McKinsey Health Institute

The future of healthy living

A $16.4 trillion opportunity



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New McKinsey Health Institute analysis finds that addressing modifiable risk factors could add 12 years to healthy life expectancy at birth and add nearly 9 percent to the global economy by 2050.

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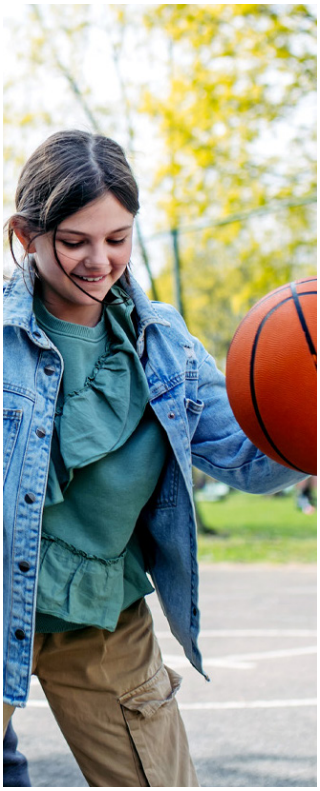
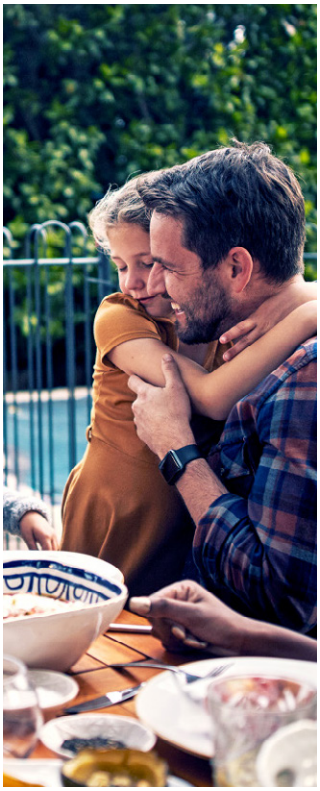








Faced with aging populations and a growing burden of preventable diseases, government officials have a transformative opportunity to create healthier, more prosperous societies. Healthy living is no longer only a social objective; it is an economic imperative and a cross-government delivery challenge.

Modifiable health risk factors represent one of the largest untapped opportunities for governments to improve population health while strengthening economic performance. In 2050, eliminating behavioral, metabolic, and environmental risk factors could add 12 years of life expectancy at birth and generate an estimated $16.4 trillion in annual GDP uplift globally, according to a McKinsey Health Institute (MHI) analysis. This is equivalent to nearly 9 percent of total GDP in 2050 (for more, see sidebar "Terminology").

Some governments are already making healthy living a strategic priority to capture the human and economic benefits of healthier lifespans. In Abu Dhabi, for example, a healthy-living strategy demonstrates how governments could mobilize a broad, cross-government agenda for healthy living. As healthy longevity increasingly becomes a priority around the world, scaling progress will require governments to lead action across the sectors that shape health, supported by stronger evidence, tools, and meaningful opportunities to learn from others.

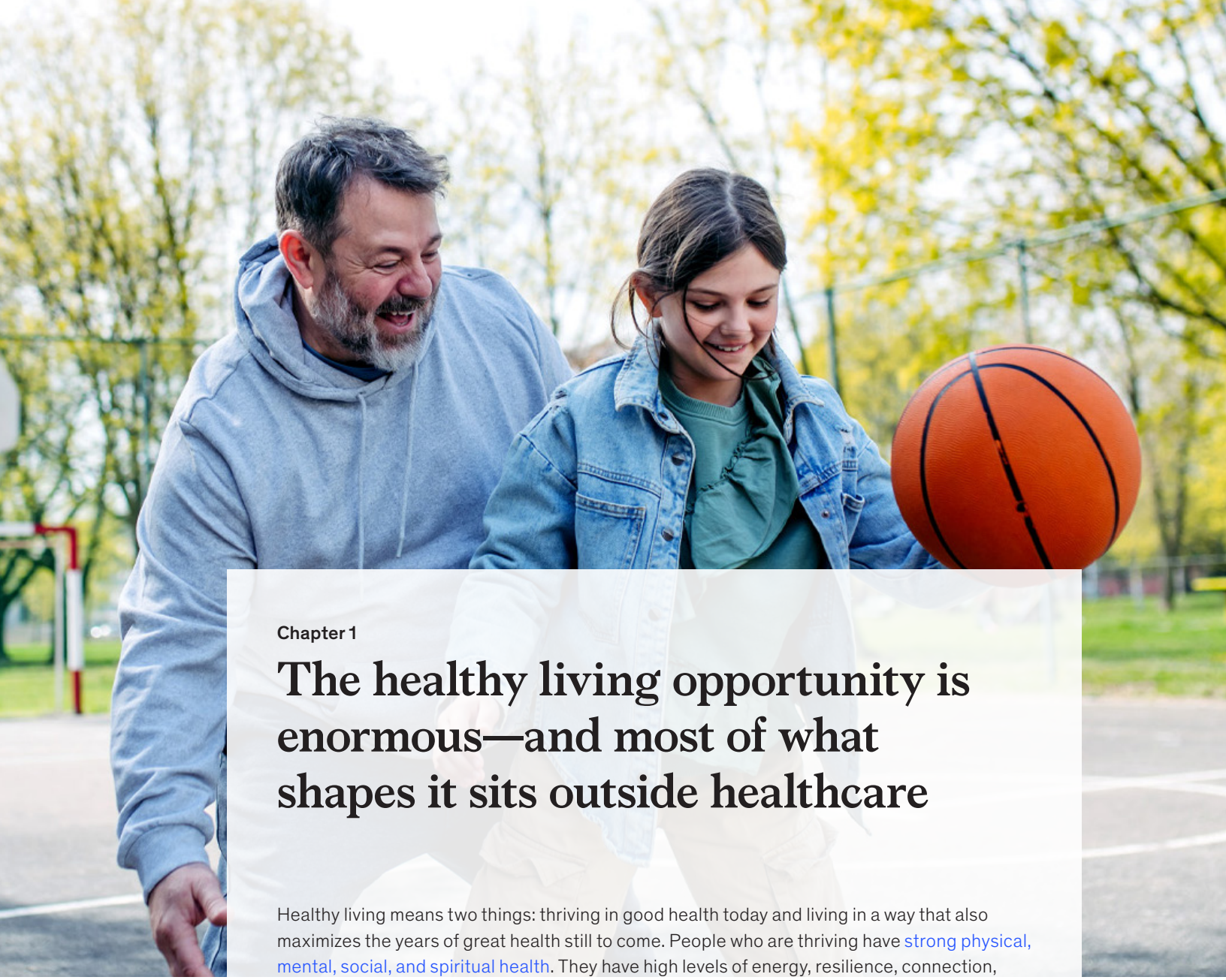
This report quantifies the opportunity, highlights lessons from Abu Dhabi and other geographies, lays out a practical delivery playbook for governments, and explores how new global collaboration can help to accelerate progress.

Healthy living is no longer only a social objective; it is an economic imperative and a cross-government delivery challenge.

Sidebar

Terminology

Term	Definition
Disability-adjusted life year (DALY)	The sum of years lost due to premature death (YLLs) and years lived with disability (YLDs). One DALY equals one lost year of healthy life.
Disease burden	The impact of health loss attributable to diseases and injuries, encompassing both premature mortality and nonfatal health loss.
Driver of health	A contributor that influences an individual's health and health outcomes and can be shaped through individual choices and/or structural and environmental conditions.
Health equity	The absence of avoidable, unfair, or remediable differences in health outcomes across groups of people.
Healthy life expectancy	The number of years that a person at a given age can expect to live in good health, assuming rates of mortality and disability remain unchanged.
Healthy longevity	The ability to live longer while spending more of those years in good health, with preserved function, well-being, and independence.
Metabolic health	The body's ability to efficiently produce, regulate, and use energy to sustain daily function, while supporting the health of key systems over the life course, including the cardiovascular, renal, and hepatic systems.
Modifiable risk factor	A risk factor that can be changed through behavior, clinical care, policy, environment, or system-level intervention. An attribute, behavior, exposure, or other factor that is causally associated with the probability of a disease or injury and is amendable to modification through behavior, clinical care, policy, environment, or system-level intervention.
Noncommunicable disease (NCD)	A disease that is typically noninfectious in origin and is not transmitted from one individual to another. Major NCDs include cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes.
Population health intelligence	The use of integrated data and analytics to generate insights into population health needs, identify priority groups, inform tailored interventions, and track outcomes over time.
Risk factor	A measurable exposure, condition, or behavior that increases the likelihood or severity of poor health.
Years lived with disability (YLD)	Years lived with any short-term or long-term health loss.



