

South East Regional Network
Association of Directors of Public Health



Making the Economic Case for Prevention

A toolkit for public health practitioners

A South East ADPH Network guide
produced in collaboration with the South East
regional Office for Health Inequalities and
Disparities.



ADPH
South East

Acknowledgements

We would like to extend sincere thanks to all those who contributed to the development of this toolkit. Many individuals generously gave their time to review drafts, provide expert input and constructive challenge, engage stakeholders for feedback, and support the production of the final manuscript.

We are especially grateful to the members of the Steering Group—Ansaf Azhar, Sara Blackmore, Alison Challenger, Debbie Chase, Tim Elwell-Sutton, Tessa Lindfield (Senior Responsible Owner), David Whiting and Rebecca Willans—whose guidance, expertise and commitment helped shape the overall approach and direction of this work. Their insights and support have been invaluable throughout the development of the toolkit.

*Steven Casson (author)
OHID South East region*

Main report:

Making the economic case for prevention: a toolkit for public health practitioners

1 Contents

1	Part 1: Principles of making the economic case for prevention.....	5
2	Part 2: The economic case for CVD prevention.....	16
3	Appendix: Toolkit resources	22
	References	37

Purpose of the toolkit

Prevention is widely recognised as essential to improving population health, reducing inequalities, and securing the long-term sustainability of health and social care systems. Yet, in practice, investment in prevention is often difficult to prioritise within current financial frameworks.

Public health professionals are frequently required to make the case for prevention in environments where decision-makers face competing demands. Economic evidence can be a useful tool in these conversations, but it is not always clear which forms of evidence are most appropriate, how they should be interpreted, or how they can be communicated effectively to different audiences.

This toolkit has been developed to support public health practitioners in making a clear, credible and proportionate economic case for investment in prevention. It offers practical guidance on how to select, frame and communicate economic evidence in ways that reflect the realities of local decision-making.

By focusing on principles, a real-world example and practical tools, this resource aims to help turn prevention from a shared aspiration into an investable proposition.

If you are short of time, consider starting with the Quick Guide document which sets out an approach to making the economic case for prevention.



Darrell Gale.

**Chair. South East ADPH Network
DPH for East Sussex**

1 Part 1: Principles of making the economic case for prevention

Economic evidence can be a powerful aid in securing and sustaining support for disease prevention, especially in environments of financial pressure and competing priorities. Its role is not to “prove” prevention always saves money, but to help decision-makers understand value, risk, affordability, and trade-offs in a structured and defensible way.

For a stepwise approach to making the economic case for prevention, see the **Quick Guide**.

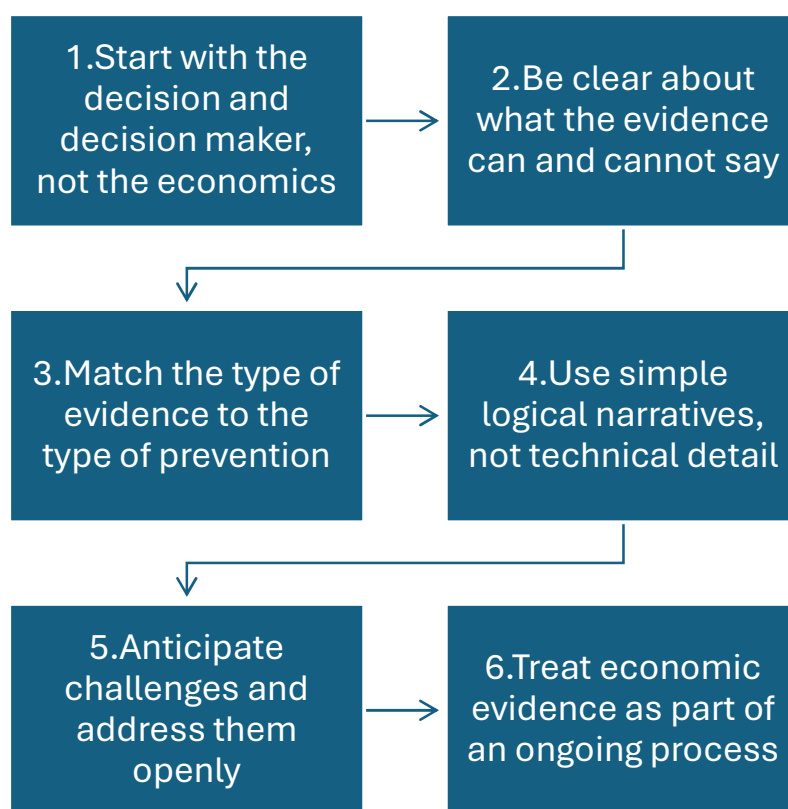


Figure 1 - Six steps to making a strong economic case for prevention

1.1 Background and policy context

Health and social care are under acute financial pressure from rising demand and workforce costs.

Prevention can help by reducing avoidable illness, slowing growth in demand, supporting productivity, and improving long-term sustainability—but only if investment is sufficient (both in terms of allocation and duration) and not displaced by short-term pressures.

Current accountability frameworks and operational pressures can place greater emphasis on short-term performance, which may limit the system's ability to prioritise longer-term prevention investment. However, prevention is now central to stated policy, particularly through the NHS 10 Year Health Plan and other public health strategies.

Value in health and wellbeing refers to the importance or worth of health improvements—such as longer life, better quality of life, and reduced inequality—relative to the resources used to achieve them. Value includes not only clinical outcomes but also social and economic benefits—such as productivity, reduced demand on services, and wider societal wellbeing. It is commonly understood as achieving the outcomes that matter most to people, populations, services and organisations in a way that is efficient, equitable, and sustainable.

Prevention can create value through a variety of means, including by improving health, reducing inequalities, easing pressure on services, strengthening the economy, and improving long-term public sector sustainability — with benefits accruing to individuals, communities, and multiple parts of the state.

While the benefits of disease prevention are widely distributed, the burden of delivering prevention is unevenly borne. In practice, the upfront costs tend to fall disproportionately, including on local government, public health teams, primary care, and community providers. By contrast, many of the financial and capacity benefits accrue later and to different parts of the system, including acute providers, the wider NHS, employers, and central government. This creates a coordination challenge, where the costs and benefits of prevention are distributed across organisations and over time.

The burden is further shaped by time horizons: prevention frequently requires sustained investment, workforce effort, and political capital in the short to medium term, while the most substantial gains emerge over longer periods and across organisational boundaries. As a result, prevention may appear less affordable within in-year budgets, even where it represents efficient use of resources from a longer-term system perspective.

Best value and social value

In local government contexts, the concept of “value” is not solely defined by financial return. Statutory frameworks require decision-makers to take a broader view.

The [Local Government Act 1999](#) requires local authorities ([and other best value authorities](#)) to [make arrangements to secure continuous improvement in the way their functions are exercised, having regard to a combination of economy, efficiency and effectiveness.](#)

In addition, the [Public Services \(Social Value\) Act 2012](#) requires public authorities to [consider how procurement might improve economic, social and environmental wellbeing in the relevant area.](#) This reinforces the need to account for wider benefits to communities and place when assessing investment decisions.

