



April 2026 | Population Health & Market Access | growth-iq.group

Smoking is Down, Gyms are Full... So Why is the Nation's Health Still Stalling?

We spend more on gyms than ever. We smoke less than any previous generation. GLP-1 drugs are being called the most significant pharmacological advance of a generation. And physical inactivity is still responsible for five million deaths a year globally. Something is not adding up.

10.4% UK adults smoking (2024)	11.5m UK gym members (2024)	5m deaths/yr from inactivity
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01 SMOKING

The smoking story: what actually changed

The UK's progress on smoking is one of the genuine public health success stories of the last two decades. In 2024, 10.4% of adults in England smoked down from 19.8% in 2011. A near-halving in just over a decade.

For context, Germany still has around 22–30% of adults smoking, having made considerably less progress despite broadly similar public health ambitions. The difference is largely attributed to weaker advertising restrictions, lower tobacco taxes, and a culture of normalisation that persisted long after other European countries moved on. Germany was the last EU member state to allow widespread billboard tobacco advertising, only introducing restrictions in 2022.

The UK approach tax rises, plain packaging, indoor bans, and a deliberately permissive attitude towards vaping as a harm reduction tool has produced a measurable dividend. Cardiovascular deaths attributable to smoking have fallen. Lung cancer rates in older cohorts are declining. These are real gains.

"We reduced one risk and introduced another whose scale we cannot yet quantify. That is not a failure of the smoking reduction strategy it is just an honest account of where we stand."

But the vaping picture is unresolved. Around 10% of UK adults now vape, with daily use rising fastest among 25–49 year olds. The long-term health consequences are still genuinely unknown.

02 THE GYM BOOM

The gym paradox

The UK fitness industry reached a record 16.9% membership penetration rate in 2024 around 11.5 million members with revenue exceeding £5.7bn and over 600 million individual gym visits recorded across the year. Low-cost gyms have removed cost as a barrier in a way that simply did not exist for previous generations.

And yet. Obesity rates have not fallen. The WHO projects UK obesity prevalence reaching 35% by 2030. Physical inactivity still costs the NHS an estimated £900 million annually and the broader economy £7.4 billion each year.

A study published in Nature Health this month found that despite two decades of policy progress on physical activity promotion across 200 countries, global inactivity levels have remained broadly unchanged.

"The gym industry's honest answer is that they serve the already-motivated. More people are going to the gym than ever before. It is, by and large, the same people who would have found a way to exercise regardless."

Membership is highest among younger adults, people with higher incomes, and people who are already reasonably active. The populations carrying the greatest burden of preventable disease

older adults, lower socioeconomic groups, people from minority backgrounds remain significantly underrepresented.

This is not a criticism of the fitness industry. It is a structural observation about how individual behaviour change works. Even when it scales impressively, it tends to scale within the same segments of the population the ones who were already engaged enough to choose it.

03 GLP-1 DRUGS

GLP-1 drugs: genuine breakthrough or very expensive sticking plaster?

Semaglutide (Ozempic, Wegovy) and tirzepatide (Mounjaro) have produced weight loss outcomes no lifestyle intervention has come close to matching at population scale. The SELECT trial, involving over 17,000 adults, demonstrated a 20% reduction in major adverse cardiovascular events.

A UCL-led analysis published in The Lancet in October 2025 went further finding that cardiovascular protection was largely independent of how much weight participants actually lost, suggesting semaglutide is acting directly on the mechanisms of cardiometabolic disease rather than purely as a consequence of weight reduction.

That is a significant finding. It shifts how these drugs should be understood. They are not simply weight loss tools. They appear to be cardiometabolic medicines with weight loss as one of several clinical effects.

Real-world persistence data shows roughly half of patients discontinued within a year though this is improving, with 63% of those starting in early 2024 still on treatment twelve months later. The evidence does not support the concern that GLP-1s are replacing exercise; patients often increase physical activity as a secondary effect of improved mobility, energy, and reduced pain.

The harder question is whether we are medicalising what is fundamentally a structural problem food environments designed around ultra-processed convenience, sedentary work patterns, cities built for cars rather than people. Prescribing a drug does not change any of those things.

04 THE HARDER TRUTH

The structural conclusion

The data across these three stories points to the same conclusion. The interventions that work tend to work for people who are already in a position to benefit from them financially, geographically, informationally.

Smoking prevalence in the most deprived areas of England is still nearly double that in the least deprived. Gym membership is heavily concentrated among higher income groups. GLP-1 drugs remain largely privately prescribed in the UK, with NHS access tightly constrained by clinical criteria, capacity, and cost.

The Nature Health study was blunt about why physical activity policy has failed to move the population-level needle: interventions have focused too narrowly on health messaging and individual motivation, and not nearly enough on the structural factors that actually drive behaviour urban infrastructure, active transport, and school sport.

This matters for anyone working in pharma or med-tech, because it directly shapes the commissioning environment. The question NHS commissioners are increasingly asking is not simply whether a product works in the trial population but whether it works for the people who represent the greatest burden on the system, and whether it can be delivered in a way that reaches them.

"Products with compelling clinical data but a story that only applies to engaged, motivated, already-health-conscious patients will find it progressively harder to secure funding in a system told to address health inequalities as a statutory priority."

Lifestyle fads have their place. The smoking reduction story is genuinely impressive. The gym boom is not meaningless. GLP-1s may turn out to be one of the most important drug classes of the century. But none of them are changing the overall picture on population health, because none of them are reaching the people at the bottom of the curve.

The five million annual deaths from inactivity are not in the gym. They are not filling in their GLP-1s prescription. They are not in any of the cohorts that lifestyle health interventions typically reach.

That is the problem worth solving.

Growth-iQ works with pharma and med-tech teams on value propositions and market access strategies built around the NHS commissioning agenda as it actually is. If you are trying to position your product in this environment, it is worth a conversation.

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