Chapter 1

The healthy living opportunity is enormous—and most of what shapes it sits outside healthcare

Healthy living means two things: thriving in good health today and living in a way that also maximizes the years of great health still to come. People who are thriving have strong physical, mental, social, and spiritual health. They have high levels of energy, resilience, connection, and a sense of purpose across the life course. Over time, healthy living is the foundation for healthy longevity.

Unfortunately, as MHI has previously explored, healthy living remains out of reach for large parts of the population. Globally, people spend roughly half of their lives in less-than-great health, including years marked by pain, limited mobility, impaired senses, cognitive decline, or loss of independence.[1] The reasons are widespread: One in three adults globally does not achieve recommended physical activity levels, nearly the entire global population is exposed to air pollution above World Health Organization guideline limits, and in the United States, more than nine in ten adults are in suboptimal cardiometabolic health.[2] This means healthy living cannot be treated as a niche wellness goal, but instead as a population-scale challenge shaped by everyday environments, behaviors, and systems.

[1] "Adding years to life and life to years," McKinsey Health Institute, March 29, 2022.
[2] "Nearly 1.8 billion adults at risk of disease from not doing enough physical activity," World Health Organization (WHO), June 24, 2024; "Billions of people still breathe unhealthy air: New WHO data," World Health Organization, April 4, 2022; Meghan O'Hearn et al., "Trends and disparities in cardiometabolic health among U.S. adults, 1999–2018," *Journal of the American College of Cardiology*, July 2022, Volume 80, Number 2.

Good health is often seen as an individual decision. Yet this underestimates how elements of daily life—ranging from access to healthy food to safe walkable neighborhoods to adequate home heating and cooling—profoundly affect one's health. Every sector and industry has a role to play in achieving healthy living for all, and governments can have a critically important role in setting aspirations and leading the change.

There are six reasons why governments may consider making healthy living an overall priority:

— *Individuals' health could substantially improve.* Eliminating modifiable risk factors could increase global healthy life expectancy at birth by 12 years in 2050, according to MHI analysis.[3] For an individual, that means more years of healthy life and more years of productivity without additional social or healthcare support.

— *The economic opportunity is substantial.* Globally, MHI finds that the total economic impact of investing in healthy living in 2050 could amount to close to 9 percent of projected GDP, or $16.4 trillion. With an opportunity of that magnitude, healthy living is a primary candidate for cross-sector investment at a national scale.

— *The cost of inaction is too high to ignore.* The current forecast for global healthcare spending in 2050 is nearly two times higher than in a future where governments act to enable healthy living and modifiable risk factors are eliminated.[4] Several advanced health systems—including in France and the United States—face projected fiscal pressures and shortfalls driven in part by rising healthcare costs.[5] Without reducing the demand for healthcare through population-level healthy living, the burden of preventable disease could push spending beyond what governments can sustain, compounding pressure on productivity, dependency ratios, and public finances.

— *Most health drivers sit outside healthcare.* Of the 23 modifiable drivers of health (Exhibit 1), 19 sit outside of the formal healthcare system,[6] making the case for action across sectors, government departments, and top-of-government leaders. By reinforcing health drivers through a whole-of-society healthy living agenda, governments can reduce risk factors for poor health, promote healthy longevity, and generate substantial economic returns.

— *People want it.* In a 2025 McKinsey Future of Wellness survey of more than 9,000 US respondents, up to 60 percent of respondents reported that healthy aging is a top or very important priority. People associate healthy aging with a broad set of benefits: living longer, maintaining cognitive and physical function, independence, energy, and preventing chronic disease. This interest spans generations, though priorities differ—younger generations emphasize health, sleep, and nutrition, while older generations focus more on independence, social connection, and purpose.[7] Importantly for governments, many respondents report that their wellness needs remain unmet. Leaders can address this strong public demand to build support for ambitious healthy-living agendas, enabling sustained implementation over the long term.

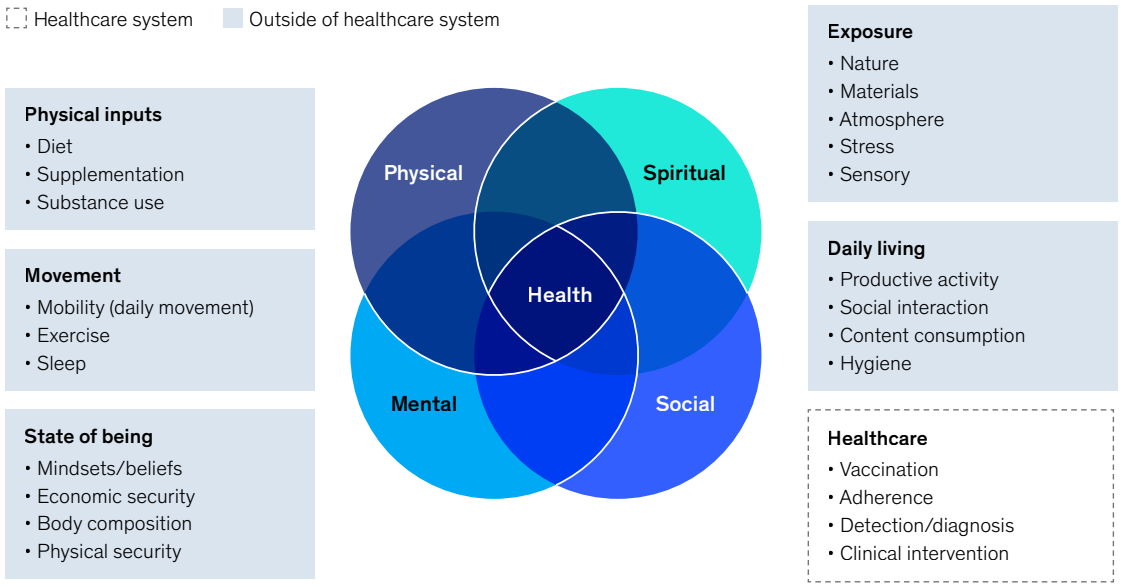
— *There is now a window of opportunity.* The emergence of therapies using glucagon-like peptide-1 (GLP-1) drugs has catalyzed a new level of attention to obesity and metabolic health, bringing these issues more firmly onto the agendas of governments, health systems,

[3] Additional healthy years of life gained from full risk elimination, calculated as the difference between forecasted healthy life expectancy (HALE) at birth under elimination of all major risk factors and baseline HALE, using forecasts from the Institute for Health Metrics and Evaluation.
[4] Estimate assumes healthcare spending scales roughly linearly with changes in disease burden as measured in disability-adjusted life years (DALYs). This is a simplifying assumption since spending is driven by prices, care mix, and system overhead as much as by burden, and the cost of averting or treating one DALY varies widely by condition and intervention.
[5] *The long-term budget outlook: 2025 to 2055*, Congressional Budget Office, March 2025; *Fiscal sustainability of health systems*, OECD, January 11, 2024.
[6] Lars Hartenstein and Tom Latkovic, "The secret to great health? Escaping the healthcare matrix," McKinsey Health Institute, December 20, 2022.
[7] "The $2 trillion global wellness market gets a millennial and Gen Z glow-up," McKinsey, May 29, 2025; "Age is just a number: How older adults view healthy aging," McKinsey Health Institute, May 22, 2023.

Exhibit 1

Health is shaped by 23 drivers, most of which sit outside traditional healthcare systems.