These frameworks support a broader interpretation of value in prevention. They also provide a formal basis for considering benefits that fall outside immediate organisational budgets or short-term financial cycles.

10 Year Health Plan for England: fit for the future

The government’s 10 Year Health Plan creates opportunities to better align incentives through neighbourhood health models, devolved and pooled funding, and new funding and payment approaches, enabling local systems to invest in prevention with greater confidence that benefits can be realised and shared across organisations over longer periods of time.

Being able to structure economic information that communicates such arrangements is key.

1.2 Important factors for making the case for prevention investment decisions

This resource deals primarily with making the case for non-communicable diseases. Considering evidence from an Australian study of senior decision-makers (see Table 2, in section 3.4) four factors are key when making the case for investing in prevention on non-communicable diseases:

- Understanding the differing needs of different types of stakeholders including finance colleagues
- Understanding and selecting relevant evidence for decision-makers
- Understanding how to communicate the evidence

- Availability and usability of quality evidence

A possible approach to addressing these factors is described in the ‘*six steps*’ below:

1. Start with the decision and decision maker, not the economics
2. Be clear about what the evidence can and cannot say
3. Match the type of evidence to the type of prevention
4. Use simple logical narratives alongside appropriate technical detail
5. Anticipate challenges and address them openly
6. Treat economic evidence as part of an ongoing process

1.3 Six steps to making a strong economic case for prevention

1.3.1 Start with the decision and decision maker, not the economics

Before seeking or presenting economic evidence, be clear about the **decision context**:

- **What decision is being made** (e.g. invest, sustain, scale, redesign, or disinvest)
- **Who the decision-maker is** (e.g. council finance lead / cabinet member, ICB partner, finance professional)
- **What their main concerns / criteria are** (deliverability, affordability, efficiency, financial control, risk management, long-term sustainability, fairness / equity, visibility, stewardship of place / system, impact on existing services and workflow etc)
- **How existing guidance for decision-makers can inform approach**

Different contexts place emphasis on different concerns / criteria. Framing can be adapted to address the needs of stakeholders. For example, it could be helpful to support communication with residents, scrutiny committees, and the media, or to support financial oversight. Clarity about the decision context can improve both relevance and usefulness of evidence.

To aid framing of evidence, it may also be useful to consider guidance already used by decision-makers. For example, guidance produced by the LGA for elected members^{1 2} about making the case for prevention. This includes LGA's five key pillars to 'slow and halt the rise of preventable disease':

1. Policies and budgets are prevention proofed
2. Service design configured to enable prevention by default
3. Clear expectations of all services and actors, clear accountability for delivery
4. Benefits and disbenefits forecasting for all policies
5. Evaluation of impact and adjustment

Toolkit: Table 3 (in section 3.5) is a practical prompt helping tailor messages in your proposals to relevant concerns / criteria.
--

1.3.2 Be clear about what the evidence can and cannot say

Economic evidence can be used to help decision-makers understand:

- The **scale of preventable harm and cost** (why action matters)

- The **types of value created, noting that absence of early cash-flow reduction does not necessarily mean an absence of value.** Many prevention interventions deliver value by slowing future cost growth, reducing risk, and avoiding predictable harm, rather than releasing cash immediately. Examples of benefit include:
 - Cash-releasing savings / cost avoidance / reduced service pressure (e.g. avoidable admissions, reduced packages of care, delayed onset of long-term conditions; reduced growth in demand)
 - Productivity improvements
 - Increased quality of care
 - Health outcomes & equity (QALYs, morbidity, wellbeing; reduced inequalities). Social Return on Investment assessments can help to identify wider benefits to individuals and communities.
 - Benefits to society, the wider economy and the environment
- **How the proposal affects short-term budgets / affordability and financial risk both short and long term**
- **How benefits and costs are distributed** across populations and organisations and in what time courses

Economic evidence can help decision makers to understand value, risk, affordability, and trade-offs.

Economic evidence rarely provides precise predictions or guaranteed savings.

Although evidence may be imperfect, it can still support decisions when used transparently and in combination with other evidence and professional judgement.

1.3.3 Match the type of evidence to the type of prevention

- **Economic evidence available will vary with stage of prevention** (e.g. wider determinants, primary, secondary)
- **Support decision-makers to consider evidence appropriate to the stage of prevention**
- **Combine multiple forms of evidence** rather than relying on a single metric

Prevention spans a continuum from upstream population-level action on the wider determinants of health through to downstream clinical interventions. Each point along this pathway differs in terms of time horizon (i.e. time to seeing benefit), measurability, and where costs and benefits fall. These differences determine what evidence is both feasible and appropriate to use.

A common challenge in practice is the expectation that all prevention interventions should demonstrate short-term financial savings. This can create challenges for upstream prevention, where the most significant long-term gains in health and reductions in demand are often achieved, but where those gains are harder to attribute, slower to emerge, and are distributed across multiple sectors. In a how-to context, it can be helpful to guide decision-makers towards evidence that matches the stage of prevention being considered.

For interventions operating upstream—such as those addressing housing, environment, or other wider determinants, conventional cost-effectiveness approaches are often not suitable, because outcomes cannot be easily linked to a single intervention or captured within short funding cycles. Evidence from burden of disease analysis, economic modelling, cost-benefit approaches, and broader social or public value frameworks may be more appropriate. These approaches help make visible the full range of impacts, including those that sit beyond healthcare budgets.

As interventions become more targeted—such as primary prevention aimed at defined risk groups—there is greater scope to use cost-effectiveness analysis, particularly where there is a clear and well-established link between the intervention and specific outcomes (for example, avoiding cardiovascular events). Here, the pathway from intervention to outcome is more direct, and attribution is more feasible, making such economic methods more appropriate.

For interventions closest to clinical care, costs and outcomes are usually more immediate and more easily measured within the health system. In these contexts, decision-makers can draw on cost-effectiveness, cost-saving, and budget impact analyses, as both the investment and the benefits tend to fall within the same organisational boundaries and over shorter timeframes.

Across all stages of prevention, a key practical principle is to avoid relying on a single metric. For example, while return on investment (ROI) is frequently used, it has well-recognised limitations. It focuses on financial returns and may fail to capture wider benefits, such as improved wellbeing, reduced inequalities, or impacts in other parts of the wider system. For this reason, a stronger approach is to combine multiple forms of evidence (e.g. epidemiological data, modelling, social ROI findings, and real-world delivery experience) to provide a fuller and more credible account of value. A 2026 study

by Pearson-Stuttard et al³ provides an example of a framework to support assessment of prevention value from a range of stakeholder perspectives.

Generalisable case studies can also be of value to decision-makers to raise confidence that proposed interventions are deliverable and will deliver value anticipated in practice. This can include demonstrating where interventions could be supported using existing levers, partnerships, and system assets and infrastructure, and emphasising alignment rather than additional complexity.

