



**POLICY SUMMARY**

# **PROSPERITY AS HEALTH**

**RECENTRING CARE  
TO GUIDE  
HEALTH SYSTEM  
REFORM**

## Publication

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This policy summary is based on a working paper commissioned as an input to Enlighten's [NHS 2048](#) initiative which aims to foster a mature cross-party debate on reforming Scotland's health and social care system.

The full working paper can be accessed on the CUSP website: <https://cusp.ac.uk/themes/health/wp45/>

## Contact details

Tim Jackson, [office@timjackson.org.uk](mailto:office@timjackson.org.uk)

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CUSP (Centre for the Understanding of Sustainable Prosperity) is an international research organisation, drawing together expert partners from academic and non-academic institutions. The overall research question is: What can prosperity possibly mean in a world of environmental, social and economic limits?

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A wealth-centred vision of prosperity drives chronic disease and embeds institutional incentives that marginalise care.

Health systems in advanced economies face persistent and intensifying challenges: high levels of chronic disease, early onset of multimorbidity, widening inequalities and sustained pressure on public health and social care services. Despite decades of stated commitment to prevention, early intervention and person-centred care, outcomes have not kept pace with ambition. Demand continues to rise, recovery remains fragile and reform cycles repeatedly return to the same operational priorities. Scotland provides a particularly clear example of these dynamics.<sup>1</sup>

This paper argues that these difficulties are not primarily failures of evidence or delivery. Neither can they be solved by imposing productivity targets and efficiency measures on already overstretched health services. They reflect a deeper misalignment between how prosperity is understood and how health is produced. The paper analyses this misalignment, proposes an alternative vision of prosperity and offers a simple test designed to guide policy reform towards long-term success.

### **The terrain of health: how demand is produced over time**

The rise in chronic disease and early-onset multimorbidity is not adequately explained by individual behaviour, genetics or clinical failure. It reflects the gradual erosion of the *terrain of health*: the set of material and social conditions in which people live, work and navigate physical, psychological and social wellbeing.

Nutrition, income security, housing quality, working conditions, social connection and time to rest all exert ongoing physiological effects on health. When adverse conditions repeatedly exceed tolerable limits, the cumulative strain becomes biologically embodied as chronic disease. Where disadvantage is continuous rather than episodic, this process begins earlier and progresses more rapidly. The result—visible in many countries and particularly clearly in Scotland—is the early onset of multiple long-term conditions and widening health inequalities.<sup>2</sup>

Rising pressures on health systems such as the National Health Service (NHS) are therefore not simply a sign of system failure. Nor can they be solved from within the healthcare system alone. They are the predictable outcome of environments that generate ill health faster than it can be prevented or reversed.

### **Prosperity as wealth: the systemic driver**

The degradation of the terrain of health does not occur by accident. It is shaped by the dominant vision of prosperity embedded in contemporary society and pursued as a political priority. In modern economies, prosperity is typically defined in terms of wealth: growth in the GDP, productivity, profit and consumption. This framing shapes what is valued, what is measured and what attracts investment in the economy.<sup>3</sup>

Systems organised around growth privilege speed, scale and throughput. They intensify work, compress time and treat stability and sufficiency as constraints rather than goals. Activities that sustain health over time—continuity, maintenance and relational care—deliver their benefits slowly and are poorly captured by short-term performance metrics. As a result, they are systematically undervalued and repeatedly displaced when healthcare comes under pressure.

The same dynamic reshapes the conditions of everyday life. Insecure work, time scarcity, poor housing, fuel poverty and unhealthy food environments are not isolated policy failures. They are structural by-products of an economic model in which success is measured primarily by expansion and output. The impacts of these conditions are socially patterned, translating inequalities in access and resources into inequalities in health.

This wealth-centred vision of prosperity therefore drives both sides of the problem. It generates the upstream conditions that produce chronic disease and it embeds institutional incentives that marginalise the forms of care and prevention capable of reducing future demand.

The pursuit of wealth is governed by a dynamic of accumulation and growth. The pursuit of health is governed by a dynamic of balance.

## The demotion of care: why prevention remains structurally marginal

Care—understood as the work that sustains balance, supports recovery and enables people to live with long-term conditions—is essential to managing chronic disease. Prevention depends on the same qualities: continuity, coordination, stable investment and long-time horizons. Yet both care and prevention remain structurally marginal not only within the health system but across the economy as a whole.

There are both institutional and normative reasons for this failure. Care resists productivity gains, delivers its benefits slowly and is poorly captured using throughput-based measures. As such it struggles to survive in a culture where ‘time is money’ and success is defined by market outcomes. Beyond this structural constraint lie normative impediments. Care work is highly gendered. It is often marginalised or even denigrated in society. These features make it particularly vulnerable in systems which prioritise growth, efficiency and short-term performance.<sup>4</sup>

Despite a succession of strategic frameworks explicitly aimed at promoting person-led and community-centred health, the work of care remains peripheral in society and vulnerable to mission failure within healthcare reform. When operational pressure intensifies, care and prevention are squeezed in favour of interventions that generate immediate, measurable output. Recovery becomes the dominant priority, while the conditions required for sustaining health remain largely unchanged.

## Prosperity as health: a different organising principle

A core proposition of this paper is to reframe prosperity as health rather than as wealth. This reframing transforms the governing dynamic of the economy.<sup>5</sup> The pursuit of wealth is governed by a dynamic of accumulation and growth. The pursuit of health is governed by a dynamic of balance. When prosperity is understood as health, the focus of economic success shifts away

from growth at all costs and is focussed instead on the capacity of individuals and populations to create, nurture and maintain wellbeing over time, to adapt to challenge and to recover from disruption.