Drivers of health, by dimension[1]



Note: Drivers of health are complex and nonlinear (eg, J-curves, U-curves) and interact with one another.
[1]This is grounded in the World Health Organization's definition of health as complete physical, mental, and social well-being; a spiritual dimension is added to reflect exposure and meaning.
Source: Lars Hartenstein and Tom Latkovic, "The secret to great health? Escaping the healthcare matrix," McKinsey Health Institute, Dec 20, 2022

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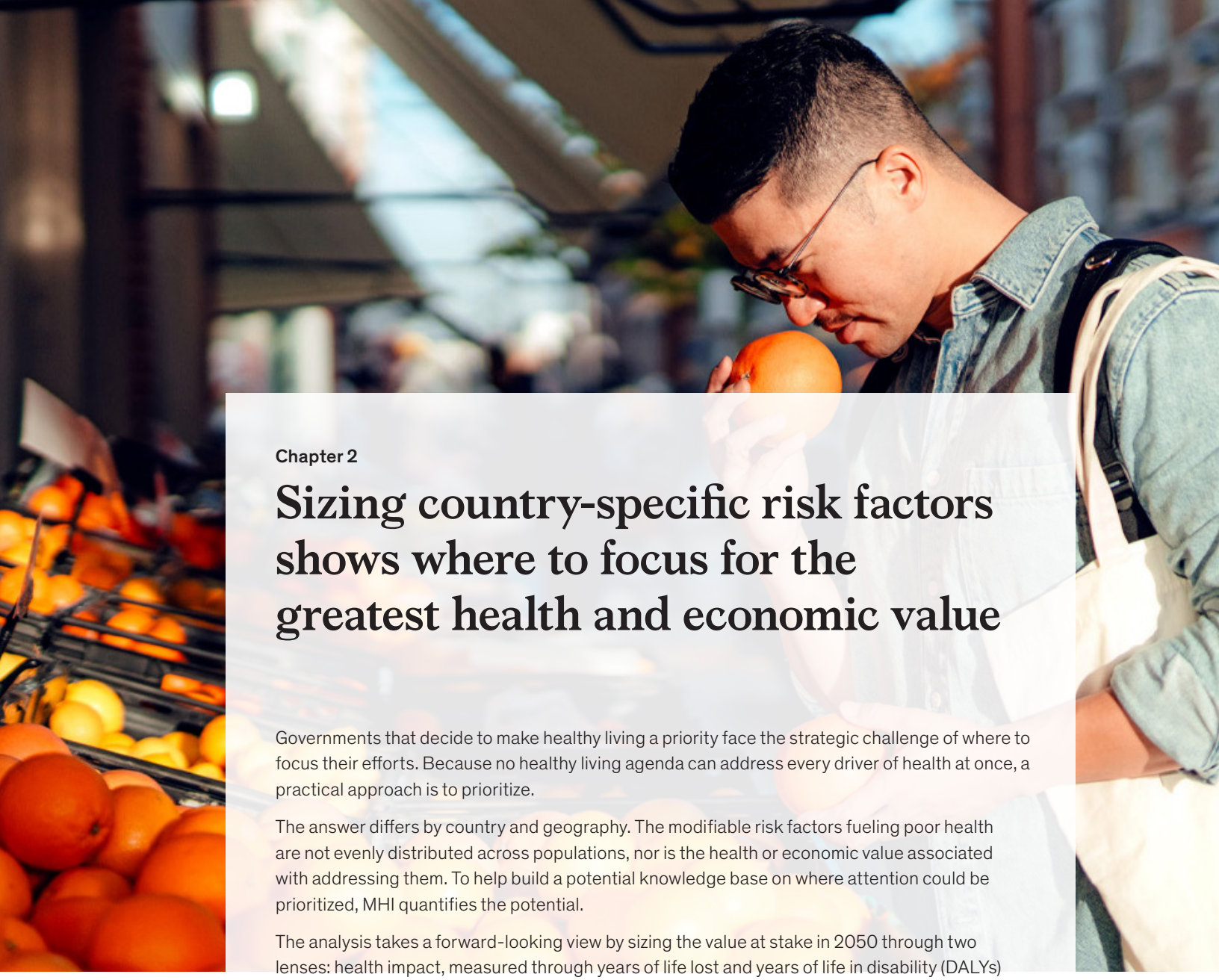
employers, and investors. This momentum extends beyond the therapies themselves, helping to shift perceptions of obesity, stimulate innovation and investment, and create greater urgency to address metabolic health. GLP-1s alone will not deliver a metabolic health revolution, but they have helped open a window for broader action—creating an opportunity for leaders to advance prevention, improve environments and incentives, and address the wider drivers of metabolic health.[8]

A practical healthy living agenda could start with a small set of priority drivers (for example, diet, physical activity, and clinical interventions targeting metabolic diseases) that are both highly influential and actionable at the population level. The objective is to build a coordinated portfolio that makes healthier choices more available, affordable, and easier to sustain, rather than prescribe a single intervention.

The execution of a healthy living agenda relies on cross-government leadership. Many of the most important drivers of health are shaped by ministries and sectors that do not define themselves as part of the health system, including education, transport, urban planning, food, technology, labor, finance, and community development. A top-of-government perspective is therefore essential: Leaders benefit from identifying where the burden is greatest, which risk factors are most addressable, which drivers can be shifted, and which accountabilities can be created to deliver results.

[8] *Catalysing cross-sector leadership for metabolic health*, World Economic Forum, January 2026.



Chapter 2

Sizing country-specific risk factors shows where to focus for the greatest health and economic value

Governments that decide to make healthy living a priority face the strategic challenge of where to focus their efforts. Because no healthy living agenda can address every driver of health at once, a practical approach is to prioritize.

The answer differs by country and geography. The modifiable risk factors fueling poor health are not evenly distributed across populations, nor is the health or economic value associated with addressing them. To help build a potential knowledge base on where attention could be prioritized, MHI quantifies the potential.

The analysis takes a forward-looking view by sizing the value at stake in 2050 through two lenses: health impact, measured through years of life lost and years of life in disability (DALYs) averted by eliminating modifiable risk factors,[9] and economic impact, measured through GDP uplift. These risk factors contribute to premature mortality and years lived in poor health, directly affecting how much time individuals can spend participating in the economy. The potential GDP uplift provides governments with a basis for prioritizing areas where public policy, regulation, infrastructure, service delivery, and partnership can propel both health outcomes and economic benefit (see sidebar "Methodological note").

The numbers are substantial across four broad scenarios of eliminating modifiable risk factors (Exhibit 2). Globally, the potential economic impact of investing in healthy living and eliminating all modifiable risk factors (Scenario A) could reach $16.4 trillion in 2050, nearly 9 percent of total GDP.[10] The total health burden averted reaches 1.5 billion DALYs, equivalent to approximately 47 percent of global disease burden in 2050.

[9] An attribute, behavior, exposure, or other factor that is causally associated with the probability of a disease or injury and is amendable to modification through behavior, clinical care, or policy. The health impact of factors such as high body mass index (BMI) or high systolic blood pressure on disease burden can be quantified as DALYs attributable to these risk factors. The IHME Global Burden of Disease 2021 framework attributes an estimated 47 percent of all disease burden to 20 risk factors, including dietary risks, low physical activity, tobacco, air pollution, high BMI, high systolic blood pressure, and others. When applied to the projected 2026 disease burden, these risk factors contribute 1.2 billion DALYs to the global disease burden.

[10] This is nearly three times the potential economic impact of $6 trillion from eliminating all modifiable risk factors in 2026.