Toolkit: You can use Table 4 (in section 3.6) to understand which kinds of economic evidence are most relevant—and realistic—to seek for different prevention activities / stages of prevention⁴.

1.3.4 Use simple logical narratives alongside appropriate technical detail

Well-designed proposals may use:

- **Plain-English logic models** (where these are possible) showing how investment leads to outcomes, although they may be less useful where complexity exists. Theories of change are also important.
- A **small number of relevant metrics**, clearly explained
- **Local data and examples**, where possible
- **Open discussion of uncertainty and assumptions, and risks of action and inaction**

Evidence is most effective when translated into a clear and accessible explanation of how an intervention works and its wider impacts.

Decision-makers need confidence that prevention proposals are grounded in a clear logic that connects resources, activities, and outcomes. Logic models (where these are possible) can play a central role in this process⁵ by showing how investment leads to a chain of effects, including direct health impacts, reduced service use, productivity gains, and wider social benefits. These models help make visible both the outcomes that are typically captured in economic analyses and those that are not, supporting a wider perspective and transparent appraisal of value.

Describing tangible outcomes (e.g. fewer emergencies, fewer families in crisis, and more people able to live independently for longer) rather than abstract metrics can be helpful.

The evidence presented should be proportionate and carefully selected. Overloading proposals with excessive amounts of evidence⁶, including technical evidence or headline ROI figures, can undermine clarity and confidence, particularly for non-technical audiences.

Economic evidence should be treated as one component of a broader decision-making process, complemented by effectiveness data, implementation experience, qualitative insights, and contextual information.

ROI should only be used when comparing like-for-like options⁵ and should be interpreted cautiously, recognising that results are context-dependent and not directly transferable across settings.

It is also important to anticipate and articulate the risks of disinvestment. Where programmes may appear vulnerable when judged narrowly on short-term financial metrics (including short term ROI), decision-makers should be supported to understand the likely consequences of withdrawal, including increased demand, loss of capacity, higher future costs and impact on related services.

1.3.5 Anticipate challenges and address them openly

- **Effective use of economic evidence includes responding to likely concerns** including about affordability, time to realise benefits, where the benefits are realised
- **Anticipating such challenges and thinking about possible responses can support making the case confidently and in a balanced way**

Short payback often reflects late intervention after harm has already occurred. Framing prevention as a form of financial risk management can help shift the discussion away from whether savings arise in-year, towards whether the system is taking reasonable steps to manage predictable future liabilities, such as rising emergency admissions, growing treatment backlogs, or increasing cost volatility in urgent care.

Long payback periods are not a weakness of prevention but a characteristic of interventions that act earlier in the causal chain. It is important to be explicit that the absence of short-term savings does not imply absence of value.

Where relevant, proposals should clearly separate near-term budget impact from longer-term return on investment, and explain which elements of the prevention portfolio are expected to influence expenditure within shorter time horizons, such as case-finding or secondary prevention, versus those that deliver value over longer periods through reduction in incidence of disease.

Toolkit: You can use Table 5 (in section 3.7) as a prompt when stress-testing your proposal, helping you think through potential objections and concerns and how to address these confidently and consistently.

1.3.6 Treat economic evidence as part of an ongoing process

- Consistent **local monitoring** can help demonstrate direction of travel, support learning, and reduce uncertainty for subsequent decisions.
- **Local generation of evidence** can have an important role, strengthening future investment cases and increasing investors' confidence over time.

The availability and usability of economic evidence is a critical factor in making robust, defensible decisions about prevention investment. While the evidence base for prevention is substantial, it is unevenly distributed across intervention types, prevention stages, and sectors.

National reviews have highlighted structural barriers that affect how prevention evidence is generated and used. These include the lack of consistent frameworks for defining⁷ and tracking prevention⁸ spend, and limited benchmarking of outcomes. Such conditions can make it difficult for systems and local organisations to evidence progress on prevention or to compare options consistently, even where there is strong underlying rationale for action.

In this context, decision-makers should be supported to work with the best available evidence rather than waiting for perfect information. This involves triangulating multiple sources, including published economic evaluations, modelling studies, routine data, case studies, and qualitative insights from implementation experience.

Local generation of evidence can have an important role. Documenting delivery costs, uptake, intermediate outcomes, and early signals of impact—for example, changes in diagnosis rates, reduced growth in avoidable admissions, or stabilisation of demand in pressured services—can strengthen future investment cases and increase confidence over time. The Chartered Institute of Public Finance and Accountancy (CIPFA) and the Health Foundation have been working to define and categorise prevention spend within local government⁹.

Even where causal attribution remains imperfect, consistent local monitoring can help demonstrate direction of travel, support learning, and reduce uncertainty for subsequent decisions. Importantly, the absence of a single summary metric such as a return-on-investment ratio should not, in itself, be a barrier to progress where there is a

strong logic model, alignment with strategic priorities, and a credible plan for evaluation¹⁰.

Communicating the economic case for prevention should be seen as an iterative process. Strengthening the evidence base through ongoing evaluation, documentation of real-world experience, and contribution to shared learning helps build confidence over time and supports more robust, defensible investment decisions.

Toolkit: *You can use sections 3.1 and 3.2 as a starting point for finding usable economic evidence and tools when building your prevention case.*

2 Part 2: The economic case for CVD prevention

2.1 Burden of CVD and risk factors

Cardiovascular disease covers a range of conditions¹ affecting the heart and blood vessels. CVD affects a significant proportion of the population with estimates varying by date and source – 6.8 million people in 2022 (The King's Fund)¹¹, around seven million people in the UK (NHS England, undated²), and in excess of 8million in 2026 (BHF)¹².

CVD is a significant cause of morbidity and mortality. CVD can have impacts on individuals' mental health, carers, the health system, the social care system, on productivity, and on the economy.

CVD is a major driver of informal care and long-term social care demand, with cost-of-illness modelling¹³ attributing around £6.4 billion annually to informal care and £4.6 billion to long-term care, reflecting largely causal pathways from illness to dependency for conditions including stroke and vascular dementia. Healthcare (NHS) costs relating to cardiovascular disease are estimated at £12 billion each year. Economic modelling suggests that CVD costs the UK economy around £29 billion per year.

Non-modifiable risk factors include age (CVD mainly affects people over 50 years old), sex (men are more likely to get CVD than women), ethnicity (South Asian, Black African, African Caribbean ethnic backgrounds have higher risk), and having family members with CVD.

However, much of the CVD burden is preventable. Modifiable risk factors include smoking, inadequate physical activity, unhealthy diet, obesity, diabetes, excess alcohol, high blood pressure, unfavourable blood lipid profiles, and certain irregular heart rhythms.

In the South East, in June 2025 66.5% of people with diagnosed high blood pressure had their condition under control but it is estimated that there are more than 400,000 people with diagnosed high blood pressure that may not be controlled optimally.

