

## 29 October 2025 - Healthy Ageing: physical activity in an ageing society - Oral evidence

Health and Social Care Committee

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Witnesses:

- Professor Chris Whitty, Chief Medical Officer at Department of Health and Social Care (DHSC)
- Dr Lis Boulton, Health and Care Policy Manager at Age UK
- Sir Muir Gray, Director of the Optimal Ageing Programme at University of Oxford
- Dr Carole Easton, Chief Executive at Centre for Ageing Better

The **Health and Social Care Committee**, chaired by **Layla Moran**, opened a new inquiry examining how physical activity contributes to healthy ageing, independence, and the sustainability of health and social care services. The evidence session featured **Professor Sir Chris Whitty**, Chief Medical Officer (Department of Health and Social Care), followed by **Dr Carole Easton** (Centre for Ageing Better), **Dr Lis Boulton** (Age UK), and **Sir Muir Gray** (Live Longer Better Programme).

At the heart of the discussion was the recognition that the UK's population is ageing rapidly, and that this demographic shift requires a recalibration of both **public health priorities** and **social care policy**. Whitty stressed that the ageing of the population is not speculative—"all these people are already alive"—and will continue until at least 2066. The inquiry sought to explore the intersection of **physical activity, health inequalities, prevention, and social infrastructure**, considering how early and sustained interventions can reduce dependency and pressure on services.

### Demographic Pressures and Inequalities

Professor Whitty's evidence painted a stark picture of the demographic landscape. Since the foundation of the NHS, the number of older people has more than tripled, and this trend will persist for decades. However, ageing is not uniformly experienced: **those in affluent areas not only live longer but also enjoy over a decade more in good health compared with those in deprived areas**. This health gap—driven by preventable factors such as smoking, poor housing, inactivity, and air pollution—was described as one of the most pressing public health inequalities of the age. Reducing it, Whitty argued, is crucial to maintaining the viability of both the NHS and the **adult social care system**, as fewer years of ill health would directly translate into reduced demand for intensive care services.

### Healthy Ageing and Dementia Prevention

One of the most significant issues discussed was dementia. Whitty cited evidence that approximately **40% of dementia cases are preventable**, largely through interventions earlier in life. He rejected the notion that dementia is an inevitable outcome of ageing, emphasising instead that it can be delayed substantially through lifestyle factors such as physical activity, blood pressure control, smoking cessation, and hearing loss management. Delaying dementia

onset by just five years could halve the national prevalence. He urged policymakers to focus on **quality of years lived**, not merely life expectancy, as a guiding principle for both **health and social care system design**.

### **Physical Activity and Preventive Health Policy**

The Committee probed the kinds of physical activity that bring the greatest benefit. Whitty explained that even modest exercise—4,000 steps a few times a week—can yield dramatic reductions in mortality, and that improving access to safe, local, and affordable opportunities for movement could have far-reaching public health and social outcomes. He identified physical activity as a multi-benefit intervention, positively impacting cardiovascular disease, diabetes, dementia, and mental health, while simultaneously **reducing the need for long-term care**.

He called for long-term thinking across Government, lamenting that many departments still operate on “three-year return on investment models” that discount benefits realised over decades. Whitty urged a **mission-led approach to Government**, coordinated by the Treasury or Cabinet Office, to overcome departmental silos, as benefits from prevention often accrue to a different department than the one shouldering the initial cost. He also touched on the potential for **joint funding models** across departments to share accountability for population health outcomes.

### **Local Environments, Housing, and Community Design**

Committee members raised questions about the role of local government and the built environment in supporting older adults’ physical activity. Whitty agreed that **investment in basic infrastructure—safe pavements, street lighting, benches, public toilets—was critical**. These, he said, are not luxuries but health interventions, preventing falls and promoting mobility. Later witnesses, particularly **Dr Easton**, expanded on this, highlighting that **millions live in homes unfit for good health**, and that housing policy should be recognised as part of the **health and social care continuum**. Poor housing conditions, including damp and mould, deter movement and accelerate frailty; conversely, investment in safe, accessible homes could yield substantial savings for the NHS and social care budgets.

