

# SILENT SYSTEMS, LOUD BURDEN

Why We Are Building a Preventive Health Readiness Index – and Why It is Important for Investors and Policymakers



Prepared by

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## 1. The Case for Preventive Health Readiness, and Why It's Stalling

➔ Non-communicable diseases alone account for roughly three-fourths of all deaths globally.<sup>1</sup> Road traffic injuries claim over 1 million lives each year.<sup>2</sup> Infectious disease outbreaks continue to disrupt economies and overwhelm health systems. Despite this scale, OECD countries allocate on average just 3% of total health expenditure to prevention.<sup>3</sup>

The imbalance is clear. Health systems globally spend the vast majority of their budgets on reactive care, treating conditions after they arise, while the upstream systems that could reduce that burden remain consistently under-resourced. Chronic disease management absorbs growing shares of national health budgets. And when acute crises do emerge, as COVID-19 demonstrated, the cost of unpreparedness may amount to trillions. In both cases, the pattern is the same: systems pay far more to respond than they would to prevent. The difference is not in the evidence or the solutions; it is in visibility. Without a structured, comparable way to see whether systems are actually equipped to prevent, and how preventive efforts are having impact, prevention will continue to lose out to reaction.

As governments and health systems face mounting fiscal pressure, the need to shift from reactive spending toward systems that deliver long-term, sustainable value has never been more urgent. Beyond the health system, preventive health readiness strengthens economic resilience, workforce productivity, and the market conditions that attract and sustain investment and human capital. The gap between where systems stand and where they need to be thus represents both a policy priority and a potential investment opportunity, but one that remains difficult to size or target without a structured way to assess readiness consistently across geographies. A prevention readiness framework would provide that infrastructure, helping governments identify where their systems need strengthening, and guiding investors and development partners identify where those gaps create opportunities for targeted, high-impact deployment of resources.

**Today, no single framework exists to holistically assess whether countries and health systems are actually ready to prevent future health burdens,** making it nearly impossible to diagnose gaps, direct investment, or track whether commitments are translating into capability. This paper proposes a path forward: a conceptual framework for defining, structuring, and ultimately measuring preventive health readiness.

The ambition around prevention is well established. The FII Institute's Healthy Humanity Blueprint positions prevention as a foundational pillar for sustainable, long-term health improvement - firmly aligned with global direction and commitments.<sup>4</sup> In 2013, World Health Organization (WHO) Member States endorsed the Global Action Plan for the Prevention and Control of Non-Communicable Diseases (NCDs) 2013–2030,<sup>5</sup> setting a comprehensive roadmap to reduce premature mortality from NCDs (e.g., cardiovascular disease, cancer, diabetes, chronic respiratory conditions, and mental health disorders) by one-third by 2030. The WHO also recommends a set of "Best Buy" interventions: cost-effective, evidence-based measures that could avert millions of premature deaths, with preventive interventions at their core.<sup>6</sup> The 2005 International Health Regulations (IHR), adopted by all 196 WHO Member States, set binding obligations for countries to build core public health capacities for detection, assessment, and response.<sup>7</sup> Furthermore, the UN's Sustainable Development Goals (SDGs) place universal health coverage and the reduction of preventable mortality at the center of the 2030 agenda.<sup>8</sup>



Why has progress towards prevention remained so uneven? Several structural challenges stand in the way:<sup>9, 10</sup>

- **The return on investment is real but delayed.** Political and budget cycles often favor short-term, tangible gains over upstream investments whose benefits materialize over years or decades.
- **Benefits are scattered.** Prevention spans health authorities, finance, environment, education, and urban planning. Benefits of investing in prevention may not be realized by the same actor investing the resources, ultimately diffusing accountability.
- **Incentives are misaligned.** Many health systems remain structured to reward treatment volume rather than sustained health.
- **Attribution is difficult.** The benefits of upstream, population-level prevention investments are often diffuse and slow to materialize, making it difficult to attribute improved outcomes to specific interventions – weakening the feedback loop that policymakers and investors need to justify sustained commitment.

Underlying these challenges sits something more fundamental: a measurement gap.

Several global indices and datasets track broad health system performance and outcomes (e.g., the Global Burden of Disease Study,<sup>11</sup> Mirror Mirror,<sup>12</sup> or the Global Health Security Index).<sup>13</sup>

Others capture narrow segments of prevention, such as specific policies or disease groups (e.g., WHO/UNICEF immunization coverage estimates,<sup>14</sup> WHO NCD Country Capacity Survey,<sup>15</sup> or the Economics for Health Cigarette Tax Scorecard).<sup>16</sup> But none bring these threads together into a comprehensive assessment of whether the systems behind prevention are fit-for-purpose. Closing this gap and translating fragmented data into meaningful insight and coordinated action is a critical next step in making prevention a measurable, improvable priority.