[Estimates from ONS in 2023](#) suggest that approximately one third of high blood pressure in England is not diagnosed. In 2023 ONS estimated that 32% of adults living in private households in England had high blood pressure (hypertension) and 3 in 10 of those (29%) were undiagnosed; this equates to approximately 4.2 million adults with undiagnosed hypertension). If the recognized cases in the South East region were to

¹ [Cardiovascular conditions | Topic | NICE](#)

² <https://www.england.nhs.uk/ourwork/clinical-policy/cvd>

represent 7 in 10 cases, there could be an additional 617,000 undiagnosed non-controlled cases in the region as of June 2025.

Controlling blood pressure in increasing numbers of the South East population is anticipated to have a major incremental impact on NHS and social care costs as shown in Figure 2.

Size of the Prize- South East BP Optimisation to Prevent Heart Attacks and Strokes at Scale

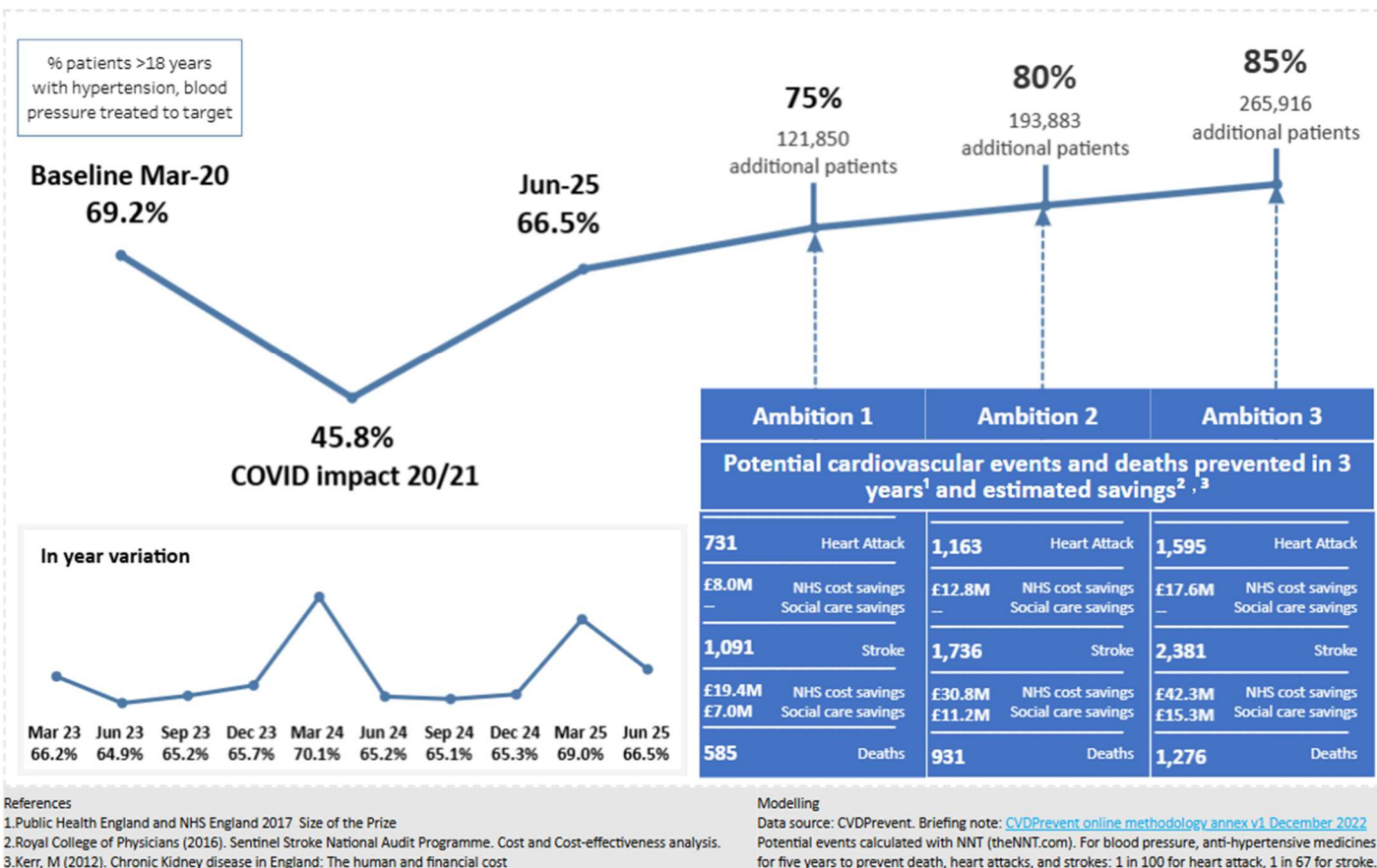


Figure 2 - Size of the prize, UCL Partners

2.2 Stages at which it is possible to intervene

Table 1 illustrates the stages of prevention, set out in a manner most likely to be recognised by public health teams – i.e. consistent with prevention terminologies and frameworks used in decades of peer-reviewed literature, public health education and practice. This is the framework utilised throughout this document and is consistent with the Local Government Association’s outline of prevention for elected members¹.

Upstream activity is dominated by **local authority-led action on wider determinants and health behaviours at a system/population level**. These interventions shape population risk and aim to prevent the development of cardiovascular disease or clinically significant risk. **Primary prevention** targets intervention before disease arises and provision includes by both local government and NHS. **Secondary prevention** sits at the interface between prevention and treatment, involving targeted interventions for individuals at high risk or with early disease. **Tertiary prevention** is largely delivered through the NHS and focuses on people with **established disease and related conditions**.

Table 1 - Traditional stages of prevention

	Upstream action	Primary	Secondary	Tertiary
Definition	Intervention on wider determinants of health at population / system level	Target individuals at risk of future disease and before disease arises	Targeted interventions for individuals with early disease or at high risk of disease	Reducing harm from established / advanced disease
Examples of intervention	Air quality; Environments including physical / built / physical activity / food / alcohol; Fuel poverty; Tobacco and nicotine control; Injury prevention and safety regulation. Access to services. Education, employment and welfare interventions.	NHS Health Check; Stop smoking services; Exercise; Alcohol; Diet & nutrition; Lipids/ BP/ obesity pathways	Management of complex cardiometabolic risk; Stop smoking services in context of existing disease; Specialist obesity services	Cardiac rehab; Post-stroke risk management; Chronic heart failure management optimisation; Post stroke rehabilitation services

2.3 Example of using approaches described in the toolkit: Finding and treating high blood pressure earlier through community-based checks and targeted outreach

Frimley ICB has outperformed the South East region for monitoring and successful treatment of known high blood pressure. Inspired by achievements in Frimley ICB the following section describes a brief pitch for investment to increase case finding and monitoring of hypertension.

2.3.1 Elevator pitch including focus on affordability and future financial risk management

This proposal focuses on finding and treating high blood pressure earlier through community-based checks and targeted outreach. High blood pressure is the leading risk factor for cardiovascular disease in England, affecting more than 1 in 4 adults, with around 1 in 3 cases still undiagnosed—over 4 million people—and costing the NHS over £2 billion each year.