Sidebar

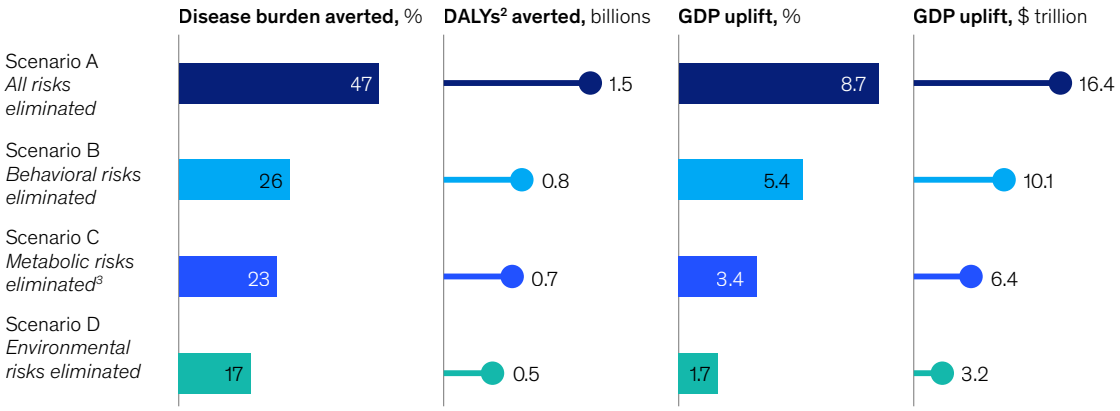
Methodological note

This analysis seeks to model the potential of healthy living—thriving in good health today while living in a way that also maximizes years in great health still to come. Its impact can be estimated by modeling a world without exposure to modifiable environmental, behavioral, and metabolic risk factors, leveraging the Institute for Health Metrics and Evaluation's Global Burden of Disease study. This analysis provides a complementary perspective to our analysis in The Health of Nations. Whereas that work estimated the burden reduction achievable through specific interventions supported by clinical evidence, this analysis estimates the theoretical potential associated with eliminating risk-factor-attributable burden, without specifying the interventions required to achieve it. As such, the estimated impact should be interpreted as an upper-bound potential: It assumes full elimination of the risk factors. While achieving this potential may require interventions beyond those for which clinical evidence exists today, the underlying shifts needed for healthy living are plausible. For example, it is conceivable that everyone eats healthily, so we model potential through the full elimination of dietary risk, while Health of Nations focuses on the impact of existing, clinically evidenced interventions such as nutrition programs and GLP-1s.

Exhibit 2

Full elimination of modifiable risk factors could avert 47 percent of the global disease burden, translating into a nearly 9 percent annual GDP uplift in 2050.

Health and economic impact in 2050[1]



Note: Scenario A eliminates every modifiable risk simultaneously; scenarios B through D each eliminate a single risk group. Scenarios are not additive. Each panel uses an independent scale.
[1]Counterfactual scenario modeled across all risks (scenario A) or per risk category (scenarios B through D), assuming 100% of risk-attributable burden averted. Economic impact is estimated by translating averted deaths and disability into additional effective workforce participation and productivity, adjusted for labor force participation and employment, and valued using GDP per employed worker.
[2]Disability-adjusted life years; one DALY equals one year of healthy life lost to illness, disability, or premature death.
[3]Scenario C was also modeled in a previous publication from the McKinsey Health Institute using the same methodology. For more, see Anas El Turabi, Drew Ungerman, Hemant Ahlawat, and Lars Hartenstein, "The path toward a metabolic health revolution," McKinsey Health Institute, May 20, 2025. Since that publication, two inputs have been updated: DALYs averted are now estimated for 2050 (previously 2022), and the 2050 economic impact now also includes caregiver productivity.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation (IHME), 2021, extended to 2050 via IHME disease burden forecasts

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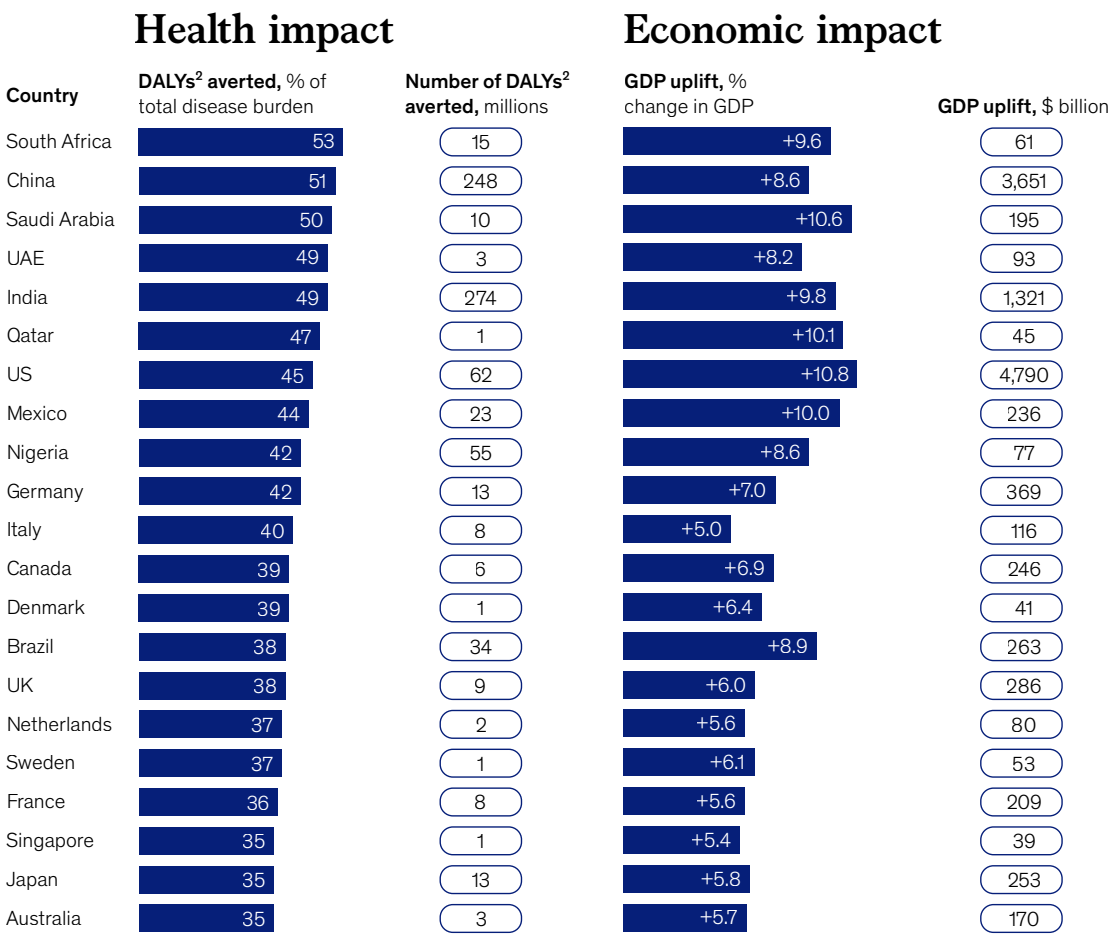
The opportunity varies by country; each differs in what share of the disease burden is modifiable, shaped by demographics, dominant risk factors, and past progress in reducing risks to human health. Countries also differ in how health gains translate into economic value (Exhibit 3). A few example country profiles can help illustrate this point:

In Saudi Arabia, the potential impact on the country's health burden is among the highest of the sample countries analyzed, with 50 percent of the overall disease burden driven by modifiable risk factors. Related trends in Saudi Arabia include rising prevalence of obesity, with high body

Exhibit 3

The health and economic impact of eliminating modifiable risk varies by country.

Impact of scenario A in 2050,[1] by country



[1]Scenario A eliminates all modifiable risks. Countries sorted by health impact share, descending. Economic impact is estimated by translating averted deaths and disability into additional effective workforce participation and productivity, adjusted for labor force participation and employment, and valued using GDP per employed worker.
[2]Disability-adjusted life years; one DALY equals one year of healthy life lost to illness, disability, or premature death.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation (IHME), 2021, extended to 2050 via IHME disease burden forecasts

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mass index (BMI) becoming the number one risk factor for males and females in 2021, and behavioral risk factors such as dietary risk and tobacco playing a role.[11]

In India, the modifiable share of disease burden is 49 percent—the fourth highest among countries analyzed—translating to a potential 9.8 percent in GDP uplift. The preventable burden in India reflects a mix of pressures on a large, relatively young population. For instance, particulate matter air pollution contributes more DALYs in India than in any other country, childhood undernutrition has improved but remains widespread, and obesity is increasing.[12]

In the United States, the share of disease burden attributable to modifiable risk factors is lower (45 percent), but still one of the highest among high-income countries analyzed. Leading risk factors include high BMI, high fasting plasma glucose, and tobacco and drug use.[13]

In Italy and Germany, 40 and 42 percent of the disease burden is modifiable, respectively—a roughly 5 percent relative difference. However, the estimated GDP uplift differs more substantially, at 5 percent of GDP in Italy versus 7 percent in Germany, a roughly 40 percent relative difference. Italy also ranks among the lowest of high-income countries analyzed in terms of GDP uplift as a percent of GDP. This demonstrates how health gains translate into economic uplift. Among other variables, Italy has one of the world's oldest populations,[14] meaning more of the burden falls on older age groups, where health gains may translate less directly into immediate workforce productivity.

