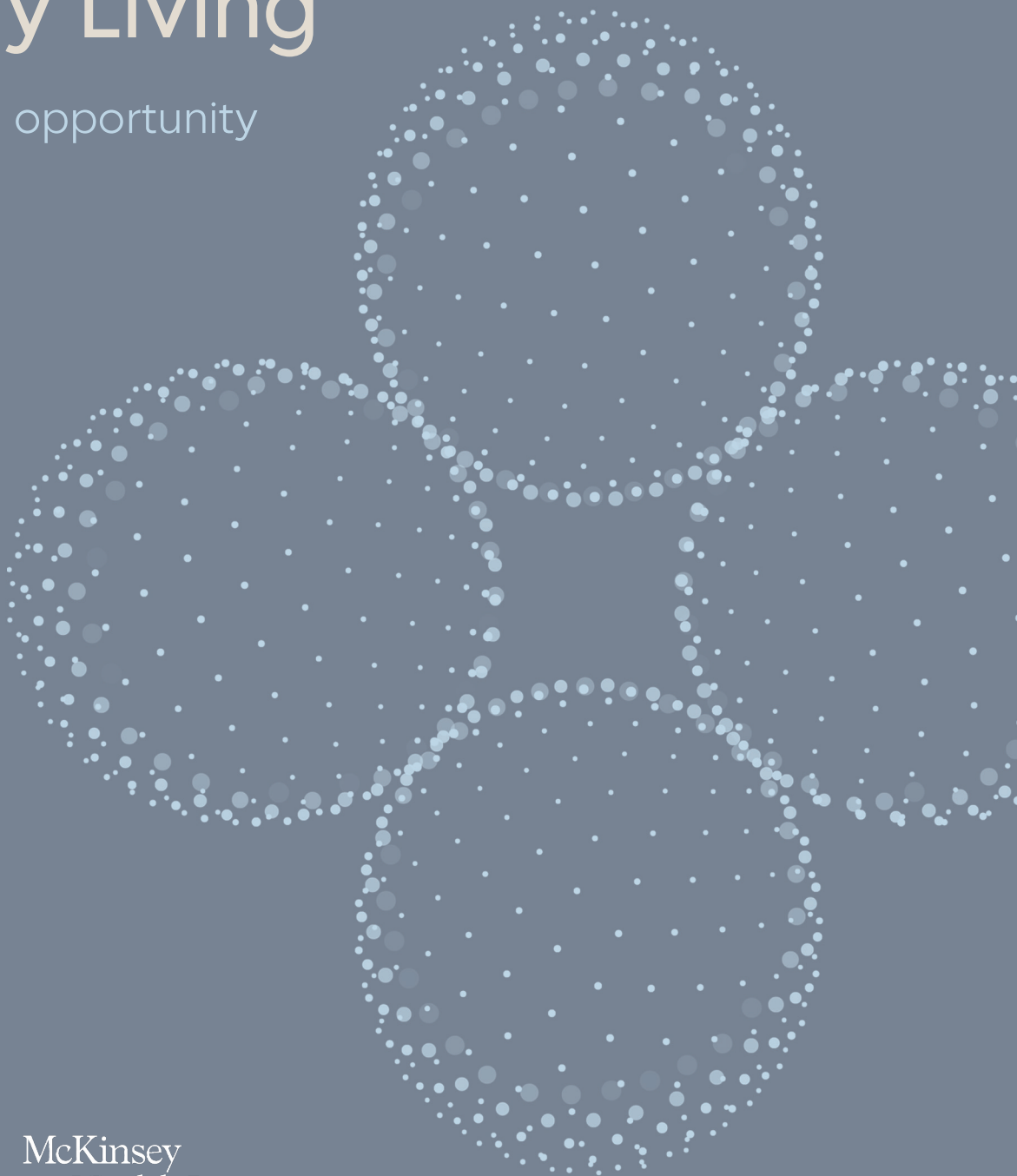
FUTURE HEALTH | A GLOBAL INITIATIVE BY ABU DHABI

The Future of Healthy Living

A $16.4 trillion opportunity



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Terminology

Term	Definition
Disability-adjusted life years (DALYs)	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.[1]
Disease burden	The impact of health loss attributable to diseases and injuries, encompassing both premature mortality and non-fatal health loss.[2]
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.[3]
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.[1]
Healthy longevity	The ability to live longer while spending more of those years in good health, with preserved function, wellbeing, and independence.[4]
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.[5]
Modifiable risk factor	An attribute, behaviour, exposure, or other factor which is causally associated with the probability of a disease or injury and is amendable to modification through behaviour, clinical care, policy, environment, or system-level intervention.[1]
Noncommunicable disease (NCD)	A disease that is typically non-infectious in origin and is not transmitted from one individual to another. Major NCDs include cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes.[6]
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.[7]
Years lived with disability (YLD)	Years lived with any short-term or long-term health loss.[1]

[1]Institute for Health Metrics and Evaluation, *GBD 2021 Data and Tools Guide* (2024).
[2]GBD 2021 Diseases and Injuries Collaborators, "Global Incidence, Prevalence, Years Lived with Disability (YLDs), Disability-Adjusted Life-Years (DALYs), and Healthy Life Expectancy (HALE) for 371 Diseases and Injuries in 204 Countries and Territories and 811 Subnational Locations, 1990–2021: A Systematic Analysis for the Global Burden of Disease Study 2021," The Lancet 403, no. 10440 (2024): 2133–2161.
[3]World Health Organization, "Social Determinants of Health."
[4] National Academy of Medicine and Commission for a Global Roadmap for Healthy Longevity, *Global Roadmap for Healthy Longevity* (Washington, DC: National Academies Press, 2022).
[5]World Economic Forum, *Catalysing Cross-Sector Leadership for Metabolic Health* (2026).
[6]U.S. National Library of Medicine, "Noncommunicable Diseases," *Medical Subject Headings (MeSH).*
[7]Arash Shaban-Nejad, Martin Michalowski and David L. Buckeridge, "Health Intelligence: How Artificial Intelligence Transforms Population and Personalized Health," *npj Digital Medicine* 1 (2018): 53.

The Future of Healthy Living: A $16.4 trillion opportunity

Future Health – A Global Initiative by Abu Dhabi, in collaboration with the McKinsey Health Institute, explore how addressing modifiable risk factors could add 12 years to healthy life expectancy at birth and create a $16.4 trillion opportunity by 2050, drawing on new analysis by MHI.

Faced with ageing 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 behavioural, metabolic and environmental risk factors could generate an estimated US $16.4 trillion in annual GDP increase globally, according to a new McKinsey Health Institute analysis. This is equivalent to an estimated 9% of total GDP in 2050.

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 mobilise a broad, cross-government healthy living agenda. As healthy longevity increasingly becomes a priority around the world, scaling progress creates an opportunity for centres of government to lead action across the sectors that shape health, supported by stronger evidence, tools, and meaningful opportunities to learn from others.

This whitepaper 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.

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 while living in a way that also maximises years in great health still to come. People who are thriving have strong physical, mental, social and spiritual health[8]; they have high levels of energy, resilience, connection, and sense of purpose across the life course. Over time, healthy living is the foundation for healthy longevity.

Unfortunately, as MHI has previously explored[9], healthy living remains out of reach for large parts of the population. Globally, people spend roughly half of their life in less-than-great health, including years marked by pain, limited mobility, impaired senses, cognitive decline, or loss of independence[8]. The drivers are widespread: one in three adults globally do not meet 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 out of ten adults are in suboptimal cardiometabolic health[10]. This means healthy living cannot be treated as a niche wellness goal, but instead a population-scale challenge shaped by everyday environments, behaviours, and systems.