## SPOTLIGHT

*The building blocks for effective prevention are well known. Whether countries have them in place is not. Prevention readiness needs a measurement lens that turns fragmented signals into a tool that forms the basis for action.*

*- Tara Makarem, Senior Managing Director, FTI Consulting*

To address the measurement gap, this paper proposes a conceptual framework - a structured way of defining what prevention encompasses, what it means for a system to be 'ready,' and how the two connect to guide meaningful measurements that form the basis for a comprehensive, universally relevant index.

## 2. A Conceptual Framework for Measuring Preventive Health Readiness

Building a fit-for-purpose measurement framework for prevention readiness requires clarity on two foundational questions. First, what do we actually mean by ‘prevention’? Second, what does it mean for a system to be ‘ready’?

### Defining Prevention: A Continuum, Not a Category

Prevention is often thought of as a single activity or intervention: vaccinate, screen, or educate. In reality, prevention operates across a full progression of health threats, from the conditions that give rise to risk all the way through to managing established illnesses to prevent complications.

Critically, it also operates at different scales: some interventions target entire populations, while others focus on individuals at elevated risk. This distinction matters because, as prominent epidemiologist Geoffrey Rose’s “prevention paradox” notes, measures that bring large benefits to the population often bring small benefits to each individual, while measures that target high-risk individuals bring large individual benefit but modest population impact.<sup>17</sup> This paradox underscores that prevention needs to balance both population- and individual- focused strategies.

As such, a clear taxonomy defines prevention via four analytical levels:

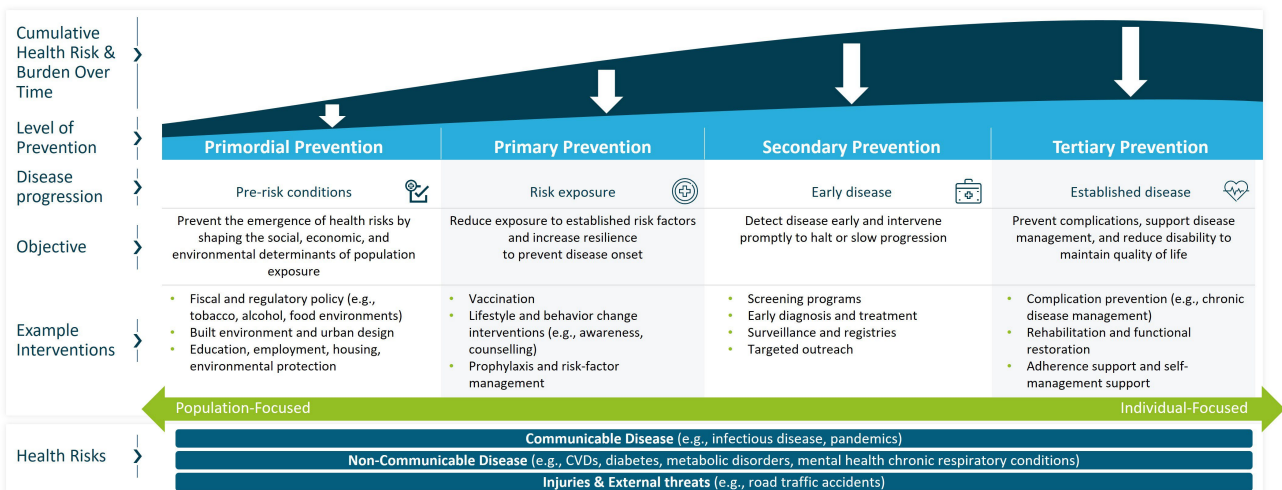


Figure 1. Defining prevention – an analytical taxonomy

It is important to note that the taxonomy and defined levels of prevention above (Figure 1) serve to guide these analytical efforts. As such, some limitations and considerations are worth noting:

- Levels of prevention are not rigid or mutually exclusive. Disease progression is continuous, and the same intervention may serve different prevention functions depending on the context. For example, a smoking cessation program delivered to a healthy population is primary prevention; delivered to someone with diagnosed cardiovascular disease, it becomes a tertiary intervention aimed at preventing further complications.