In this framing, economic activity itself becomes a means to sustain the conditions under which balance can be achieved. Care is no longer a residual or discretionary activity. It is the essential infrastructure required to maintain the terrain of health: protecting continuity, enabling coordination and protecting the time required for recovery and adaptation. Prevention is not an optional add-on justified by downstream savings. It is essential to the maintenance of balance and the pursuit of prosperity.

This shift in perspective is foundational. But it does not necessarily imply an entirely new policy agenda. Many of the necessary elements are already present in current policy debates—including those in Scotland. **What is needed is a consistent way of judging whether reform choices reinforce the production of ill health or reduce it over time.** To support that task, this paper proposes a simple policy test.

## The policy test: a decision discipline for reform

- **Does this intervention move institutions closer to prosperity understood as health—or does it merely cushion the costs of prosperity understood as wealth?**

This test is not a scoring tool or a binary judgement. Measures that cushion the costs of ill health are often necessary, particularly in periods of acute operational pressure. But they do not, on their own, alter the future trajectory of demand. The purpose of the test is to distinguish between policies aimed solely at improving operational efficiency and interventions which progressively improve the terrain of health and thereby reduce the demand for healthcare services.



The choice facing policy makers is therefore a strategic one.. to pursue prosperity in ways that generate ill health.. or organise reform around sustaining the conditions in which people can remain well.

When applied to contemporary policy directions, the test reveals some clear patterns. Operational recovery is indispensable but largely leaves future demand unchanged. Policies that act directly on the environments in which health is produced—for example through the regulation of food systems or improvements in housing and energy efficiency—have a clear potential to reduce future harm and moderate demand over time.

Many of the reforms proposed in Scotland (and elsewhere)—such as primary care transformation, care integration, workforce changes and digital innovation—turn out to be conditional. Their impact depends on whether they strengthen continuity, coordination and sustained relationships or whether they are absorbed into a throughput-driven model of healthcare.

### Policy directions aligned with prosperity as health

Viewed through this lens, re-centring care implies a clear realignment of priorities which needs to foreground several distinct policy directions.

- Care capacity is treated as essential infrastructure investment and is protected during periods of acute pressure.
- Performance frameworks value continuity, coordination and long-term outcomes alongside access and throughput.
- The working conditions of care roles across health and social care are continuously improved and supported.
- Time is recognised as a therapeutic resource, particularly for people with multiple long-term conditions.
- Major drivers of avoidable demand—such as diet, exposure to environmental toxins and work-related stress—are systematically addressed upstream.
- False economies – which generate private gain at the expense of social costs and lock society into indefinite disease management – are avoided.
- Proven prevention and care models are promoted from pilots to permanence.
- Healthcare leadership is framed around stewardship of population health over time.

Many of these elements are present in some form within recent policy debates around the world and in particular within the Scottish Government’s Health and Social Care Service Renewal Framework (SRF).<sup>6</sup> What is missing is a consistent way of identifying and prioritising these kinds of policies—particularly in the context of rising demand and limited public funding.

### The choice ahead

Policymakers face no shortage of ambition or professional commitment when it comes to health system reform. The question is not whether to invest in health, but what kind of system those investments will entrench. Without deliberate protection for care, prevention and the conditions of health, public health systems will continue to face rising demand regardless of how efficiently they are managed.

It is impracticable—and unfair—to expect these challenges to be met entirely from within the healthcare service. The operational pressures on NHS staff, for example, are already unmanageable. Prosperity understood as health re-centres care and enables health service reform to move beyond the absorption of pressure towards the prevention and reduction of future harm. But it requires political and economic change to be viable.

The choice facing policymakers is therefore a strategic one. It is a choice between continuing to pursue prosperity in ways that generate ill health, which health services like the NHS must absorb at cost, or organising reform around sustaining the conditions in which people can remain well. Making that distinction explicit is the first step towards a health system—and a society—capable of supporting wellbeing over time.

## Notes

1 SG 2024 The Scottish Health Survey 2024. <https://www.gov.scot/publications/scottish-health-survey-2024-volume-1-main-report/documents/>.

2 Mercer, S et al 2024. Health inequalities, multimorbidity and primary care in Scotland. *Future Healthcare Journal* 10(3): 219-225. <https://doi.org/10.7861/fhj.2023-0069>;

3 Jackson, T 2017. *Prosperity without Growth—Foundations for the Economy of Tomorrow*. London: Routledge; Jackson, T 2021. *Post Growth—life after capitalism*. Cambridge: Polity; see also: Kallis, G et al 2025. Post-growth: the science of wellbeing within planetary boundaries. *The Lancet Planetary Health* 9(1). [https://doi.org/10.1016/S2542-5196\(24\)00310-3](https://doi.org/10.1016/S2542-5196(24)00310-3).

4 Jackson, T 2025. *The Care Economy*. Cambridge: Polity.

5 Jackson, T 2026. Prosperity as health—why we need an economy of care for a liveable future. *BMJ* 2026; 392: r2573. <https://doi:10.1136/bmj.r2573>.

6 Scottish Government 2025. Health and Social Care Service Renewal Framework 2025-2035. Edinburgh: Scottish Government. <https://www.gov.scot/publications/health-social-care-service-renewal-framework/documents/>.

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## Further reading

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### **Contact**

Prof Tim Jackson  
[office@timjackson.org.uk](mailto:office@timjackson.org.uk)