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 neighbourhoods 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 the ambition and leading the change.

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

1. **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[11]. For an individual, that means more years of healthy life and more years being productive without additional social or healthcare support.

2. **The economic opportunity is significant**. Globally, in this new analysis MHI finds that the total economic impact in 2050 of investing in healthy living could equate to 9% of projected GDP, or US $16.4 trillion. With an opportunity at that scale, healthy living is a primary candidate for cross-sector investment at a national scale.

[8]McKinsey Health Institute, Adding Years to Life and Life to Years (McKinsey & Company, 2022).
[9]Hemant Ahlawat et al., "Age Is Just a Number: How Older Adults View Healthy Aging," McKinsey Health Institute (2023).
[10]World Health Organization, "Nearly 1.8 Billion Adults at Risk of Disease from Not Doing Enough Physical Activity" (2024); World Health Organization, "Billions of People Still Breathe Unhealthy Air: New WHO Data" (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* 80, no. 2 (2022): 138–151.
[11]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 IHME forecasts.

3. **The high cost of inaction.** Current forecast of global healthcare spending in 2050 is nearly 2 times higher than in a future where governments act to enable healthy living and modifiable risk factors are eliminated[12]. Several advanced health systems — including in the United States and France — face projected fiscal pressures and shortfalls driven in part by rising healthcare costs.[13] 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.

4. **Most health drivers sit outside healthcare.** Of the 23 modifiable drivers of health (see Exhibit 1), 19 sit outside of the formal healthcare system[14], 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 that lead to poor health, facilitate healthy longevity, and generate substantial economic returns.

5. **People want it.** In a 2025 survey of more than 9,000 US respondents[15], up to 60% of respondents reported that healthy ageing is a "top" or "very important" priority. People associate healthy ageing 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 emphasise health, sleep, and nutrition, while older generations focus more on independence, social connection, and purpose.[16] Importantly for governments, many respondents report 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.

6. **There is now a window of opportunity**. The emergence of GLP-1–based therapies has catalysed a new level of attention to obesity and metabolic health, bringing these issues more firmly onto the agendas of governments, health systems, employers, and investors. This momentum extends beyond the therapies themselves: it has helped shift perceptions of obesity, stimulated innovation and investment, and created greater urgency around addressing metabolic health. GLP-1s alone will not deliver a metabolic health revolution[17], but they have helped open a window for broader action - creating an opportunity for leaders[18] to advance prevention, improve environments and incentives, and address the wider drivers of metabolic health.

[12]Estimate assumes healthcare spending scales roughly linearly with changes in disease burden as measured in 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.

[13]Congressional Budget Office, *The Long-Term Budget Outlook: 2025 to 2055* (2025); OECD, *OECD Economic Surveys: France 2026* (Organisation for Economic Co-operation and Development, 2026); OECD, *Fiscal Sustainability of Health Systems* (OECD Publishing, 2024).

[14]McKinsey Health Institute, *Table 1: The Healthy 23 Drivers* (McKinsey & Company, 2023).

[15]McKinsey & Company, *Future of Wellness Survey* (2025).

[16]Anna Pione et al., "The $2 Trillion Global Wellness Market Gets a Millennial and Gen Z Glow-Up", McKinsey & Company (2025); Hemant Ahlawat et al., "Age Is Just a Number: How Older Adults View Healthy Aging," McKinsey Health Institute (2023).

[17]Anas El Turabi, Drew Ungerman, Hemant Ahlawat and Lars Hartenstein, *The Path Toward a Metabolic Health Revolution* (McKinsey Health Institute, 2025).

[18]McKinsey Health Institute and World Economic Forum, *Catalysing Cross-Sector Leadership for Metabolic Health* (2026).

Exhibit 1:

Healthy living includes 23 drivers of health, most of which sit outside of the traditional healthcare systems

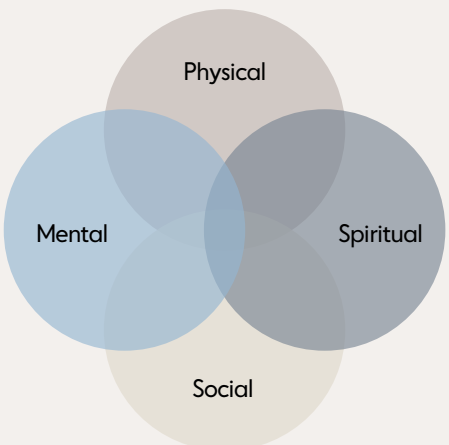
Drivers outside the healthcare system

Physical inputs
Diet
Supplementation
Substance use

Movement
Mobility (daily movement)
Exercise
Sleep

Daily living
Productive activity
Social interaction
Content consumption
Hygiene

Across four dimensions of well-being



Exposure
Nature
Atmosphere
Sensory
Materials
Stress

State of being
Mindsets/beliefs
Body composition
Physical security
Economic security

Healthcare
Vaccination
Detection/diagnosis
Clinical intervention
Adherence

Notes: Drivers of health are complex, non-linear (e.g. J-curves, U curves) and interact with each other. Grounded in the World Health Organization's definition of health: "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity"; Constitution of World Health Organization, WHO, 1948.

Source: McKinsey Health Institute, "The Secret to Great Health? Escaping the Healthcare Matrix", 2022.

A practical healthy living agenda could start with a small number of priority drivers (for example, diet, physical activity, and clinical interventions targeted at metabolic diseases) that are both highly influential and actionable at population level. The objective is not to prescribe a single intervention, but to build a coordinated portfolio that makes healthier choices more available, affordable, and easier to sustain.

The execution of a healthy living agenda relies on cross-government leadership. Many of the most important drivers of healthy living are shaped by ministries and sectors that do not define themselves as part of the health system, including education, transport, urban planning, food, technology, labour, 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.

Chapter 2: Sizing country-specific risk factors shows where to focus for the greatest health and economic value

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

The answer will differ by country and geography. The modifiable risk factors driving poor health are not distributed evenly across populations, and neither is the health or economic value associated with addressing them. To help build a potential knowledge base on where attention could be prioritised, MHI quantifies the potential.

The analysis takes a future-looking view by sizing the value at stake in 2050 through the two lenses: health impact, measured through years of life lost and years of life in disability (DALYs) averted by eliminating modifiable risk factors[19], 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 prioritising areas where public policy, regulation, infrastructure, service delivery, and partnership can drive both health outcomes and economic benefit.

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 modelling a world without exposure to modifiable environmental, behavioural, and metabolic risk factors, leveraging risk factor data from IHME's Global Burden of Disease (GBD) study. This analysis provides a complementary perspective to our analysis in Health of Nations[20]: whereas that work estimated 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 would 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 everybody eats healthily, so we model potential through the full elimination of dietary risk, while Health of Nations would focus on modelling the impact of existing, clinically evidenced interventions such as nutrition programs and GLP-1s.