### **Voluntary Sector and Social Prescribing**

The second witness panel underscored the importance of the **voluntary and community sector** in promoting healthy ageing. **Dr Boulton** of Age UK explained that while many older adults understand the value of exercise, they lack the confidence or social networks to engage in it. She recommended **reframing messaging** around “movement” rather than “exercise”, to appeal to those who do not see themselves as sporty. She also called for **paid support for community groups** to ensure sustainability, noting that many rely on volunteers who may themselves become frail or assume caring roles.

Social isolation was linked closely to inactivity, with Age UK’s annual research showing persistent post-pandemic withdrawal among older people. Both Boulton and Easton advocated for **social prescribing models** that connect individuals to community activity—walking groups, dance classes, knitting circles—but warned that **funding for voluntary organisations is declining sharply**, undermining local capacity. They recommended ensuring “money follows the person”

and **mandating voluntary sector delivery** of social prescribing rather than relying solely on GP staff.

### Digital Inclusion and Innovation

Sir Muir Gray introduced the concept of “**digital prescribing**”, where GPs could automatically link patients to local activity programmes through integrated databases. However, witnesses agreed that **digital exclusion remains a major barrier** for many older people. While Age UK is running digital skills training, Boulton cautioned that a segment of the population will always remain offline, and alternative engagement methods are essential. The NHS app’s role as a “digital front door” was debated, with concerns that physical activity promotion could become marginalised within its structure.

### Prevention, Learning, and ‘Renaissance’ Thinking

Gray also advocated for a cultural shift towards “**pre-renaissance planning**” rather than retirement, promoting lifelong learning as a health intervention. He argued that **knowledge is the “elixir of life”**, urging government to harness pension and insurance networks to deliver learning about healthy ageing. He suggested that pension providers, employers, and unions all have a role to play in educating citizens on health and wellbeing in later life.

### Governance and Strategic Leadership

The witnesses repeatedly called for **systemic leadership and coordination across government**. Dr Easton proposed creating a **Commissioner for Older People and Ageing**, based in the **Cabinet Office**, to champion cross-departmental strategy on ageing—spanning housing, health, environment, and employment. She argued that population ageing should be treated with the same seriousness as climate change, with an explicit **government mission** to deliver age-friendly communities. Easton also described the **Age-Friendly Communities initiative**, highlighting practical examples like *Take a Seat* in Barnsley and toilet strategies in Cardiff, which make everyday mobility easier for older citizens.

Sir Muir Gray likened the challenge to a military campaign requiring “strategic objectives owned by the Committee,” advocating for population-based goals aligned across NHS, ICBs (Integrated Care Boards), and local neighbourhoods. He and Easton both stressed the need for **a joined-up national approach** linking health, social care, housing, and community sectors.

### Adult Social Care Relevance

Throughout the session, witnesses explicitly tied preventive measures to **reducing the burden on adult social care**. Whitty emphasised that narrowing the health gap between rich and poor could “substantially reduce the pressure on NHS and social care services.” Likewise, Gray and Easton argued that enabling older adults to remain active and independent longer would ease future care costs and workforce pressures. There was consensus that **prevention policy, housing investment, and community engagement must be integrated into social care strategy** if the sector is to remain sustainable.

### Closing Reflections and Recommendations

In concluding remarks, the witnesses were asked what one policy change they would implement if they were Prime Minister. **Dr Easton** proposed a **commissioner for ageing** with a cross-cutting national strategy. **Sir Muir Gray** suggested universal learning opportunities for those aged 60 and above to enhance contribution and wellbeing. **Dr Boulton** called for mandated voluntary sector participation in primary care. Collectively, their responses encapsulated the inquiry's message: healthy ageing is not a single-department issue but a national mission requiring coordination, long-term vision, and prevention-led policy.