The intervention is a modest, controllable investment—the salary and on-costs of a skilled manager—who would mobilise existing community resources to reach people less likely to be diagnosed through GP-led care and link them back into treatment. This improves detection and ensures more people are treated effectively, particularly in higher-risk groups. Delivery will also depend on senior leadership involvement, helping maintain focus and strategic oversight, together with ICB analytical support and use of existing integrated care data. Clinical follow-up is dependent on primary care resource. There may also be some additional administrative and operational costs associated with outreach and patient engagement activity in the community setting.

An uplift of around 8.5 percentage points in the proportion of patients receiving optimised treatment (to around 75%)—that is, optimising the care of an additional 122k known hypertensive patients, even before identifying further cases (which using a rough extrapolation could be up to ~617k, although this number is uncertain)—is estimated to prevent around 700 heart attacks, over 1,000 strokes, and nearly 600 deaths. This translates to around £27 million in NHS savings and £7 million in social care savings, reflecting avoided demand rather than immediate cash release.

The costs of delivery are modest when set against the downstream costs of stroke units, rehabilitation, repeat admissions and long-term prescribing that follow late presentation.

The timing aligns with planning cycles. Early signals—more people identified and treated—can be seen within annual cycles, with reductions in heart attacks and strokes emerging within a few years and meaningful impact by around year 4. Benefits then build over time as more people are managed earlier.

Crucially, this reduces exposure to future cost growth and volatility by preventing high-cost events that would otherwise present late and require expensive treatment. It also addresses inequalities that would otherwise concentrate future demand and costs in higher-risk populations.

In summary, this is a relatively low-cost practical intervention that mobilises existing community and neighbourhood assets. It aims to increase the proportion of patients receiving optimised treatment, and to deliver measurable reductions in avoidable events, reducing future demand and cost pressure across the system within a 3–5 year horizon.

1. Ettehad D et al. Effects of blood pressure lowering on cardiovascular risk. The Lancet (2016): [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)30906-7/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30906-7/fulltext)
2. Office for National Statistics. Health and life expectancies and undiagnosed hypertension patterns: [Risk factors for undiagnosed high blood pressure in England - Office for National Statistics](#)
3. Pharmacy Magazine. Case-finding and outreach delivery context: <https://www.pharmacymagazine.co.uk/clinical/hypertension-case-finding-in-pharmacy>
4. NHS England. CVDPREVENT audit: <https://www.cvdprevent.nhs.uk/>

3 Appendix: Toolkit resources

3.1 Some sources of economic evidence

- WHO Collaborating Centre on Investment for Health and Well-being, Public Health Wales **social value scoping reviews** on [life course](#), [physical activity and nutrition](#)¹⁴, and [mental health](#)¹⁵
- DHSC [Health economics: evidence resource - GOV.UK](#) - Provides a summary of economic evidence underpinning public health interventions.
- [Return on Investment for public health, Kent Public Health Observatory \(2018\)](#)
- [Masters, R., et al. \(2017\). "Return on investment of public health interventions: a systematic review." Journal of epidemiology and community health](#)¹⁶
- [Paving a new pathway to prevention: leveraging increased returns on our collective investment](#), NHS Confederation 2024¹⁷

3.2 Decision aids

Decision aids such as these examples can provide indication of impact of different investment strategies:

- [ASH Inpatient Tobacco Dependence Treatment Services Impact Calculator 2024](#)
- [ASH Ready Reckoner](#) provides estimates of costs to society of smoking which could be saved through prevention activity.
- Guidance: Health economics: a guide for public health teams: Resources to help local commissioners achieve value for money by estimating the return on investment (ROI) and cost-effectiveness of public health programmes. [The cost-effectiveness of specific topic areas](#)
- HEE example: ROI tool to support surgical teams who are looking to demonstrate the economic return from investing in the extended surgical team staffing model. [Return on Investment Tool \(Business Case\) | NHS England | Workforce, training and education](#)

3.3 Other resources

- Structured decision making approaches such as “[The Prioritisation Framework: making the most of your budget Structured discussions](#)” by Public Health England.¹⁸

3.4 Themes relevant to a decision-making process for non-communicable disease prevention

Table 2 - Themes relevant to a decision-making process for non-communicable disease prevention from an Australian study of senior decision-makers⁶

CATEGORY (NOT FROM PAPER)	SUB-THEME FROM PAPER ⁶	IMPLICATION	CAPABILITY
CONFIDENCE	Data is a tool to generate trust in decision-making	Access to relevant economic information is important	Availability, access
PERSUASION	Data storytelling is used to demonstrate the value of prevention	Effective communication of economic evidence is important	Communication
MAKING DECISIONS EASIER	Better data access and quality is needed to improve the precision of decision-making	Access to relevant economic information is important	Accessibility/ usability, generation, selection, quality
	The data paradox: change-agents want more data, but data usability is inversely proportional to data amount	Presentation of the optimal amount evidence	Selection
EVIDENCE REQUIRED	Traditional evidence is critical to decision-making but is only one piece of a larger evidential puzzle	Economic evidence is not enough alone	Triangulation, augmentation
	Non-traditional sources of evidence (e.g., innovation, experience) are strongly weighted in prevention	Other types of evidence are important	Augmentation
OBLIGATIONS	Decisions carry a weight of responsibility to the taxpayer, community, and organisation	Decisions must be defensible	
	Decisions must ultimately be fair and contextualised for equity—to target those with the greatest health need	Decisions must address equity	
DRIVERS OF CHOICE	“Health” decisions are driven by everything outside of health	Taking a wider perspective is important	Financial planning
	‘Healthcare and disease prevention ultimately relates back to dollars’	Regard for longer term cashflow impact is important	Financial planning
STRONG EVIDENCE DEMONSTRATES RIGOUR	The strength of all evidence (traditional and non-traditional) is directly proportional to the ethical rigor of a decision	Strong evidence supports decision makers	Quality

