

Reform UK's 2026 Health Plans: An Overview

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Understanding the potential impact of political health policies is essential for healthcare planning. Reform UK's proposed health plans for 2026 involve increasing overall public health expenditure, a strategy that, based on available evidence, may not inherently reduce health inequalities without targeted resource allocation.¹

KEY TAKEAWAYS

- The Pivot: Reform UK plans to increase overall public health expenditure in 2026.
- The Data: Increased public health spending in a comparable context showed no statistically significant impact on overall mortality levels, and increased inequality in under-five mortality rates across socioeconomic groups.¹
- The Action: Clinicians and policymakers should consider that increased overall spending alone may not address health inequalities; targeted resource direction towards disadvantaged groups is crucial.

The proposed health strategy from Reform UK for 2026 includes an increase in overall public health expenditure.² The assumption that increased public health expenditure reduces health inequalities is widespread, yet empirical evidence, particularly from low- and middle-income countries, is limited.¹

What the evidence shows

A study examining the effects of increased public health spending in Indonesia between 2010 and 2017 provides relevant insights.¹ This research assessed whether such increases reduced inequalities in under-five mortality rates (U5MR).¹ The study employed two primary approaches: a dynamic panel System-GMM model to estimate the impact of public health expenditure on within-province inequality in U5MR, measured by the concentration index across household wealth quintiles, and instrumental variable quantile regression to identify heterogeneous treatment effects across provinces with different baseline mortality burdens.¹

The study found no statistically significant impact of increased public health expenditure on overall U5MR levels.¹ Crucially, the results indicated that higher public health spending actually increased inequality in U5MR across socioeconomic groups.¹ Wealthier households captured a disproportionate share of the mortality reductions.¹ Conversely, the study identified no statistically significant heterogeneity in the impact of spending between high- and low-mortality provinces.¹ These findings suggest that increases in spending were not well-targeted to disadvantaged groups or high-mortality regions.¹

The research concludes that raising overall levels of public spending is not sufficient to reduce health inequalities unless resources are explicitly directed toward disadvantaged groups and underserved areas.¹ This study offers a proof of concept for applying distribution-sensitive methods to assess the equity impact of health financing.¹

The implications of these findings for Reform UK's 2026 health plans are significant. While the party proposes an increase in public health expenditure, the Indonesian study underscores that the mere allocation of additional funds does not guarantee a reduction in health inequalities. Instead, a poorly targeted increase in spending can exacerbate existing disparities, with wealthier segments of the population disproportionately benefiting from improved health outcomes. This suggests that Reform UK's strategy must incorporate robust mechanisms for equitable resource distribution, specifically designed to reach and benefit socioeconomically disadvantaged groups and geographically underserved areas.

One potential mechanism could involve the implementation of a health equity impact assessment (HEIA) for all new health spending initiatives. HEIA frameworks systematically evaluate the potential effects of policies, programs, or projects on health inequalities, identifying both positive and negative impacts across different population groups. By integrating HEIA into the planning and implementation phases, Reform UK could proactively identify and mitigate risks of increased inequality, ensuring that public health investments are genuinely pro-equity. This would move beyond a simple increase in expenditure to a more sophisticated, evidence-informed approach to health financing.

Clinical and Policy Considerations for the UK Context

While the Indonesian study provides valuable insights, it is crucial to consider its applicability to the UK's high-income context. The UK's healthcare system, primarily the National Health Service (NHS), operates under different structural and funding models compared to Indonesia. However, the fundamental principle that untargeted spending can worsen inequalities remains relevant. In the UK, health inequalities are well-documented, with significant disparities in life expectancy, chronic disease prevalence, and access to services across different socioeconomic groups and regions. For instance, areas with higher deprivation often experience poorer health outcomes and face greater challenges in accessing primary care and specialist services.

Reform UK's plans should therefore not only focus on the quantum of spending but also on how these funds are allocated within the NHS and public health services. This could involve ring-fencing funds for specific interventions aimed at reducing inequalities, such as enhanced outreach programs in deprived communities, targeted screening initiatives for high-risk populations, or investment in social prescribing link workers in areas with high social determinants of health challenges. Furthermore, strengthening primary care in underserved areas and ensuring equitable access to digital health technologies could be critical components of an equity-focused spending strategy.

Limitations and Future Research Directions: The Indonesian study, while robust, focused on under-five mortality rates as its primary outcome. While U5MR is a critical indicator of population health and equity, a broader range of health outcomes, including chronic disease prevalence, mental health indicators, and access to preventative services, would need to be considered in the UK context. Future research could explore the impact of targeted health expenditures on these diverse outcomes within high-income settings. Additionally, the study's reliance on wealth quintiles as a measure of socioeconomic status, while appropriate for its context, might need to be complemented by other indicators such of

education, occupation, and geographical deprivation when applied to the UK's multifaceted socioeconomic landscape. Understanding the nuanced interplay between increased spending, specific intervention types, and their differential impact across various social determinants of health will be paramount for Reform UK to develop truly effective and equitable health policies.

CLINICAL IMPLICATIONS

The Reform UK proposal to increase overall health expenditure in 2026, while seemingly beneficial, warrants careful consideration. The Indonesian data, though from a different economic context, provides a stark reminder that simply increasing the financial envelope does not automatically translate into equitable health outcomes. If resources are not explicitly ring-fenced and directed towards the most vulnerable populations, we risk exacerbating existing health disparities, with wealthier segments of society disproportionately benefiting from any improvements.

For clinicians on the ground, this means that without clear policy directives for equitable distribution, any new funding may not alleviate the pressures in underserved areas or for disadvantaged patient groups. The onus will remain on local commissioning groups and individual practices to advocate for targeted interventions, rather than assuming a rising tide will lift all boats. The lesson from Indonesia is clear: an equity-weighted evaluation framework is essential, not just for low- and middle-income countries, but for any health system aiming for genuine equality.

The pharmaceutical and medical device industries should also take note. While increased overall spending might suggest a larger market, the actual impact on patient access and outcomes will depend on how these funds are allocated. Companies developing therapies for conditions prevalent in disadvantaged communities may find that without specific policy mechanisms to ensure access, the benefits of increased spending remain concentrated among those already well-served by the healthcare system.

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