Similarly, in Japan, an older population and long-run historical progress on smoking and blood pressure may be producing a smaller modifiable share (35 percent) than other sample countries. However, opportunity remains meaningful, particularly as high fasting plasma glucose becomes the leading risk factor alongside increasing diabetes rates.[15]

What are practical ways to prioritize which risk factors to address? One way is to define thematic priorities to kick-start a healthy living agenda and group risk factors into "packages" accordingly (Exhibit 4). For example, government stakeholders could focus on delivering metabolic health for all, or see it as a "metabolic health revolution," an approach that is compelling in countries with elevated disease burden. It would mean targeting metabolic health risk factors, including high BMI and high systolic blood pressure, as well as key behaviors such as dietary risk and low physical activity. Abu Dhabi is one case in point (see sidebar "Abu Dhabi's Healthy Living agenda: A cross-government model example") where this package is also by far the largest potential value at stake. Another starting point could be to focus on women's health by addressing risk factors where the attributable burden falls disproportionately on women, from low bone mineral density to intimate-partner violence.

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[11] In Saudi Arabia, the age standardized DALY rate in those with high BMI more than doubled between 1990 and 2021, and prevalence of male tobacco use reached greater than 26 percent in 2022, according to data from the World Health Organization; Amal Zaidan, "Three decades of trends in risk factors attributed to disease burden in Saudi Arabia: Findings from the Global Burden of Disease Study 2021," *Healthcare (Basel)*, July 2025, Volume 13, Number 14.

[12] Neha Jain, Srinivas Goli, and Arjun Jana. "Population age structural transition, demographic dividend and economic growth in India," *Humanities and Social Sciences Communications*, June 2025, Volume 12; "Temporal trends of particulate matter pollution and its health burden, 1990–2021, with projections to 2036: A systematic analysis for the global burden of disease study 2021," *Frontiers in Public Health*, April 2025, Volume 13; Jithin Sam Varghese et al., "Changes in child undernutrition and overweight in India from 2006 to 2021: An ecological analysis of 36 states," *Global Health: Science and Practice*, October 2022, Volume 10, Number 5; Chandan Roy and Pooja Kalbalia, "Epidemiological trends and burden of nutritional deficiencies among infants in India: Evidences from the Global Burden of Disease study, 1990–2021," *Nutrition and Health*, September 2026, Volume 32, Number 5; Meekang Sung et al., "Temporal change in prevalence of BMI categories in India: Patterns across states and union territories, 1999–2021," *BMC Public Health*, May 2024, Volume 24, Number 1; World Population Prospects 2024, Department of Economic and Social Affairs, United Nations, 2024.

[13] "The burden of diseases, injuries, and risk factors by state in the USA, 1990–2021: A systematic analysis for the Global Burden of Disease Study 2021," *Lancet*, January 2025, Volume 404, Number 10469.

[14] Mohsen Naghavi, "State of health and inequalities among Italian regions from 2000 to 2021: A systematic analysis based on the Global Burden of Disease Study 2021," *Lancet Public Health*, April 2025, Volume 10, Number 4.

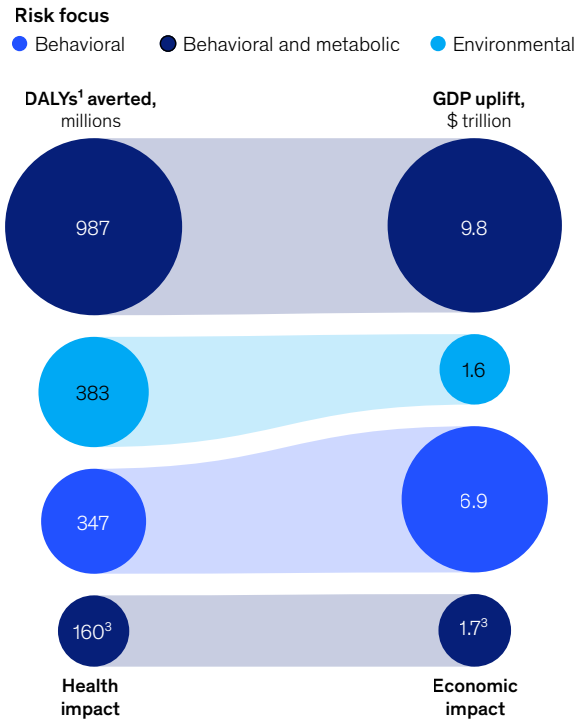
[15] From 1990 to 2021, Japan shows consistently negative annual rates of change for leading risk factors of high systolic blood pressure and tobacco; "Three decades of population health changes in Japan, 1990–2021: A subnational analysis for the Global Burden of Disease Study 2021," *Lancet Public Health*, April 2025, Volume 10, Number 4.

Exhibit 4

Leaders could strategically prioritize themes and target an associated 'package' of risk factors.

Risk packages and potential impact in 2050, by healthy-living theme

Healthy-living themes	Risk package to target
Metabolic health revolution	• All metabolic risk factors[2] • Closely related behavioral risk factors[2]
Healthy infrastructure	• Nonoptimal temperature • Unsafe water, sanitation and handwashing[2] • Air pollution • Other environmental risks[2]
Fight against substance use	• Alcohol use • Drug use • Tobacco
Elevating women's health	• Intimate-partner violence • Unsafe sex • Low physical activity • Low bone mineral density • High body mass index



Note: Economic impact is estimated by translating averted deaths and disability into additional effective workforce participation and productivity, adjusted for labor force participation and employment, and valued using GDP per employed worker. Packages should not be viewed as additive, as some risk factors repeat across risk packages; summing the impact of risk packages may create duplicative accounting of disability-adjusted life years (DALYs) attributable to modifiable risk factors.
[1]Disability-adjusted life years; one DALY equals one year of healthy life lost to illness, disability, or premature death.
[2]Metabolic risk factors include the following: high body mass index; high fasting plasma glucose; high LDL cholesterol; high systolic blood pressure; impaired kidney function; low bone mineral density. Closely related behavioral risks include the following: alcohol use; child and maternal malnutrition; dietary risks; low physical activity. Unsafe water, sanitation, and handwashing includes the following: unsafe water source, unsafe sanitation, and no access to handwashing facility. Other environmental risks include the following: residential radon, lead exposure in blood, lead exposure in bone.
[3]Impact in 2050 for the women's health package reflects the share of risk-attributable burden among females only and the corresponding GDP uplift. Impact of eliminating modifiable risks on women can extend beyond the women's health package, and the package itself may also affect both sexes. Across all individuals, the women's health package is estimated to address 280 million DALYs of risk-attributable burden and generate $3.8 trillion in GDP uplift in 2050. Within this package, women's share of the economic impact is lower than their share of the health impact, reflecting lower labor force participation for women globally.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation (IHME), 2021; McKinsey Health Institute analysis