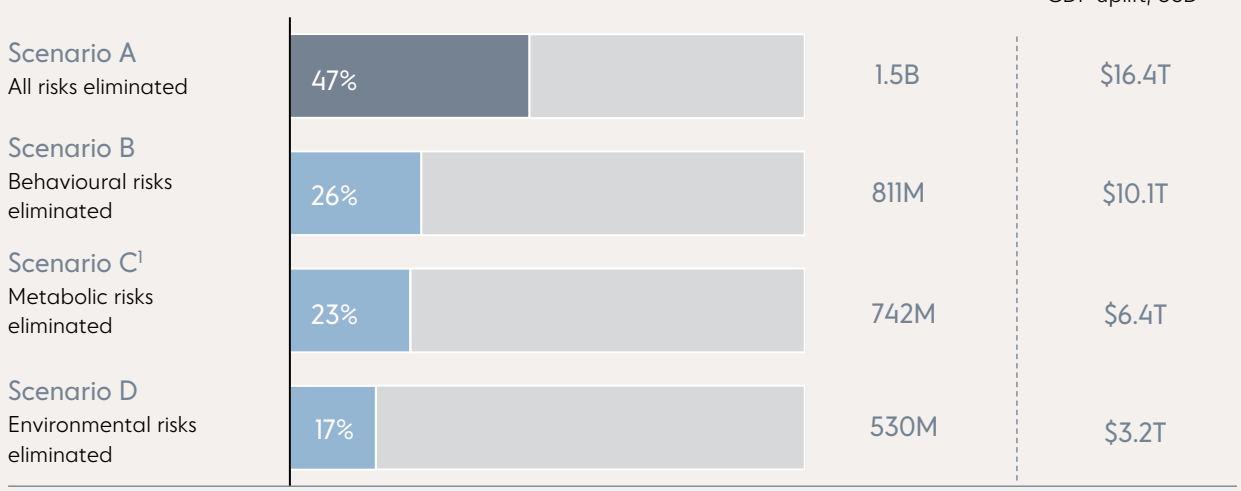
[19]An attribute, behaviour, exposure, or other factor which is causally associated with the probability of a disease or injury and is amendable to modification through behaviour, clinical care, policy, environment, or system-level intervention. The health impact of factors such as high BMI or high systolic blood pressure on disease burden can be quantified as disability-adjusted life years (DALYs), that are attributable to risk factors. The Institute for Health Metrics and Evaluation (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 disease burden for 2026, these risk factors contribute 1.2 billion DALYs to the global disease burden.

[20]McKinsey Health Institute, *The Health of Nations: Stronger Health, Stronger Economies* (McKinsey & Company, 2026).

The numbers are substantial across four broad scenarios of eliminating modifiable risk factors (see Exhibit 2). Globally, the potential economic impact in 2050 of investing in healthy living and eliminating all modifiable risk factors (Scenario A) could reach US $16.4 trillion, 9% of total GDP in 2050[21]. The total health burden averted reaches 1.5 billion DALYs, equivalent to approximately 47% of global disease burden in 2050.

Exhibit 2 : Full elimination of modifiable risk factors could avert 47% of global disease burden and generate US $16.4 trillion in annual GDP uplift in 2050

These scenarios are not additive, as individual diseases are often attributable to multiple interacting risk factors.[22]



1. Scenario C (elimination of all metabolic risks) was also modeled in MHI's previous publication, The path toward a metabolic health revolution, using the same methodology. 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.
Methods: 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.
Source: IHME Global Burden of Disease GBD 2021 data, extended to 2050 via IHME's disease-burden forecast growth.

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 (see Exhibit 3 for a select set of example countries).

[21]This is nearly 3 times the potential economic impact of US $6 trillion from eliminating all modifiable risk factors today (2026).
[22]Scenarios B through D are not additive portions of Scenario A. Across the three scenarios B through D, estimates of DALYs averted account for all DALYs attributable to that specific risk factor plus those attributable to the intersection of that risk factor with the risk factor of one or both of the other two scenarios. For this reason, summing scenarios B through D would overestimate the potential impact of all risk factors – behavioural, metabolic, and environmental – being eliminated. Scenario A avoids this overestimation by only accounting for intersections once.

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 sample countries analysed, with 50% of the overall disease burden driven by modifiable risk factors. Related trends in Saudi Arabia include rising prevalence of obesity, with high BMI becoming the number one leading risk factor for males and females in 2021, and behavioural risk factors such as dietary risk and tobacco playing a role.[23]

- In India, the modifiable share of disease burden is 49% — the fourth highest among countries analysed — translating to a potential 9.8% 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.[24]

- In the United States, the share of disease burden attributable to modifiable risk factors is lower (45%), but still one of the highest among high-income countries analysed. Leading risk factors include high BMI, high fasting plasma glucose, tobacco, and drug use.[25]

- In Italy and Germany, the share of disease burden that is modifiable is similar, at 40% and 42% respectively – a ~5% relative difference. However, the estimated GDP uplift differs more substantially, at 5.0% of GDP in Italy versus 7.0% in Germany – a ~40% relative difference. Italy also ranks among the lowest of high-income countries analysed in terms of relative GDP uplift. This demonstrates how the translation of health gains into economic uplift depends on various factors. Among other variables, Italy has one of the world's oldest populations[26], meaning more burden sits in 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%) than other sample countries, though opportunity remains meaningful, particularly as high fasting plasma glucose rises as the leading risk factor alongside increasing diabetes rates.[27]

[23]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 over 26% in 2022 according to data from the World Health Organization; Zaidan, A. (2025). Three decades of trends in risk factors attributed to disease burden in Saudi Arabia: Findings from the Global Burden of Disease Study 2021. *Healthcare*, 13, no. 14, 1717.

