHIS) in the NHS, government should introduce a children's investment standard to protect the baseline level of public spending on children's wellbeing. This should apply across relevant public bodies – not just the NHS, but also commissioners of local public health and early years services. This would embed a principle of 'do no harm' to the children's budget and guard against erosion during periods of fiscal pressure.

Such a mechanism need not imply a rigid requirement for ever-higher spending. Instead, it could be designed to prevent reductions in investment unless there is independent, robust evidence that the same or better outcomes can be achieved for less – for example, through reform, integration, or innovation.

Recommendation 3: Strengthen accountability for delivery through clear leadership, consolidated data, and an empowered watchdog

To make meaningful progress on children's health, government must overcome the fragmentation that characterises current delivery and funding arrangements. While cross-departmental groups – such as interministerial groups or cabinet committees – have aimed to foster collaboration, they lack the authority and accountability for sustained, decisive action. A more robust model of internal leadership and external accountability is needed.

The government should:

- **put a single person in charge of overseeing the government's action on children**. There are various approaches government might take in this area. What matters is that the person has sufficient backing from the prime minister and/or independent authority to be able to mobilise other departments – and their secretaries of state – to change course as needed. As a result, it is likely that this role would need to sit centrally, rather than in a line department – for example in Number 10, Cabinet Office or Treasury
- **establish a permanent children's unit**, reporting to the responsible minister above, tasked with gathering, analysing and publishing joined-up data on investment, delivery, and outcomes across departments. This unit should develop and maintain a consolidated dashboard that brings together spending data, service performance, and progress toward children's health goals
- **strengthen the role of the children's commissioner**, expanding their mandate to explicitly include oversight of cross-government performance on children's health and wellbeing. This would also mean government and other public bodies providing comprehensive and timely departmental data to inform the commissioner's assessments. This is a significant shortcoming of the current system, where the post holder has had to issue freedom of information requests in order to gain access to data on children's mental health services.

Recommendation 4: Adopt a phased prevention strategy to shift the system out of crisis mode

Government must reject the notion that it has to choose between supporting children in crisis today and investing in prevention for tomorrow. It should adopt a phased prevention strategy that prioritises high-impact, cost-saving interventions in the short term – particularly those targeting the most disadvantaged groups and capable of relieving pressure on acute services. These early wins should be designed with a view to unlocking fiscal headroom for longer-term reform on a more universal basis.

The government should:

- **start with high-impact, cost-saving interventions** that can deliver early wins – targeting those areas simultaneously most likely to help the children

most in need and to release fiscal pressure. Such interventions could include adolescent mental health support for 14- to 19-year-olds soon to enter the labour market, or support with nutrition and development in the early years, where the right intervention can drive down demand for hospital admissions, children's social care and SEND support (even upon entry to primary school)

- **embed early wins within a longer-term reinvestment strategy.** These initial interventions should be designed with a dual purpose: to improve children's lives now *and* to reduce demand on high-cost crisis services. Policy officials and practitioners must understand both goals and be supported to deliver them. This means creating clear mechanisms to track progress, such as regular data releases to local services on key indicators like A&E attendance or social care referrals. Crucially, there should be a clear commitment that any savings generated will be reinvested locally – providing a powerful incentive for services to focus on prevention and sustained impact. The promise of longer-term reinvestment – as well as live evidence of demand being shifted – could be a powerful incentive for progress.

Recommendation 5: Prioritise bold regulatory action now to protect children's health

Not all progress depends on spending. In a fiscally constrained Parliament, government should prioritise bold regulatory action to protect children from public health harms – from the marketing of unhealthy food and drink to harmful digital content and poor housing and air quality.

Well-designed levies – for example, expanding the sugar tax to other products (such as milk and juice-based drinks or snack foods marketed for children) – should also be explored as a means of raising revenue while simultaneously delivering health benefit. This aligns well with an initial strategy of securing 'quick wins' to unlock funding for longer-term investment.

Crucially, the government should not fear these measures as inconsistent with their strategy on economic growth. Their vision for market-shaping, mission-driven government is better realised by fostering *good* growth, rather than avoiding tackling business models that profit from making children and young people unwell.

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