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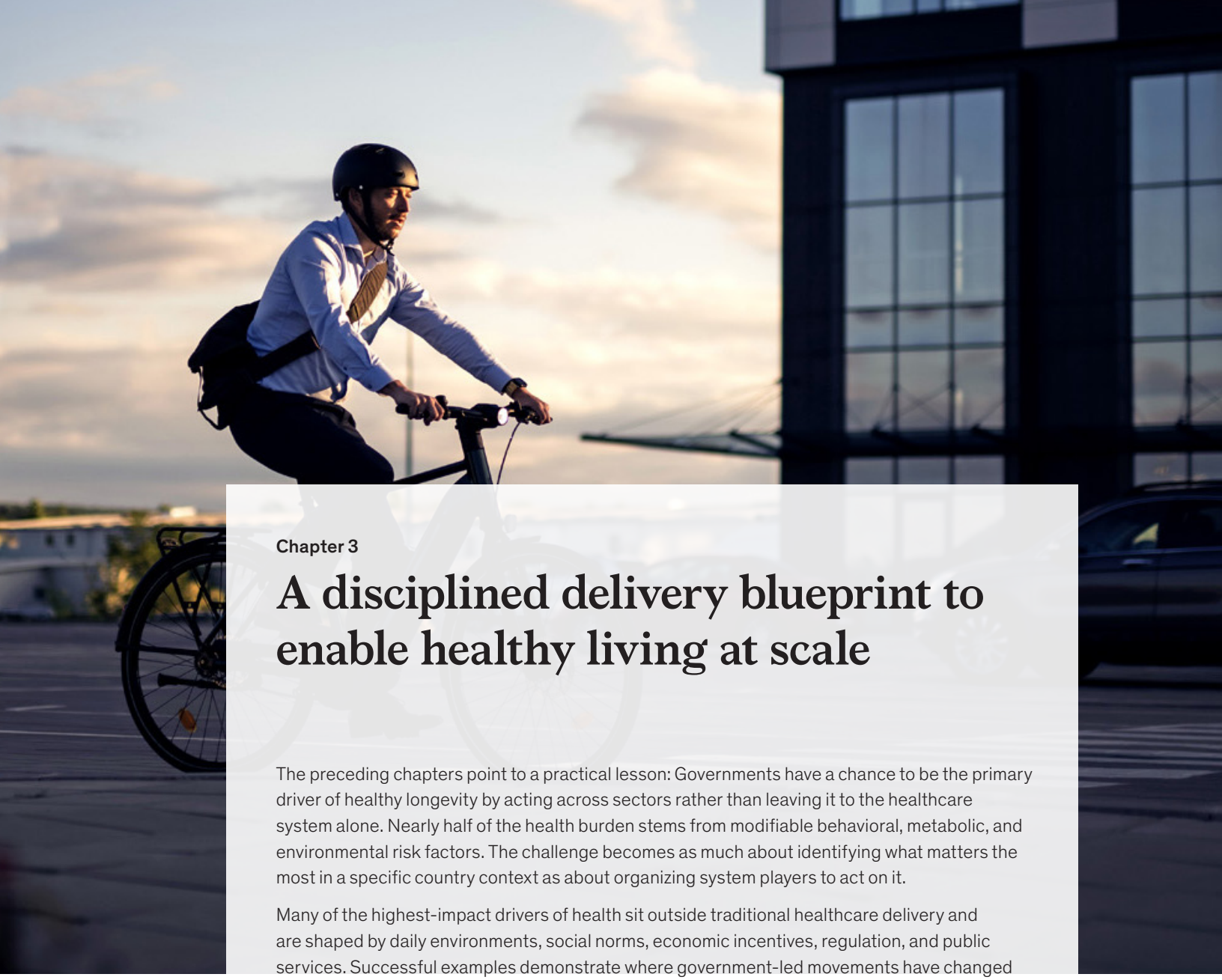
Exhibit 4 helps leaders weigh three practical considerations for any package: what risk factors it addresses, the scale of health benefit, and the economic return. The metabolic health revolution covers the widest set of risks and could generate the largest uplift, but narrower packages still deliver strong value. For instance, addressing substance use could avert 347 million DALYs and produce $6.9 trillion in GDP uplift.

In practice, leaders can select a thematic focus and associated package of risk factors that align with existing momentum, quantify the case for investment, and define the cross-sector coalition needed to deliver it.[16] The next step is turning priorities into action.

[16] Individual countries can consider both the potential and the feasibility of these packages. Feasibility depends on many dimensions, including income level, access to technology, and strength of institutions.



Chapter 3

A disciplined delivery blueprint to enable healthy living at scale

The preceding chapters point to a practical lesson: Governments have a chance to be the primary driver of healthy longevity by acting across sectors rather than leaving it to the healthcare system alone. Nearly half of the health burden stems from modifiable behavioral, metabolic, and environmental risk factors. The challenge becomes as much about identifying what matters the most in a specific country context as about organizing system players to act on it.

Many of the highest-impact drivers of health sit outside traditional healthcare delivery and are shaped by daily environments, social norms, economic incentives, regulation, and public services. Successful examples demonstrate where government-led movements have changed the conditions of everyday life and generated both health and economic impact. Global road safety efforts that combined vehicle standards, street design, law enforcement, and public promotional campaigns into behavior changes, which reduced road traffic deaths by more than 20 percent in the past 15 years.[17] Likewise, worldwide sanitation reforms turned every dollar invested in clean water supply and improved sewerage into a five-time economic return from lower health costs, more productivity, and fewer premature deaths.[18] Healthy living requires the same kind of aspiration and orchestration.

Governments could lead a cross-department, cross-sector movement by setting the ambition, identifying where burden and value at stake are greatest, designing a coordinated intervention portfolio, executing through accountable owners and measurable milestones, and institutionalizing learning over time (Table 1). To turn strategy into execution, it is critical to convene and align ministries, health systems, employers, communities, and private-sector actors around shared outcomes.

[17] "Road deaths fall by 21% globally, but stronger action is needed to save lives," WHO, July 20, 2026; "Road traffic injuries," World Health Organization, accessed September 2026.
[18] "Global costs and benefits of drinking-water supply and sanitation interventions to reach the MDG target and universal coverage," WHO, May 5, 2012.

Table 1

Five potential steps to lead a healthy living movement.

Step	A blueprint of what this could mean in practice	Example
Step 1: Set the ambition	• Identify top-of-government appetite to pursue a healthy living agenda. If there is already appetite, move onto later steps; if not, focus first on building the mandate • Define a small set (maximum 3–5) population-wide goals, keeping them aspirational and concrete • Ensure broader alignment with relevant government and cross-sector leaders	Japan's Health Japan 21 initiative illustrates the importance of setting a national ambition. Through successive multiyear plans, the government established population-wide targets across physical activity, nutrition, smoking, alcohol consumption, and healthy aging, creating a common agenda across ministries and public institutions.[1]
Step 2: Assess the opportunity	• Map the burden by using existing data and (if necessary) investing in new data that gives you an understanding of the specific outcomes and attributes of the target population • Rank opportunities by health impact, economic value, time to effect, and feasibility—deprioritize those with low scores across all factors • Assess system readiness to implement, including existing infrastructure, workforce and delivery capacity, and incentives alignment. Consider various dimensions such as strength of institutions, income level, and access to technology.	McKinsey Health Institute tools such as the one highlighted in Chapter 2 can help leaders move from aggregate burden to country-level priorities. Governments have already leveraged population-scale data to identify priority populations and inform interventions. For instance, Finland's national population registries provide policymakers with longitudinal health data across the population, including chronic disease burden, risk factors, and outcomes to develop targeted national prevention strategies.[2]
Step 3: Design the portfolio	• Sequence interventions, organizing what can launch in 6 months vs 1–3 years vs a long-term build • Develop a shortlist of no-regret interventions, ideally including actions that can produce early wins (positive results in 0–2 years to support future investment and coordination). These will make up the prioritized interventions. • Expand to a balanced portfolio in the long term with interventions spanning the environment, behavior, clinical applications, and technology • Build the coordinating body, and identify the incentives and accountabilities required for these stakeholders to deliver	Abu Dhabi translated its healthy-living ambition into a coordinated portfolio spanning physical activity, nutrition, mental well-being, and sleep, while prioritizing physical activity and nutrition as early focus areas to build momentum and demonstrate impact.
Step 4: Implement and scale	• Prepare to implement by establishing success indicators, feedback loops, scale-up criteria, and dedicated, sustained operating capacity • Launch prioritized interventions as a core program, treating healthy living initiatives as a central workstream, not a secondary responsibility • Build public trust through clear communication, credible messengers, citizen engagement, and community-tailored campaigns	Singapore's National Steps Challenge shows execution at scale, engaging more than 2 million participants through incentives, behavioral nudges, digital tools, and wearable technology to promote sustained physical activity and continuous program refinement.[3]
Step 5: Learn and adapt	• Track and act on your feedback loops, aiming for near real-time data from day one to inform continuous improvement • Course correct if needed to adapt interventions, scale up or down, and continuously improve • Institutionalize what works and share learnings based on transparency across initiatives to inform future work	Abu Dhabi's Population Health Intelligence platform demonstrates how governments can institutionalize learning. By creating an AI-enabled digital twin that integrates clinical, behavioral, and environmental data based on 3.5 billion clinical records, leaders can identify high-risk populations, model intervention scenarios, monitor outcomes, and adapt programs based on emerging evidence.[4]

[1] Yasuyo Wada, "Start of the 12-year initiative for the third term of Health Japan 21," *Health and Medical Sciences*, 2024, Volume 73, Number 2.
[2] "Data and statistics," Finnish Institute for Health and Welfare, accessed August 2026.
[3] Bekzod Normatov et al., "Impact of the national steps challenge physical activity programme on obesity and type 2 diabetes prevalence in Singapore to 2050: simulation-based forecasting analysis," *Lancet Regional Health—Western Pacific*, March 2026, Volume 68, Number 101831.
[4] *A new era for digital health: Abu Dhabi's leap to health intelligence*, World Economic Forum, January 2026.