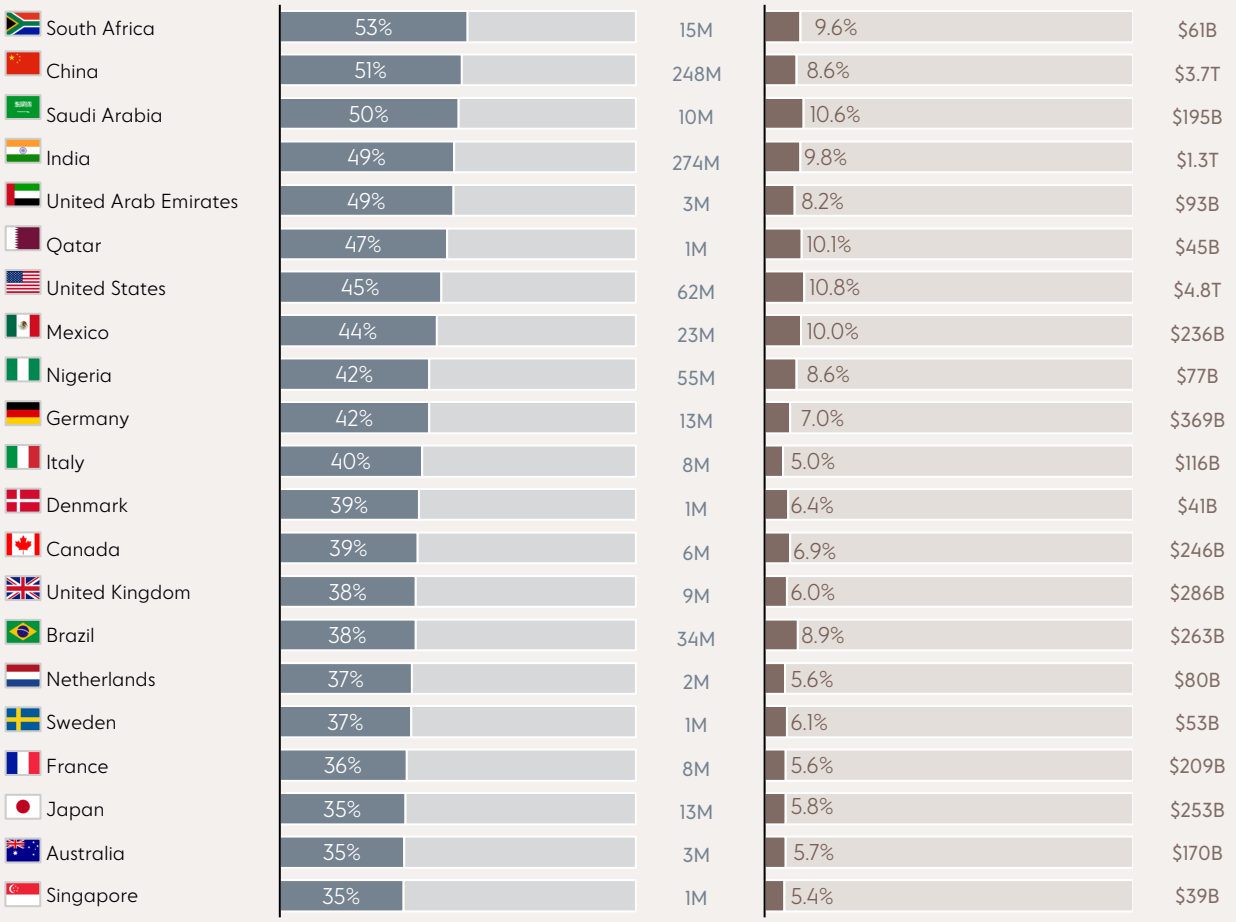
[24]Jain, Neha, Srinivas Goli, and Arjun Jana. "Population Age Structural Transition, Demographic Dividend and Economic Growth in India." *Humanities and Social Sciences Communications* 12 (2025): 771.; Fang, T., Di, Y., Liu, Y., et al. (2025). Temporal trends of particulate matter pollution and its health burden, 1990–2021, with projections to 2036: A systematic analysis for the Global Burden of Disease Study 2021. *Frontiers in Public Health*, 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* 10, no. 5 (2022): e2100569; Roy, Chandan, 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* (2025).; Meekang Sung et al. "Temporal change in prevalence of BMI categories in India: Patterns across states and union territories, 1999–2021", *BMC Public Health*, 24 (2024):1322.

[25]GBD 2021 US Burden of Disease Collaborators, "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," *The Lancet* 404, no. 10469 (2024): 2314–2340

[26]Mohsen Naghavi et al., "State of Health and Inequalities among Italian Regions from 2000 to 2021: A Systematic Analysis Based on the Global Burden of Disease Study 2021," *The Lancet Public Health* 10, no. 4 (2025): e309–e320.

[27]From 1990 to 2021, Japan shows consistently negative annual rates of change for leading risk factors of high systolic blood pressure and tobacco; Nomura, S., Murakami, M., Sakamoto, H., et al. (2025). Three decades of population health changes in Japan, 1990–2021: A subnational analysis for the Global Burden of Disease Study 2021. *The Lancet Public Health* 10, no. 4 (2025): e321–e332.

Exhibit 3: The health and economic impact of eliminating modifiable risk varies by country

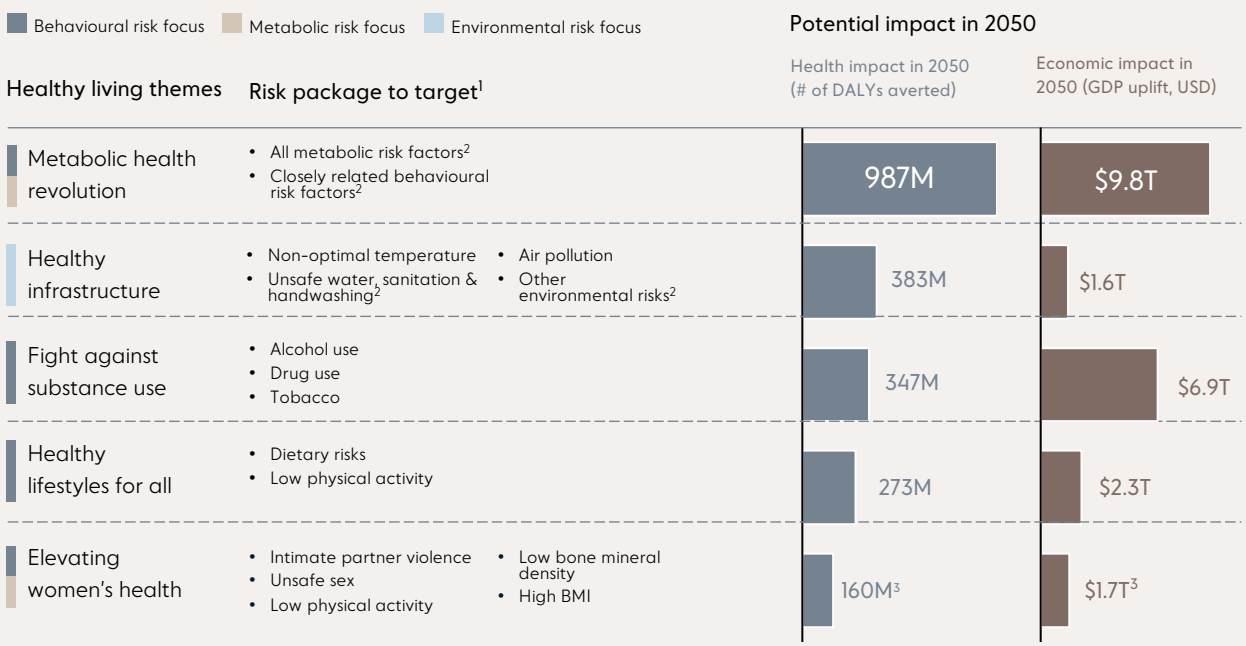


Methods: Counterfactual scenario modeled across all risks (Scenario A), assuming 100% of risk-attributable burden averted, per country. Economic impact is estimated by translating averted deaths and disability into additional effective workforce participation and productivity, adjusted for labor-force participation and employment, and valued using GDP per employed worker.

Source: IHME Global Burden of Disease GBD 2021 data, extended to 2050 via IHME's disease-burden forecast growth.

What are practical ways to prioritise 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 (see Exhibit 4). For example, government stakeholders could focus on delivering metabolic health for all, or a "metabolic health revolution". An approach that is compelling in countries where the associated disease burden is elevated. It would mean targeting metabolic health risk factors, from high BMI to high systolic blood pressure, as well as key behaviours like dietary risk and low physical activity. Abu Dhabi is a case in point (see Chapter 3), 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.

Exhibit 4: Leaders can strategically prioritise themes and target an associated "package" of risk factors



1. Packages should not be viewed as additive as some risk factors repeat across risk packages. Summing impact of risk packages may create duplicative accounting of DALYs attributable to modifiable risk factors
2. Metabolic risk factors includes the following: high BMI; high fasting plasma glucose; high LDL cholesterol; high systolic blood pressure; impaired kidney function; low bone mineral density. Closely related behavioural risks includes the following: alcohol use; child and maternal malnutrition; dietary risks; low physical activity. Unsafe water, sanitation, & handwashing includes the following: unsafe water source, unsafe sanitation, and no access to handwashing facility. Other environmental risks includes the following: residential radon, lead exposure in blood, lead exposure in bone
3. The risk factors in the elevating women's health risks package were selected based on the top 5 risk factors for which the share of risk-attributable-burden disproportionately falls on women in the IHME GBD 2021 dataset. Impact in 2050 for the elevating women's health risks package reflects the share of risk-attributable burden among females only and the corresponding GDP uplift. Impact of eliminating modifiable risks on women extends beyond the elevating women's health risks package, and the package itself also impacts both sexes. Across all individuals, the women's health package is estimated to address 280M DALYs of risk-attributable burden and generate $3.8T 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.
Methods: Analysis conducted using IHME 2021 Global Burden of Disease Dataset. Economic impact is estimated by translating averted deaths and disability into additional effective workforce participation and productivity, adjusted for labour-force participation and employment, and valued using GDP per employed worker.