3.5 Informing communication relating to various concerns

Table 3 - Informing communication relating to various concerns

CONCERNS / CRITERIA	TIME HORIZON	WHAT COUNTS AS SUCCESS	CONCERNS	TYPICAL QUESTION ASKED	SUPPORTIVE FEATURES	HELPFUL LANGUAGE
AFFORDABILITY; FISCAL CONTROL; RISK MANAGEMENT	Annual to spending-review cycle	Budget adherence; predictable expenditure	Upfront cost and uncertain payback	What happens to the budget this year?	Separation of value from cash flow, phased spend, and explicit risk management	Affordability, cash flow, risk, sensitivity analysis, control totals
BENEFIT TO PLACE; PUBLIC ACCEPTABILITY	Electoral cycle	Tangible local improvements; fairness; voter support; good stewardship	Political risk and controversy		Clear public narrative, visible local benefits, and alignment with fairness and place-based priorities	Fairness, prevention, protecting communities, visible local benefit, common sense
VALUE FOR MONEY; DEMAND MANAGEMENT;	Short to medium term	Slowed demand growth; measurable outcomes within contract period	Affordability and opportunity cost	What do I stop or reduce to pay for this?	Clear budget impact, credible demand reduction, and deliverable implementation plan	Value for money, demand reduction, outcomes, invest-to-save, prioritisation
IMPACT ON SERVICE DELIVERY	Short term	Improved flow, staffing sustainability, care quality	Increased workload without resources	Will this help or hinder day-to-day delivery?	Evidence of reduced workload or improved flow, plus resources to support delivery	Flow, capacity, workload, safety, practical implementation
POPULATION HEALTH GAIN; EVIDENCE STRENGTH; PREVENTION EFFECTIVENESS	Medium to long term	Reduced incidence, morbidity, and inequalities	Insufficient investment upstream; weak translation into policy	Does this intervention work and for whom?	Strong evidence base, clear theory of change, and alignment with population health priorities	Effectiveness, population impact, inequalities, evidence-based, upstream prevention

3.6 Evidence types and fit with stages of prevention

Table 4 - Evidence types and fit with stages of prevention (non-exhaustive)

EVIDENCE TYPE	BEST-FIT PREVENTION STAGE(S)	SUMMARY	KEY ADVANTAGES	KEY LIMITATIONS	EXAMPLE OF HOW REPORTED (CVD)
EPIDEMIOLOGY / COST-OF-ILLNESS / BURDEN OF DISEASE ANALYSIS	Upstream action on wider determinants; Primary	Estimates current and future costs of preventable disease. Supports the case for action rather than intervention comparison. Commonly used upstream of formal economic evaluation.	Quantifies scale of preventable harm; strong agenda-setting tool; intuitive for non-technical audiences	Does not compare interventions; not a value-for-money metric; attribution can be contested	Annual cost of cardiovascular disease to the NHS and lost productivity
COST-CONSEQUENCE ANALYSIS (CCA)	Upstream action on wider determinants; Primary	Presents costs alongside multiple outcomes without aggregation. Useful where benefits are diverse or hard to monetise. Common in complex, multi-component prevention programmes.	Flexible; accommodates multiple outcomes; avoids over-aggregation	No single summary metric; relies on judgement; harder to rank options	A table showing various costs alongside changes in admissions / number of contacts / engagement, satisfaction / experience, safety, wellbeing etc
RETURN ON INVESTMENT (ROI) / FISCAL ROI	Upstream action on wider determinants; Primary; Secondary	Compares financial savings to programme costs. Speaks directly to Treasury, ICB and local authority decision-makers. Often underestimates wider and long-term benefits.	Simple and intuitive; resonates with finance audiences; advocacy-friendly	Often narrow fiscal scope; underestimates long-term and non-health benefits	£X NHS savings per £1 invested in hypertension case-finding. Can also be presented as a ROI ratio = (Total benefits – Total costs) / Total costs

EVIDENCE TYPE	BEST-FIT PREVENTION STAGE(S)	SUMMARY	KEY ADVANTAGES	KEY LIMITATIONS	EXAMPLE OF HOW REPORTED (CVD)
COST-BENEFIT ANALYSIS (CBA)	Upstream action on wider determinants; Primary	Values both costs and benefits in monetary terms using market values and standard shadow prices. Enables comparison across sectors such as health, transport and housing. Often used for upstream or population-level prevention. Can be extended (in the form of Social CBA¹⁹) to take into account the full spectrum of costs and benefits (including social and environmental effects) borne by society as a whole as a result of an intervention. As such, SCBA as a methodology sits between CBA and SROI.	More robust than ROI. Supports allocative efficiency and option appraisal; Enables comparison of interventions in different fields; monetises diverse outcomes; well-established in policy appraisal	Requires monetisation assumptions; sensitive to discount rates and valuations; excludes outcomes that cannot be credibly valued monetarily. Distributional equity impacts may not be covered unless explicitly added. Risk of understatement: prevention benefits can appear modest if hard-to-value outcomes dominate.	Net Present Value benefit-cost ratio for minimum salt reformulation policies to prevent CVD
SOCIAL RETURN ON INVESTMENT (SROI)	Upstream action on wider determinants; Primary	Monetises social, health and wider system outcomes using stakeholder-defined values. Captures benefits beyond health budgets such as wellbeing, community impact, social connection, confidence, independence.	Demonstrates and articulates wider social value; accessible to non-health stakeholders; participatory / ground up (stakeholder-defined)	Less standardised: methods vary widely; results sensitive to assumptions; limited comparability	£X social value generated per £1 invested in community physical activity to reduce CVD risk

EVIDENCE TYPE	BEST-FIT PREVENTION STAGE(S)	SUMMARY	KEY ADVANTAGES	KEY LIMITATIONS	EXAMPLE OF HOW REPORTED (CVD)
WIDER PUBLIC VALUE / SOCIAL VALUE ASSESSMENT	Upstream action on wider determinants; Primary	Assesses economic, social and environmental value without full monetisation. Aligned with public-sector value frameworks and procurement rules. Often narrative-plus-quantitative rather than a single ratio. https://www.local.gov.uk/our-support/procurement-hub/national-procurement-strategy/toolkit-social-value-achieving-community	Aligned with public value frameworks; flexible; avoids forced monetisation	Less standardised; weaker decision rules; often descriptive	Narrative assessment of health, social and environmental benefits of active travel for CVD prevention
MIXED-METHODS ECONOMIC APPRAISAL		A mixed-methods economic appraisal framework (such as that described by Pearson-Stuttard et al³) that combines quantitative, monetised estimates of prevention value (where evidence is robust) with structured qualitative reporting of additional societal and fiscal impacts. Like SROI: • mixed quantitative + qualitative • multi-stakeholder value Unlike SROI: • evidence-led rather than stakeholder-defined • avoids forced monetisation • preserves HTA-compatible metrics	The framework plays the analytical role that SROI often aspires to, but with greater methodological discipline for prevention.		