Every government can start with one question: Where do the threads of power over our population's health converge, and who in that office holds them?

Governments therefore have a potential approach. Next is finding an owner. Ownership belongs wherever the threads of power over the drivers of health converge, and that intersection differs by country. In centralized systems—often in smaller countries—these drivers converge nationally, typically within a prime minister's office. In larger countries, they usually converge at one level below, such as a governor's office, where the departments that shape daily life are already colocated. In some contexts, they operate at the regional or continental level, where organizations such as the European Union inform many of the aspects of everyday life across borders. Every government can start with one question: Where do the threads of power over our population's health converge, and who in that office holds them? Answer those questions, and the blueprint could become a work plan. Answer them together with others, and it could become a movement.



Chapter 4

Why healthy living has not scaled yet, and how to change that

The potential prize is extraordinary: Addressing modifiable risk factors could add nearly 12 years to healthy life expectancy at birth and create up to $16.4 trillion in economic value by 2050, while inaction likely leaves global healthcare spending two to three times higher than it needs to be (Chapter 1). The blueprint for pursuing it is practical and increasingly well understood (Chapter 3). And some governments are already learning from it.

So why is this not happening in far more places? Because the agenda—reducing risks to human health so that everyone can prosper—cuts across silos. For example, health sits within one ministry, but most of what determines health, such as transport, education, housing, agriculture, and industry, sits elsewhere. Companies compete on products whose health consequences fall on public budgets decades later. As a result, almost everyone in government affects healthy living, but nobody owns it. National ambitions require cross-cutting and cross-sector agendas, supported by global evidence and engagement.

That agenda can't simply restate what health systems should do—that's the healthcare matrix MHI has described: a worldview where real health happens in clinics and everything else is filed under "lifestyle."[19] The harder, less charted work lies outside it, in science, measurement, technology, economics, and the social fabric (Table 2). Five shifts can help make healthy living realistic at scale, and they hold regardless of a country's starting point:[20]

[19] Lars Hartenstein and Tom Latkovic, "The secret to great health? Escaping the healthcare matrix," McKinsey Health Institute, December 20, 2022.
[20] *Catalysing cross-sector leadership for metabolic health*, World Economic Forum, January 2026.

Table 2

Scaling healthy living globally requires five shifts—and delivery at both local and global levels.

What are the five shifts needed to make healthy living scalable?	How can we deliver these shifts?
• Science • Transparency • Technology • Economy • Society	Local execution: follow the five-step blueprint (see Chapter 3) 1. Set the ambition 2. Assess the opportunity 3. Design the portfolio 4. Execute and scale 5. Learn and adapt Global learning and enablement across governments and companies

— *Science:* Build the evidence base for what actually drives health. The 19 modifiable drivers of health that sit outside the formal healthcare system have been studied far less rigorously than the clinical interventions inside it. Decades of trials have established what a given medicine does. Far less is known about what a redesigned street, a reformulated staple food, or a shift in working patterns does to a population's health, over what time horizon, and at what cost. Technology is changing what is knowable: AI, combined with the data people now generate through consumer devices and services, makes it possible to study healthy living at a scale and granularity that was previously out of reach. Closing the insight gap between the nonhealthcare and healthcare drivers is a global research agenda, and no country can do it alone.

— *Transparency:* Agree on what healthy living means and measure it for individuals and populations alike. Healthy living today has neither a common definition nor a common yardstick, which makes it nearly impossible to steer. Progress requires both. The country analysis in Chapter 2 works from the top down, sizing where burden and economic value are concentrated across whole populations. What is missing is its mirror image: a view built up from the individual as the unit of analysis, able to say what living healthfully means across the drivers of health, while recognizing that what people value and prioritize may differ across individuals and contexts. The country-level analysis and the individual-level view are both needed. Governments need population measures to direct policy and demonstrate returns; individuals require something personal enough to act on. A shared yardstick that holds up at both ends could let a country steer toward healthy living rather than merely hope for it.

— *Technology:* Put healthy living within reach of the individual. For all that governments can shape, healthy living is a personal journey, shaped by daily choices that policy can influence but cannot make. Technology's potential role is to make those choices easier and better informed, and the consumer market is moving faster than the health system. For example, continuous glucose monitors show nondiabetic people which foods spike their blood sugar, turning general dietary advice into personal feedback.[21] Point-of-purchase tools such as food-scanning apps deliver a legible verdict on a product in the seconds before someone

[21] David C. Klonoff et al., "Use of continuous glucose monitors by people without diabetes: An idea whose time has come?," *Journal of Diabetes Science and Technology*, November 2023, Volume 17, Number 6; Ty Ferguson et al., "Effectiveness of wearable activity trackers to increase physical activity and improve health: A systematic review of systematic reviews and meta-analyses," *Lancet Digital Health*, August 2022, Volume 4, Number 8.

buys it.[22] Wearables, home testing kits, and AI-based nutrition and exercise assistants extend the same logic across sleep, movement, and diet. Together, they improve upon something that never was before at scale: the healthy-living IQ of a population and the everyday ability to know what a choice will do. What is needed now is better validation, since much of what is marketed still runs ahead of the evidence behind it.

— *Economy:* Make healthy choices affordable, available, and desirable. Much of a person's health is determined by the products and services they buy and enjoy: the food on the shelf, the buildings they work in, the way they travel, and how they spend an evening. Those portfolios follow commercial logic, and today, that logic does not consistently reward health. Part of it does: whole categories, from wellness and sport to preventive services and better food, are already large and growing quickly.[23] But across much of the everyday economy, the incentives still run the other way, because what makes a product cheap, convenient, durable, and highly scalable is not reliably what makes it good for the person consuming it, and the health consequences surface years later on someone else's balance sheet. This is a problem of incentives rather than of intent, which is also what makes it solvable. Closing the gap means making the healthier product genuinely competitive on price, attractiveness, and convenience through innovation, and changing the underlying economics where innovation alone will not suffice. The target is to ensure the healthy choice is consistently the affordable, available, and desirable one—backed by structurally aligned incentives rather than achieved despite them.

— *Society:* Make healthy living socially supported rather than individually heroic. Science, technology, and economics all matter, but individual behavior is often shaped by the people nearby. Schools, employers, and community groups build the supportive environments that normalize healthy living, engaging with individuals in daily life in ways that national ministries cannot replicate. Much good work is already underway here, rooted in a long public health tradition. What it often lacks is a standing on the national agenda commensurate with its influence.

Almost all of this would likely need to be delivered at a national or state level to achieve meaningful impact. That is where cross-sector coordination happens and where accountability for a population's health sits. But that level cannot carry a cohesive, multisector agenda on its own, and the support it most needs could come from two collaborations: one among governments, and one among companies:

— *A global coalition of companies:* Employers, insurers, food and consumer-packaged-goods companies, retailers, technology platforms, and healthcare innovators together shape most of the products, places, and defaults that determine how people live. Metabolic health shows how such a coalition can begin to form. MHI worked with the World Economic Forum to set out a first perspective on what leadership in metabolic health could mean, industry by industry, and, within it, proposed a pragmatic working definition of metabolic health so that different sectors could at least aim at the same target.[24] That conversation widened at a business-building summit MHI cohosted with Stanford Medicine last July, bringing investors, corporate leaders, insurers, providers, and scientists around one question: Can metabolic health become the next frontier of science-based business building?[25]

[22] L. Nynke van der Laan and Oliwia Orcholska, "Effects of digital Just-In-Time nudges on healthy food choice—A field experiment," *Food Quality and Preference*, June 22, Volume 98, Number 104535.
[23] Katherine Johnston, *Global Wellness Economy Monitor 2025*, Global Wellness Institute, November 2025; "The $2 trillion global wellness market gets a millennial and Gen Z glow-up," McKinsey, May 29, 2025.
[24] *Catalysing cross-sector leadership for metabolic health*, World Economic Forum, January 2026.
[25] McKinsey Health Institute, "Rising interest in addressing metabolic health as a pathway to thriving societies and economic growth," LinkedIn, July 2026.