Source: IHME Global Burden of Disease GBD 2021 data, extended to 2050 via IHME's disease-burden forecast growth.

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. 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 US $6.9 trillion in GDP uplift.

With these considerations in mind, leaders can select a thematic focus and associated package of risk factors that aligns with existing momentum, quantify the case for investment, and define the cross-sector coalition needed to deliver it.[28] The next step is turning priorities into action.

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

Chapter 3: Abu Dhabi's Healthy Living agenda: a cross-government model in action

For governments seeking to advance healthy living at scale, the analysis in the previous chapter offers data-driven support to move from aspirations to a focused agenda. It identifies key risk factors, the scale of potential health and economic return, and themes for coordinated action across sectors.

MHI and Abu Dhabi have previously collaborated on a blueprint for metabolic health, which helped inform Abu Dhabi's Healthy Living agenda. This chapter presents Abu Dhabi's experience as a series of questions and answers by leaders from Abu Dhabi.

Abu Dhabi's experience illustrates something beyond the data: how a healthy living agenda can be framed not only as a health-sector strategy, but as a top-of-government delivery effort that mobilises multiple government entities and private sector partners around shared outcomes. Importantly, it also highlights how health system partners can play a vital supporting role within a whole-of-society agenda.

Undersecretary of the Department of Health- Abu Dhabi, H.E. Dr. Noura Al Ghaithi, explains the motivations and vision for healthy living in Abu Dhabi:

"As people live longer and the burden of non-communicable diseases continues to rise, the way we think about health must evolve. The future of health cannot be built around treating illness alone: It requires a system that can anticipate risk, intervene earlier, and create conditions for people to remain healthy throughout their lives.

"For Abu Dhabi, this means moving progressively from a reactive model of care towards one that is proactive, predictive, and preventive. World-class clinical care remains fundamental, but the ambition in Abu Dhabi extends beyond what happens when someone becomes unwell. It is about looking upstream at the factors driving health and addressing them before they translate into disease."

What is Abu Dhabi's Healthy Living Strategy?

H.E. Dr Ahmed Alkhazraji, Executive Director, Healthy Living:

"Healthy Living starts from a simple premise: much of what determines our health happens outside the healthcare system. If we want to improve health at a population level, we need to shape the environments and everyday conditions that influence how people eat, move, sleep, and support their mental wellbeing.

"Healthy Living is designed as a whole-of-society effort. Across more than 28 initiatives, Healthy Living 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. The aim is to hardwire prevention and healthy living into everyday life, making healthier choices easier and more accessible for everyone."

In alignment with Abu Dhabi's Healthy Living Strategy, a portfolio of cross-sector initiatives is being implemented across five dimensions.

1. **Infrastructure:** Building new (and enhancing current) fitness infrastructure to make physical activity accessible within a five-to-ten-minute driving distance to everyone in Abu Dhabi – gyms, pools, pitches, courts, and walkways; infrastructure that enables people to be physically active

2. **Programs:** Increasing amounts of physical activity and promoting healthier nutrition across schools, workplaces, and the wider community

3. **Regulations & Nudges:** Limiting the visibility and influence of unhealthy food and beverages, while promoting and raising awareness of healthier practices

4. **Promotion:** Executing mass health campaigns to increase health literacy and raise awareness of available resources, making it easier and more accessible to be healthy

5. **Medical Care:** Expanding access to novel weight loss drugs, coupled with required lifestyle changes to support sustained weight loss, alongside innovative care delivery including "Food as Medicine" and "Exercise as Medicine"

Tangible examples show how Abu Dhabi's Healthy Living Strategy is translating into practical change:

- ***Reducing exposure to unhealthy food and beverage advertising:*** *In December 2025 Abu Dhabi introduced a policy to ensure responsible advertising of unhealthy food and beverage products[29] across out-of-home media, including billboards, street banners and other prominent public-facing assets. The policy aims to create a healthier information environment and reduce the influence of unhealthy food marketing on dietary choices.*

- ***Making healthier choices easier in supermarkets:*** *Newly-launched standards regulate the placement and promotion of less healthy food and beverage products[30] in prominent, high-exposure locations across physical and digital grocery environments – including entrances, checkouts and end-of-aisle displays. While all items remain on shelves and no products are banned, the aim is to reduce impulse purchases on unhealthy food and beverages while increasing the visibility and accessibility of healthier alternatives.*

- ***Children are eating better and moving more in schools:*** *New requirements were introduced in schools in November 2025 to ensure school-aged children engage in at least 30 minutes of moderate-to-vigorous physical activity each school day, alongside one 60-minute physical education session per week, a total of 210 minutes of physical activity per student per week. In addition, the list of restricted F&B products in schools was expanded to include high-fat and high-sugar foods, processed and fried foods, unhealthy beverages, and additive-containing foods. Schools must also provide meals customised to age-specific portion sizes and nutritional requirements based on the SEHHI healthy food initiative.*

- ***Creating more opportunities for communities to move:*** *Through a dedicated community health activation initiative more than 1,613 free, community-based physical activity events were delivered in Abu Dhabi, Al Ain and Al Dhafra regions, tailored to different fitness levels, age groups and communities between October 2025-July 2026. In 2027, the program is expanding from 10 to 21 districts across the emirate, bringing more opportunities to be active closer to where people live.*

- ***Making healthier choices easier when dining out:*** *Restaurants across Abu Dhabi have introduced healthier dining measures for consumers[31]. Starting with hotel restaurants, these requirements include a requirement for at least 50% of children's menu items to meet SEHHI healthy menu criteria[32], and at least one healthy option available across every menu category – starters, mains, desserts. Further, low-sodium salt was introduced as the default table option instead of regular table salt. This will be expanded to all restaurants in 2027.*

- ***Giving people clearer nutritional information:*** *Starting Q1 2027, calorie information will be required on physical and digital menus across establishments offering ready-to-eat food and beverages, helping people make more informed choices when eating out.*

- ***Making nutritional quality easier to understand at a glance:*** *Nutri-Mark[33], an easy-to-read, colour-coded front-of-pack nutrition labelling system launched in Abu Dhabi in November 2025 helps consumers make informed food choices, by making it easier to compare the nutritional quality of products within the same categories at the point of purchase.*

- ***Improving the nutritional profile of everyday foods:*** *Advanced planned mandatory reformulation targets across six highly consumed food and beverage categories, with proposed limits on fat, sugar and salt to drive system-wide improvements in the UAE's food supply. This shift is already underway: some of the country's most consumed beverages have reduced their sugar content by 20-60+%, while dairy producers such as Al Ain Farms are reformulating everyday products to further reduce added sugar.*

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[29]Department of Health – Abu Dhabi, Policy for Regulating Advertising of Unhealthy Food and Beverages on Out-of-Home Media Assets (2025).
[30]Abu Dhabi Media Office, "Healthy Living and Abu Dhabi Registration Authority Introduce New Responsible Placement of Food and Beverage Policy for Supermarkets and Their Online Platforms" (30 July 2026)
[31]Department of Culture and Tourism – Abu Dhabi, Circular No. 7/2026: Implementation of Mandatory Minimum Healthy Food Options in Hotel Restaurant Menus (2026).
[32]Abu Dhabi Public Health Centre, "SEHHI Programmes."
[33]Abu Dhabi Quality and Conformity Council, "Nutri-Mark: Overview."