EVIDENCE TYPE	BEST-FIT PREVENTION STAGE(S)	SUMMARY	KEY ADVANTAGES	KEY LIMITATIONS	EXAMPLE OF HOW REPORTED (CVD)
COST-EFFECTIVENESS ANALYSIS (CEA)	Primary; Secondary; Tertiary	Compares the costs of an intervention with outcomes gained measured in natural/physical units of health outcomes (e.g. CVD events avoided, life-years gained, mmHg BP reduction).	Does not require monetising health benefits; transparent; supports clear value-for-money judgments within health care; suitable for clinical and targeted prevention	Results not comparable across outcome types	£X per CVD event prevented; £X per life-year gained for NHS Health Checks or smoking cessation
DISTRIBUTIONAL COST-EFFECTIVENESS ANALYSIS (DCEA)	Primary; Secondary	Extends CEA to show impacts across population subgroups. Explicitly trades off efficiency against equity. Useful where reducing inequalities is a core objective.	Explicitly quantifies equity-efficiency trade-offs	More complex; data-intensive; not yet routine	Net CVD health gains by deprivation group compared with standard CEA
COST-UTILITY ANALYSIS (CUA)	Primary; Secondary; Tertiary	A form of CEA using utility-based outcomes (usually QALYs). Allows comparison across different diseases and interventions. Dominant in healthcare-sector prevention decisions.	Allows comparison across diseases; integrates quality and length of life	QALYs may miss wider benefits; distributional concerns	Incremental cost per QALY gained for statin therapy in primary prevention

EVIDENCE TYPE	BEST-FIT PREVENTION STAGE(S)	SUMMARY	KEY ADVANTAGES	KEY LIMITATIONS	EXAMPLE OF HOW REPORTED (CVD)
COST-SAVING / COST-AVOIDANCE EVIDENCE	Secondary; Tertiary	Shows interventions that reduce net expenditure. Typical for secondary prevention and high-risk clinical care. Rare for upstream prevention but highly persuasive.	Highly persuasive; releases cash; simple to communicate	Rare upstream; risks bias toward short-term gains	Net reduction in CVD-related hospital admissions and spend
CASE STUDIES	Upstream action on wider determinants; Primary; Secondary; Tertiary	Uses observed costs and outcomes from implemented programmes. Increases credibility with local decision-makers. Often limited in generalisability.	High credibility; locally relevant; implementation-focused	Limited generalisability; weaker causal inference	Observed reduction in CVD emergency admissions after pathway redesign

3.7 Response to challenge

Table 5 – Response to challenge (produced in context of developing toolkit draft with support of AI with human review)

CHALLENGE	EXAMPLE THEME	IDEAS TO THINK ABOUT IN FORMULATING A RESPONSE. NB NOT ALL IDEAS WILL BE RELEVANT OR APPROPRIATE IN ANY GIVEN REAL-WORLD CASE. (PRODUCED IN CONTEXT OF DEVELOPING TOOLKIT DRAFT WITH SUPPORT OF AI WITH HUMAN REVIEW)
CONCERN ABOUT AFFORDABILITY	Overspend makes prevention more, not less, necessary A response might include thinking on cost-pressure containment — disinvestment reduces apparent spend now but may increase demand for care later”	“Overspend is exactly when prevention matters — because without it, demand and cost pressures continue to rise.” “Disinvestment in prevention is a short-term fix that worsens the medium-term position.” “Without prevention, the overspend becomes structural, not temporary.” “Disinvesting in prevention during financial recovery increases downstream cost, particularly emergency and acute pressure.” “Prevention is about avoiding future cost and harm.” Sharing experience/ evidence of consequences of past local inaction (e.g. overspend resulting from delays in transformation of adult social care delivery) may be a useful input to colleagues’ reflection and decision-making on value of investment

**“WE SHOULD
FOCUS ON
HIGH-RISK
PATIENTS
FIRST.”**

Population and high-risk approaches are complementary, not substitutes

A focus solely on high-risk groups and downstream prevention cannot bend population incidence or inequality curves.”

“High-risk approaches are essential — but on their own they cannot reduce overall incidence or inequalities.”

“Population approaches shift the whole risk curve; high-risk approaches only treat the tail.”

“The most effective systems do both — not one instead of the other.”

“High-risk approaches are necessary but insufficient — population approaches deliver the largest aggregate fiscal and health gains.”

**“THE EVIDENCE
ISN’T STRONG
ENOUGH.”**

Evidence must match the decision being made / realistic expectations of evidence available

For example, upstream prevention may not have strong evidence of early cash savings but can be judged by whether it reduces risk, changes where things are heading, and avoids worse outcomes that would otherwise happen.

“The evidence challenge isn’t about whether prevention works — it’s about matching the right type of evidence to the right decision.”

“Upstream prevention won’t look good on short-term budget impact — that’s not what it’s designed to do.”

“Different rungs of the ladder require different evidence standards.”

“Population prevention can be evaluated through directional impact and risk reduction”

“Different prevention stages don’t fail on economics — they fail when we apply the wrong economic test.”

“THERE ARE NO CASHABLE SAVINGS.”

Prevention as value, not short-term cash release

A response might include consideration of wider measures of value. Also, liability avoidance and risk management, where benefits accrue over time and across budgets.”

“Upstream prevention delivers the largest long-term return on investment, but the benefits accrue over time and largely outside our/the organisation, which is why it requires system level leadership rather than programme by programme funding.”

“This is about avoiding future, unavoidable cost pressure, not short-term savings.”

“Lack of immediate cashable savings doesn’t mean lack of value — it reflects where and when the benefits fall, not whether they exist.”

“Prevention is primarily about avoiding future cost growth, not releasing cash in year — and that’s critical for system financial sustainability.”

“Prevention reduces future cost growth and volatility, which is the risk we’re managing.”

“THE PAYBACK PERIOD SEEMS LONG.”

Time horizons and payback are features, not flaws

Short payback usually signals late, downstream intervention, while long payback reflects genuine incidence reduction and demand control.

“A long payback period is a feature of effective prevention, not a flaw — short payback usually means we’re intervening too late.”

“Primary prevention offers good value for money, can improve equity, and reduces future demand, but its benefits are typically realised over the medium term rather than within annual financial cycles.”

“Long payback reflects risk reduction, not weak value.”

“Long payback is inherent to interventions that genuinely change population health trajectories.”

“THE SAVINGS SIT ELSEWHERE / ACROSS THE WIDER SYSTEM”	A response might address coordination and governance of prevention investment across system partners	“The economic case is strongest when framed across health, productivity, and public finances, rather than individual budgets alone.” “That’s exactly why prevention needs system leadership — not because the value is unclear, but because it’s shared.” “That’s precisely the case for prevention — it generates cross system value that no single department / organisation can capture alone.” “The question isn’t whether prevention delivers value — it’s who benefits and when. That’s a governance challenge, not an evidence gap.”
“THE INTERVENTION LOOKS JUST LIKE GOOD CARE.”	Case finding and secondary prevention as near-term financial levers Preventing recurrence and acute events is prevention - these rungs are often the most financially persuasive.	“Case finding in CVD prevention is often associated with favourable return on investment because it converts undetected risk into preventable events.” “Benefits are seen quickly and are more likely to be cashable within NHS budgets.” “This is prevention that behaves financially like service improvement.”
“WE NEED THINGS WE CAN EXPLAIN SIMPLY.”	Explainability as a strength of prevention	“Stop illness before it starts. Find problems early. Help people stay independent.”