A healthy-living coalition needs a small number of concrete tasks, not a statement of intent: Create a clear, actionable definition of healthy living for industries to align around, mirroring the progress made in the field of metabolic health. Prove a credible base of business models where health and commercial return genuinely align so that a case can be made within a company with numbers, not conviction alone. Standardize voluntary cross-industry specifications for certain cases where no firm can move alone without surrendering share. Aggregate demand, as the First Movers Coalition has done in clean technology, so that pooled commitments can create markets that no single buyer could.[26]

— *A space for cross-government learning:* The logic for companies can apply equally to governments: Leaders pursuing this agenda say they want some place to compare notes, but there's no such safe place. The COVID-19 pandemic showed this is feasible—many heads of government acted on a sense of ownership, mobilizing every department, and speaking constantly with counterparts about what they were seeing and trying. Much of that was improvised, but it showed that change can happen quickly. It also showed governments doing what this paper suggests—acting as evidence accumulates, launching publicly, and adapting along the way. The blueprint asks the same of institutions built to be predictable, which is exactly why hearing what a peer government tried last year, and what it would change now, is more valuable than any finished playbook.

  What the pandemic had, and healthy living lacks, is urgency—so this mindset has to be chosen. However, existing systems aren't built for it: The world's leading health institutions convene regularly, but often with health ministries and traditional global health actors—and, as Chapter 3 argues, this isn't principally a health minister's agenda. Government-driven forums are beginning to appear, such as Abu Dhabi and Qatar convening around longevity,[27] but they remain geographically bounded.

  What such a coalition would need first is not architecture but a safe place to learn. The value of a safe place lies in the candid discussions among people doing the same difficult thing at the same time. In other words, a sandbox. This format has a track record in other domains, where some of the most durable international cooperation began as small, informal groups meeting alongside the formal processes, working through technical questions one at a time and proceeding on a start-and-strengthen basis: Begin with whatever can be agreed upon, and then tighten it as evidence accumulates.[28] The substance of those efforts does not transfer to healthy living. The format does. Nor would such a coalition need to create a new convening infrastructure from scratch. Initial exchanges could take place alongside established global gatherings where senior government leaders already come together—such as the World Bank, World Economic Forum, and International Monetary Fund annual meetings, and the UN General Assembly, or the G20—as well as health-focused platforms such as Abu Dhabi Future Health Week, which is designed in part as a launch point for global initiatives (see sidebar "Abu Dhabi's Healthy Living agenda: A cross-government model example").

[26] First Movers Coalition, World Economic Forum, 2026; Note: None of this is friction-free. An agenda that changes what people buy and how they spend their time will move value between categories and companies, and those most exposed today may have the least reason to move first. But this isn't a zero-sum game—early movers stand to capture new value that exceeds redistributed share. A coalition can make that first move safe, in a way no single company can, by leveling the playing field.

[27] "Qatar hosts high-level event focused on healthy longevity," Qatar News Agency, May 23, 2026.

[28] An example of such an approach is provided by the ozone regime, where the Toronto Group—a handful of governments meeting informally from 1983 alongside the formal negotiations, under the Chatham House Rule so officials could speak without attribution—built the consensus that became the 1985 Vienna Convention and the 1987 Montreal Protocol, the only environmental treaty to achieve universal membership. Stephen O. Andersen and Marco González, *A brief history of the Toronto, Stockholm and Accra-Helsinki Groups: The importance of the Toronto Group, Stockholm Group, and Accra-Helsinki Group in protecting stratospheric ozone and climate*, UNEP Ozone Secretariat, July 2025.

Sidebar

Abu Dhabi's Healthy Living agenda: A cross-government model example

The McKinsey Health Institute (MHI) and Abu Dhabi have previously collaborated on a blueprint for metabolic health, which helped inform Abu Dhabi's Healthy Living agenda. Today, Abu Dhabi leaders are focused on preventing disease and creating conditions for longer, healthier lives. The Undersecretary of the Department of Health, Abu Dhabi, noted that this requires systems that anticipate risk, intervene earlier, and create conditions for people to remain healthy throughout their lives.

Government leaders added that healthy living starts by understanding how much of living in good health happens outside of the healthcare system. Across more than 28 initiatives, Future Health—A Global Initiative by Abu Dhabi is bringing together government entities, the private sector, and communities to drive system-level change—from the food environment and physical activity to the wider settings in which people live, work, and learn, they said.

The strategy spans five dimensions:

- infrastructure to build and enhance spaces for physical activity, making it more accessible and within a five-to-ten-minute driving distance for everyone in Abu Dhabi
- programs to increase physical activity and promote healthier nutrition across schools, workplaces, and communities
- regulations and nudges to reduce exposure to unhealthy choices and make healthier choices easier
- promotion to strengthen health literacy and awareness
- medical care to expand access to treatments and innovative care models such as "Food as Medicine" and "Exercise as Medicine"

Early initiatives demonstrate how the strategy is translating into practical change. Abu Dhabi has introduced policies limiting unhealthy food and beverage advertising and prominent supermarket placement; mandated 210 minutes of physical activity per student per week alongside stronger school nutrition standards; and introduced healthier restaurant menu requirements, with calorie labeling to follow in 2027. Nutri-Mark, a color-coded front-of-pack labeling system, is helping consumers compare nutritional quality, while planned reformulation targets aim to reduce fat, sugar, and salt in commonly consumed products. Beyond nutrition, 1,600-plus free community physical activity events were delivered across Abu Dhabi, Al Ain, and Al Dhafra regions between October 2025 and July 2026, with the program set to expand. Government leaders noted that system-level change may start with political will but succeeds through collective accountability.

Data, insights, and behavioral science help us understand what is working, where we need to adapt, and where we can have the greatest impact, they added. That includes digital tools, disease registries, and population health intelligence systems that help Abu Dhabi identify priority populations, tailor interventions, and track effectiveness. A unified digital health infrastructure connects clinical data with population-level insights and positions the emirate to integrate emerging data streams from consumer sensing technologies such as smartwatches, rings, bands, and beds.[1]

[1] Future Health—A Global Initiative by Abu Dhabi, accessed September 2026.

One reservation deserves a direct answer, because it's often at the heart of the matter: that the returns on healthy living arrive long after whoever commissioned them left the room. Some do. But the assumption is more pessimistic than the evidence, and the fastest returns come not from restricting what people can do, but from investing in what they can do. Singapore's National Steps Challenge is a case in point. Launched in 2015, it offered residents a free activity tracker and reward points redeemable against everyday vouchers. Across its first four seasons, it drew in roughly 1.3 million people, or about a quarter of the adult population, and participants recorded about 1,500 additional steps a day during a five-month challenge season.[29] No new institution and no new rules—just a well-designed program, funded and launched, with participation and behavior change visible within months. Healthy living does have a long tail of compounding returns. But it also can yield early, measurable, and publishable wins that leaders can secure well within their performance horizons.

Which leaves the question of who moves first. The answer is someone senior enough to convene the departments that shape daily life, and accountable enough to be judged on the result—a single, sector-specific minister rarely has both. In this case, there are three things worth considering. Name an owner for healthy living and give them a real mandate. Back one visible program that can show results within a year or two so that the agenda earns its next round of support. And join or help convene the exchange that does not yet exist, because those who help set the definitions and the measures will not spend the following decade adopting someone else's.

The evidence is in, the economics are compelling, and the blueprint is on the table. Healthy living is not waiting for discovery. It is waiting for the first few people willing to act as though the movement already exists, which is, in the end, how every movement has ever started. So, the question is a personal one: What will you attach your name to this year?

[29] Jiali Yao et al., "Bright spots, physical activity investments that work: National Steps Challenge, Singapore: a nationwide mHealth physical activity programme," *British Journal of Sports Medicine*, September 2020, Volume 54, Number 17; *Decade of healthy ageing: baseline report*, WHO, 2020.

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