How is Abu Dhabi organising and mobilising for success across government and sectors, and leveraging data, analytics, and innovations in artificial and population health intelligence to enable healthy living?

H.E. Dr Ahmed Alkhazraji, Executive Director, Healthy Living:

"System-level change starts with political will, but it succeeds through collective accountability. Healthy Living brings government entities, the private sector, and communities behind shared ambition, clear ownership, regular reporting on progress, and aligned success measures.

"Data, insights, and behavioural science help us understand what is working, where we need to adapt, and where we can have the greatest impact. For example, digital tools, including Sahatna, disease registries, and population health intelligence systems, help Abu Dhabi identify priority populations, tailor interventions, and track effectiveness. Malaffi, Abu Dhabi's 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.

"It is this combination of shared accountability and continuous learning that enables us to translate our ambition into measurable improvements in people's lives."

Perspectives from Future Health – A Global Initiative by Abu Dhabi Partners

While most drivers of healthy living sit outside the traditional healthcare system, it is still important to have a healthcare system fully enabling a broad healthy living agenda. A critical element of Abu Dhabi's approach is to not only bring partners beyond the health sector, but at the same time ensure the healthcare system remains supportive of the healthy living agenda.

Dr. Nicole Sirotin, CEO, IHLAD:

"Abu Dhabi has a real opportunity because it combines strong public-sector leadership, digital health infrastructure, population health programmes and a clear ambition to move from reactive care to more anticipatory models of health. The next step is to connect those strengths into clear pathways, so that when risks are identified, people can access the right interventions early. This also creates an opportunity to test and generate evidence around new approaches to prevention, understand what works, and support their integration into the broader health system. That is where IHLAD can contribute. We are not trying to recreate the health system. We are trying to help solve complex prevention problems, generate evidence, and hand what works back into the system."

Mr. Albarah El Khani, COO, M42:

"Today's tools can identify meaningful risk years before disease develops. Proteomics, multi-omics, genomic screening and liquid biopsy can reveal cardiovascular, cancer and other chronic disease risks long before symptoms appear, while providing deeper insight into the inherited and environmental factors that shape health outcomes across a lifetime. But technology alone does not improve outcomes. An identified risk only matters if people are screened and there is a clear pathway to act on what is found. Prevention therefore requires alignment across the health system, payors, government and individuals so early identification leads to meaningful intervention that extends healthspan, improves population health, and supports longer, healthier lives."

Mediclinic Middle East:

"Healthy-living services should be integrated into primary care, making prevention a more accessible and consistent part of the patient journey. Primary care is the natural setting for risk assessment, screening, behaviour-change support, monitoring and referral to specialist services. Healthcare providers can bring clinical governance, multidisciplinary expertise, trusted communication and validated testing to support this approach. Effective prevention also requires capabilities across lifestyle medicine, nutrition, genomics and digital health, supported by models of care that enable sustainable delivery."

Mr. Rashed Al Qubaisi, Group COO, PureHealth:

"The future of healthcare is not simply to treat disease better, but to make disease less inevitable. We have more knowledge than ever about what enables people to remain healthy, yet our systems are still largely designed to intervene after something goes wrong. The opportunity is to fundamentally shift that model - from episodic treatment to continuous health management, and from reacting to illness to anticipating and preventing it. By bringing together primary care, diagnostics, digital health, community-based interventions and personalised longevity services, we can make prevention more than a clinical intervention; we can make it part of how people live. The future of healthcare should be measured not only by how effectively we treat disease, but by how many healthy years we help people gain."

Dr. Essam Mohamed, Group CEO, Mubadala Bio

"Healthy living begins with prevention, but it must also be supported by strong life sciences capabilities that translate scientific progress into solutions people can access. As the burden of metabolic and other noncommunicable diseases grows, local pharmaceutical manufacturing, reliable supply chains and partnerships that expand access to innovative therapies can help health systems intervene earlier and sustain access at scale. These capabilities are an integral part of the healthy-living ecosystem, strengthening health system resilience while supporting better long-term outcomes for people."

Burjeel Holdings:

"For healthcare providers, healthy living means moving beyond episodic treatment toward continuous support: identifying risks earlier, offering practical counselling, connecting patients to prevention-focused care and following progress over time. These interventions scale best when embedded into structured care pathways rather than delivered as one-time advice. Providers cannot deliver healthy living alone, but they can make risks visible and actionable through screening, education, clinical support and follow-up, helping turn prevention into measurable outcomes."

Chapter 4: From ambition to impact: a disciplined delivery blueprint that could 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 health burden stems from modifiable behavioural, metabolic, and environmental risk factors - the challenge becomes as much about identifying what matters the most in a specific country context as about organising system players to act on it.

Many of the highest-impact drivers of healthy living 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 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 behaviour change that reduced road traffic deaths by over 20% in the past 15 years.[34] Likewise, worldwide sanitation reforms that turned every dollar invested in clean water supply and improved sewerage into five-time economic return from lower health costs, more productivity and fewer premature deaths.[35] 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 institutionalising learning over time (see Exhibit 5). To turn strategy into execution, it is critical to convene and align ministries, health systems, employers, communities, and private-sector actors around shared outcomes.

[34]World Health Organization, "Road Deaths Fall by 21% Globally, but Stronger Action Is Needed to Save Lives" (20 July 2026); World Health Organization, "Road Traffic Injuries."
[35]World Health Organization, Global Costs and Benefits of Drinking-Water Supply and Sanitation Interventions to Reach the MDG Target and Universal Coverage (2012).

Exhibit 5: 5 potential steps to lead a healthy living movement

Step	A blueprint of what this could mean in practice	Example
Step 01: 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 (max. 3-5) of 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 multi-year plans, the government established population-wide targets across physical activity, nutrition, smoking, alcohol consumption, and healthy ageing, creating a common agenda across ministries and public institutions.[36]
Step 02: 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 – deprioritise 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 policy makers with longitudinal health data across the population, including chronic disease burden, risk factors, and outcomes to develop targeted national prevention strategies.[37]

[36]Yasuyo Wada, "Start of the 12-Year Initiative for the Third Term of Health Japan 21," *Journal of the National Institute of Public Health* 73, no. 2 (2024): 68–78.
[37]Finnish Institute for Health and Welfare (THL), "Data and Statistics."

Step	A blueprint of what this could mean in practice	Example
Step 03: Design the portfolio	• **Sequence interventions**, organising 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 prioritised interventions • **Expand to a balanced portfolio in the long-term** with interventions spanning the environment, behaviour, 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 prioritising physical activity and nutrition as early focus areas to build momentum and demonstrate impact (see Chapter 3).
Step 04: Implement and scale	• **Prepare to implement** by establishing success indicators, feedback loops, scale-up criteria, and dedicated, sustained operating capacity • **Launch prioritised 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 two million participants through incentives, behavioural nudges, digital tools, and wearable technology to promote sustained physical activity and continuous program refinement.[38]

[38]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," *The Lancet Regional Health – Western Pacific* 68 (2026): 101831.