3.8 Mapping interventions to economic metrics

Table 6 - Mapping interventions to economic metrics to data sources

LA-COMMISSIONED CVD PREVENTION ACTIVITY	PURPOSE IN CVD PREVENTION	SOME RELEVANT ECONOMIC METRICS AND APPROACHES (NON-EXHAUSTIVE)	EXAMPLE METRIC WORDING
NEIGHBOURHOOD PREVENTION INFRASTRUCTURE AND SYSTEM LEADERSHIP	Enable integrated, sustained CVD prevention	Cost-consequence analysis; Portfolio-level ROI	£ per neighbourhood with functioning prevention model; Portfolio ROI across prevention activity
VCSE-LED COMMUNITY PREVENTION AND OUTREACH	Improve engagement and reach high-risk groups	SROI; Cost-consequence analysis; Cost per engagement	£1 invested → £X social value; £ per resident engaged from priority group
PHYSICAL ACTIVITY PROGRAMMES (COMMUNITY / VCSE)	Reduce inactivity-related CVD risk and inequalities	Social Return on Investment (SROI); Cost-consequence analysis; Cost per individual changing behaviour	£1 invested → £X social value; £ per inactive adult becoming active
CLINICAL MANAGEMENT IMPROVEMENT (SHARED LA–NHS SPACE)	Improve treatment to target for BP and lipids	Cost per percentage-point improvement; Cost-consequence analysis	£ per 1% increase in hypertension treated to target
SMOKING CESSATION SERVICES	Reduce major modifiable CVD risk	Cost per quitter; Cost-benefit; ROI	£ per 4- or 12-week quitter; Net savings from avoided CVD events
NHS HEALTH CHECKS	Early identification of CVD risk	Cost per output; Cost-consequence analysis	£ per NHS Health Check completed; £ per high-risk individual identified
HYPERTENSION CASE-FINDING LINKED TO HEALTH CHECKS	Increase diagnosis and entry to treatment	Cost per case detected; Cost-consequence analysis	£ per additional hypertension diagnosis attributable to programme; Checks needed to detect one new case
WEIGHT MANAGEMENT SERVICES	Reduce obesity-related CVD risk	Cost-utility (QALYs); ROI (modelled); Cost-consequence analysis	£ per participant achieving ≥5% weight loss; £ per QALY gained
COMMUNITY CARDIAC REHABILITATION (NON-CLINICAL)	Prevent recurrence and support secondary prevention	Cost-utility (QALYs); Cost per avoided admission	£ per QALY gained; £ per CVD admission avoided

3.9 Quick-reference summary of communication themes

Table 7 - Quick-reference summary of communication themes

COMMUNICATION ELEMENT	GENERAL FEATURES	ADDITIONAL FEATURES RELATED TO FINANCES	ADDITIONAL FEATURES RELATED TO PLACE	ADDITIONAL FEATURES RELATED TO COMMISSIONING	ADDITIONAL FEATURES RELATED TO SERVICE PROVISION
OVERALL FRAMING	Prevention as value creation, risk management and system stewardship,	Budget impact and affordability, financial risk, liability avoidance and spend control	Stewardship of place; residents, accountability, fairness, protection, avoiding visible future crises, legacy	Affordability, value for money, prioritisation and opportunity cost, managing demand, capacity and system sustainability	Operational impact (e.g. flow, capacity, safety, practicality) quality, outcomes and avoidable workload
CAUSAL LOGIC	Clear, simple logic models linking investment to outcomes	Shows pathway to future cost pressure reduction	Shows how harm to residents is avoided	Shows link to demand moderation and outcomes	Shows link to workload and patient / service user benefit
RISKS OF INACTION	Bigger, more visible and costly problems later	Future cost growth and volatility		Escalating demand and inequality	Rising workload

EQUITY & FAIRNESS	Equity is a legitimate and important test for all decisions				
ECONOMIC METRICS	Availability will vary by stage of prevention; proportionate and selective use; economics is one input, not sufficient alone, wider perspectives (e.g. social, economy, environmental, equity-related) are important				
TIME HORIZON	There will not always be short-term savings; long payback is a feature of early prevention. Show how the intervention creates <i>decision-relevant signals</i> within various time horizon, and when main benefits accrue	Annual / spending-review cycles	Electoral cycle	Short to medium-term planning cycles	Short-term operational cycles

References

1. LGA. Making the case for prevention: a must know for elected members: Local Government Association, 2025.
2. LGA. Prevention: How do you know that your council is doing all it can to deliver on prevention?: LGA, 2017.
3. Pearson-Stuttard FRSPH J, Treharne MSc C, King MSc R, et al. A novel framework to assess the prevention value of a health intervention. *Diabetes, Obesity and Metabolism*, 2025.
4. Prevention explainer table: The King's Fund, 2025.
5. Brousselle A, Benmarhnia T, Benhadj L. What are the benefits and risks of using return on investment to defend public health programs? *Preventive medicine reports* 2016;3:135-38. doi: 10.1016/j.pmedr.2015.11.015
6. Canfell OJ, Davidson K, Sullivan C, et al. PREVIDE: A Qualitative Study to Develop a Decision-Making Framework (PREvention decIDE) for Noncommunicable Disease Prevention in Healthcare Organisations. *International journal of environmental research and public health* 2022;19(22) doi: 10.3390/ijerph192215285
7. Arnold S, Holden J. What is prevention in health?, 2025.
8. Cairney P, Boswell J, Bliss A, et al. Unlocking prevention in integrated care systems: How ICSs can unlock the prevention agenda by overcoming the persistent barriers to prevention, and examples of existing best practice.: NHS Confederation, 2024.
9. Scott Z, Roy E. Understanding preventative investment: A practical approach to map and measure spend: Chartered Institute of Public Finance and Accountancy (CIPFA) supported by the Health Foundation 2025.
10. Hopkinson E. Return on investment - A guide for NHS finance teams: HFMA, 2025.
11. Raleigh V, Jefferies D, Wellings D. Cardiovascular disease in England - Supporting leaders to take actions: The King's Fund, 2022.
12. Team BHA. 2026 01 BHF CVD Statistics UK Factsheet: British Heart Foundation, 2026.
13. Shih K, Herz N, Sheikh A, et al. Economic burden of cardiovascular disease in the United Kingdom. *European Heart Journal - Quality of Care and Clinical Outcomes* 2025;11(5):678-90. doi: 10.1093/ehjqcco/qcaf011
14. Stielke A, Ashton K, Cotter-Roberts A, et al. The social return on investment of physical activity and nutrition interventions-a scoping review. *Frontiers in sports and active living* 2024;5:1296407. doi: 10.3389/fspor.2023.1296407
15. Kadel R, Stielke A, Ashton K, et al. Social Return on Investment (SROI) of mental health related interventions-A scoping review. *Frontiers in public health* 2022;10:965148. doi: 10.3389/fpubh.2022.965148
16. Masters R, Anwar E, Collins B, et al. Return on investment of public health interventions: a systematic review. *Journal of epidemiology and community health* 2017;71(8):827-34. doi: 10.1136/jech-2016-208141

17. Wood M, Patel A, Richardson B. Paving a new pathway to prevention: leveraging increased returns on our collective investment: NHS Confederation, 2024.
18. The Prioritisation Framework: making the most of your budget. In: England PH, ed., 2018.
19. Vardakoulis O. Social CBA and SROI. Economics in policy-making: NEF, 2013.