Step	A blueprint of what this could mean in practice	Example
Step 05: 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 • **Institutionalise 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 institutionalise learning. By creating an AI-enabled digital twin that integrates clinical, behavioural, 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. [39]

Governments now have a potential approach (see Exhibit 5). 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 centralised systems – which are often smaller countries – these drivers converge nationally, typically within the prime minister's office. In larger countries, they usually converge one level down, such as in a governor's office, where the departments that shape daily life already co-locate. In some contexts, they operate at the regional or continental level, where organisations such as the European Union inform many of the terms of 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.

[39]World Economic Forum, *A New Era for Digital Health: Abu Dhabi's Leap to Health Intelligence* (2026).

Chapter 5: Why healthy living has not scaled yet — and how to change that through global coalitions of the willing

The potential prize is extraordinary: addressing modifiable risk factors could add 12 years to healthy life expectancy at birth and create up to US $16.4 trillion in economic value by 2050, while inaction likely leaves global healthcare spending two to three times higher than it need be (Chapter 1). The blueprint for pursuing it is practical and increasingly well understood (Chapter 4). And some governments are already learning from it (Chapter 3).

So why is it 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 — transport, education, housing, agriculture, and industry – sits elsewhere. Companies compete on products whose health consequences land on public budgets decades later. The result: almost everyone in government affects healthy living, but nobody owns it. National ambitions need a cross-cutting and cross-sector agenda behind them, supported by global evidence and engagement.

That agenda can't just 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".[40] The harder, less charted work lies outside it — in science, measurement, technology, economics, and social fabric (see Exhibit 6). Five shifts can help make healthy living realistic at scale, and they hold regardless of a country's starting point.[41]

1. Science: build the evidence base for what actually drives healthy living.

The 19 modifiable drivers of health that sit outside the formal healthcare system (Exhibit 1) 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 non-healthcare and healthcare drivers is a global research agenda, and no single country can do it alone.

[40]McKinsey Health Institute, "The Secret to Great Health? Escaping the Healthcare Matrix" (2022).
[41]Refers to the 5-shifts framework for metabolic health, expanded to healthy living. McKinsey Health Institute and World Economic Forum, *Catalysing Cross-Sector Leadership for Metabolic Health* (2026).

2. Transparency: agree 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 healthily means across the drivers of health, while recognising that what people value and prioritise 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 is what could let a country steer toward healthy living rather than merely hope for it.

3. 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 non-diabetic people which foods spike their blood sugar, turning general dietary advice into personal feedback.[42] Point-of-purchase tools such as food-scanning apps deliver a legible verdict on a product in the seconds before someone buys it.[43] Wearables, home testing kits, and AI-based nutrition and exercise assistants extend the same logic across sleep, movement, and diet. Together they make something improvable that never was before at scale: the healthy living IQ of a population, 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.

4. Economy: make the healthy choice 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, 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.[44] 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 version 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 in spite of them.

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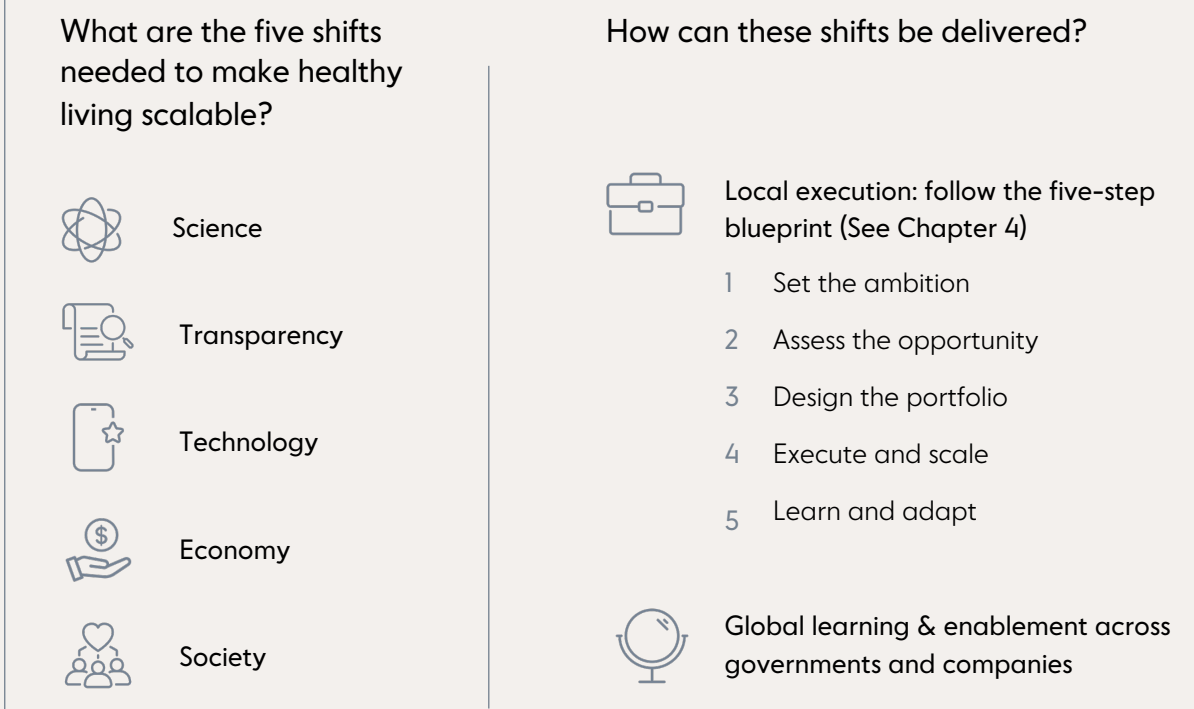
[42]David C. Klonoff et al., "Use of Continuous Glucose Monitors by People Without Diabetes: An Idea Whose Time Has Come?," *Journal of Diabetes Science and Technology* 17, no. 6 (2023): 1686–1697; Ty Ferguson et al., "Effectiveness of Wearable Activity Trackers to Increase Physical Activity and Improve Health: A Systematic Review of Systematic Reviews and Meta-Analyses," *The Lancet Digital Health* 4, no. 8 (2022): e615–e626.

[43]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* 98 (2022): 104535.

[44]Global Wellness Institute, *Global Wellness Economy Monitor 2025* (November 2025); Anna Pione et al., "The $2 Trillion Global Wellness Market Gets a Millennial and Gen Z Glow-Up," McKinsey & Company (2025).

5. Society: Make healthy living socially supported rather than individually heroic.
   Science, technology and economics all matter, but individual behaviour is often shaped by the people nearby. Schools, employers and community groups build the supportive environments that normalise 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.

Exhibit 6: Scaling healthy living globally is enabled by five shifts—and delivery at both local and global levels



Almost all of this would likely need to be delivered at the 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, multi-sector agenda on its own, and the support it most needs could come from two collaborations: one among governments, one among companies.

- A global coalition of companies. Employers, insurers, food and CPG 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.[45] That conversation widened at a business-building summit MHI co-hosted 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.[46]

  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; standardise 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 pooled commitments create markets no single buyer could.[47,48]

- 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, mobilising every department, and speaking constantly with counterparts about what they were seeing and trying. Much of that was improvised, but it showed change can happen quickly. It also showed governments doing what this paper suggests — acting as evidence accumulates, launching publicly, and adapting as they go. The blueprint in Chapter 4 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 any finished playbook.

  What the pandemic had and healthy living lacks is a sense of 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 4 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[49,50], 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.

[45]McKinsey Health Institute and World Economic Forum, *Catalysing Cross-Sector Leadership for Metabolic Health* (2026).
[46]McKinsey Health Institute, "Rising Interest in Addressing Metabolic Health as a Pathway to Thriving Societies and Economic Growth Is Rippling across Sectors and Industries," LinkedIn, 9 July 2026.
[47]World Economic Forum, "First Movers Coalition."
[48]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 levelling the playing field.
[49]Department of Health – Abu Dhabi, "Healthy Living".
[50]Qatar News Agency, "Qatar Hosts High-Level Event Focused on Healthy Longevity" (23 May 2026).

> 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, then tighten it as evidence accumulates.[51] 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 IMF annual meetings, and the UN General Assembly, or the G20 - as well as health-focused platforms such as the Abu Dhabi Future Health Summit, which is designed in part as a launch point for global initiatives.

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.

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, about a quarter of the adult population, and participants recorded about 1,500 additional steps a day during a five-month challenge season.[52] No new institution and no new rules - a well-designed program, funded and launched, with participation and behaviour change visible within months. Healthy living does have a long tail of compounding returns. But it can also 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?

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[51] 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; United Nations Environment Programme Ozone Secretariat, 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* (Nairobi: UNEP Ozone Secretariat, July 2025).

[52] Jiali Yao et al., "Bright Spots, Physical Activity Investments That Work: National Steps Challenge, Singapore: A Nationwide Health Physical Activity Programme," *British Journal of Sports Medicine* 54, no. 17 (2019): 1047–1048; World Health Organization, *Decade of Healthy Ageing: Baseline Report* (2020).

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About Future Health – A Global Initiative by Abu Dhabi

Future Health is a year-round platform for global collaboration and transformative health innovation, held under the patronage of His Highness Sheikh Khaled bin Mohamed bin Zayed Al Nahyan, Crown Prince of Abu Dhabi and Chairman of the Abu Dhabi Executive Council.

Bringing together health researchers, policymakers, business leaders, investors and entrepreneurs from across disciplines and geographies, Future Health drives collective action to strengthen health systems and unlock longer, healthier lives for all.

Through a year-round programme of research insights, publications, impact initiatives, Challenges, R&D funding, and cross-sector convenings, Future Health advances progress across four focus areas: longevity and precision medicine, health systems and sustainability, digital health and AI, and investment in life sciences.

Future Health is curated and convened by the Department of Health – Abu Dhabi and its Founding Partners M42, PureHealth, the Institute for Healthier Living Abu Dhabi and Mubadala Bio. Mediclinic Middle East serves as Strategic Partner and Burjeel Holdings as Associate Partner.

For more information, visit www.futurehealthinitiative.ae and follow Future Health on social media platforms.

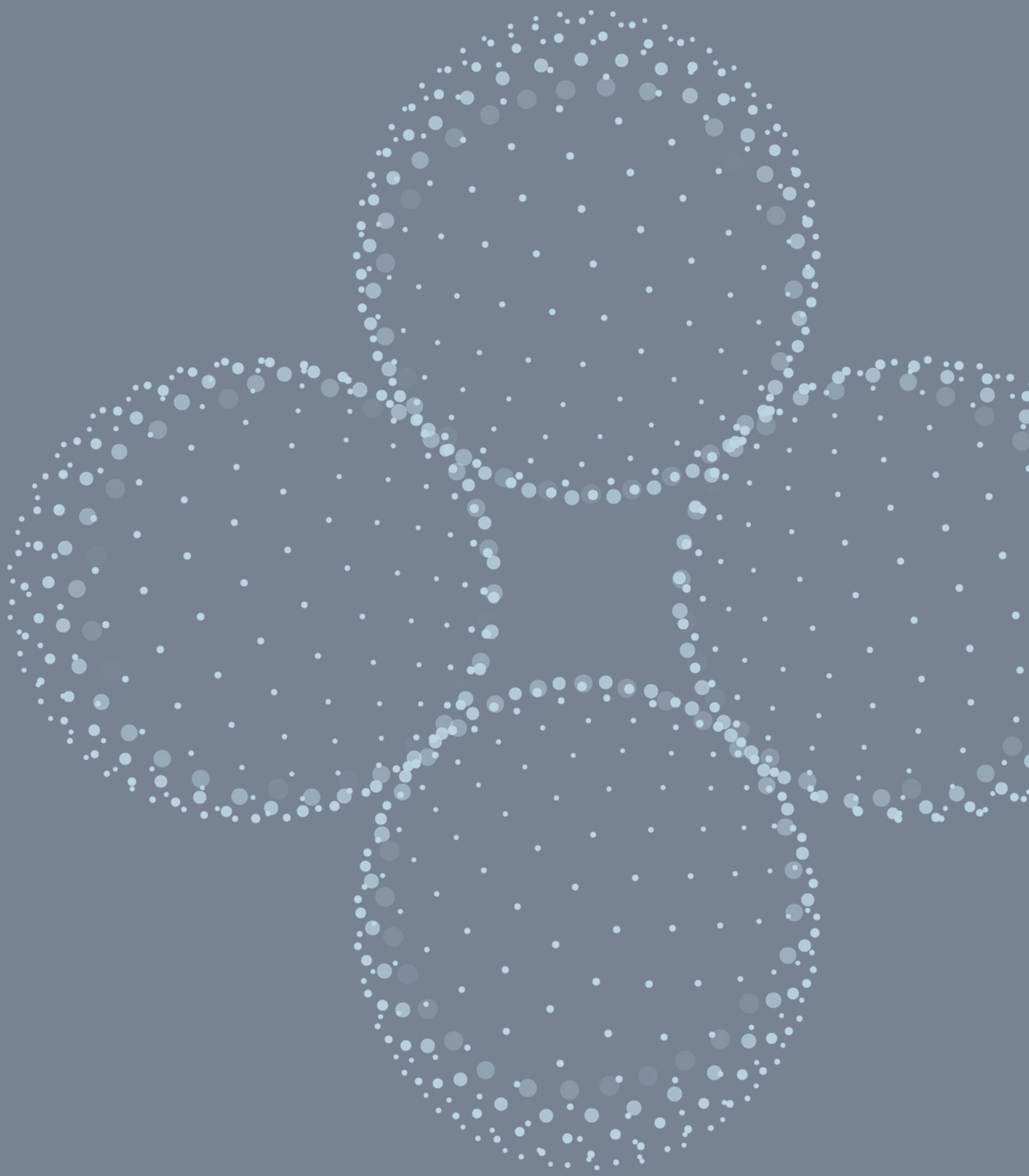
About McKinsey Health Institute

The McKinsey Health Institute (MHI) is an enduring institute within McKinsey & Company. It was founded on the conviction that, over the next decade, humanity could add as much as 45 billion extra years of higher-quality life.

MHI's mission is to catalyze the actions and investment needed across continents, sectors, and communities to realize this possibility. Collaboration with a robust ecosystem of organizations, enables work to catalyze impact across historically underinvested areas of health. MHI does this by convening and activating leaders; advancing research; creating and promoting data and tools; and stimulating investment and innovation.

The Institute holds the deep belief that every institution, every leader, and every person has an important role to play in advancing human health.

FUTURE HEALTH | A GLOBAL INITIATIVE BY ABU DHABI



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