- Second, the above taxonomy (Figure 1) supports a condition-agnostic approach to measurement and can be applied to major health threats including NCDs, infectious disease and injuries or external threats. While emerging and evolving threats such as antimicrobial resistance and climate-related health risks are becoming increasingly important, they may not be comprehensibly measurable at this stage given their emerging and cross-cutting nature.

- Lastly, established and emerging literature may define and categorize prevention in different ways. For example, quaternary prevention (i.e., protecting patients from unnecessary or harmful medical interventions) is a growing area of interest; however, it is excluded from this analytical taxonomy at this stage as it primarily concerns what clinicians should not do, rather than broader system-level readiness.

While these variations are acknowledged, the above proposed taxonomy (Figure 1) aims to provide a shared basis for defining prevention in a consistent manner, enabling structured and comparable measurement across countries and health systems.

### Defining Readiness: The Capabilities That Can Be Deliberately Built and Measured

Being clear on what prevention is (and what it is not) tells us what should happen. The more difficult question is: does the system (both health-care systems and broader country-level systems that influence the determinants of health) have the capability to deliver?

Health outcomes are shaped by a wide array of factors: genetics, behavior, social and economic conditions, environmental exposures, and the

the health system itself. Some of these determinants sit outside any system's direct control. Others can be deliberately built and strengthened. This is why a measurement framework anchored in outcomes alone would be insufficient. Outcomes are lagging, confounded by factors beyond any system's influence, and offer limited guidance on what to do differently. **Readiness is about what systems can deliberately build and control:** the tangible levers that determine whether proven prevention can be implemented effectively, equitably, and at scale. Measuring readiness creates a direct line between assessment and action — it tells decision-makers not just where a country stands, but where it can intervene.

The proposed measurement framework identifies five measurement dimensions:

- Four core readiness enablers covering **policy and governance, funding and incentives, data and digital, and access and capacity.**
- A fifth dimension, **health outcomes and impact,** provides a complementary lens to assess population-level results. While outcomes like life expectancy, disease burden, and risk-factor prevalence are lagging indicators, influenced by factors well beyond any health system's direct control, they offer essential context for interpreting whether

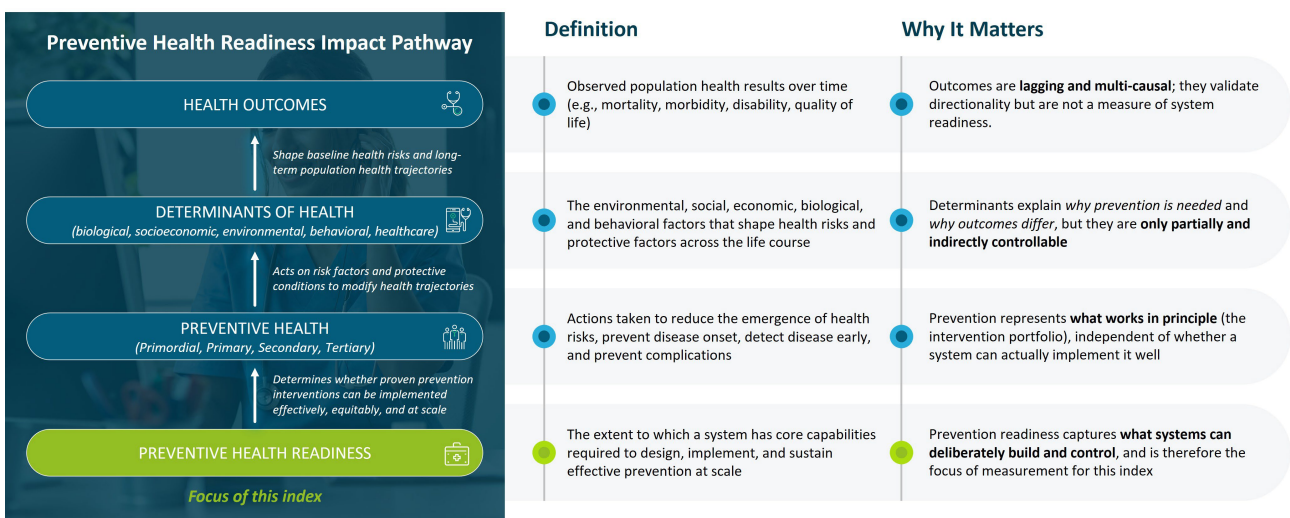


Figure 2. Logic map – why readiness matters and how it links to outcomes

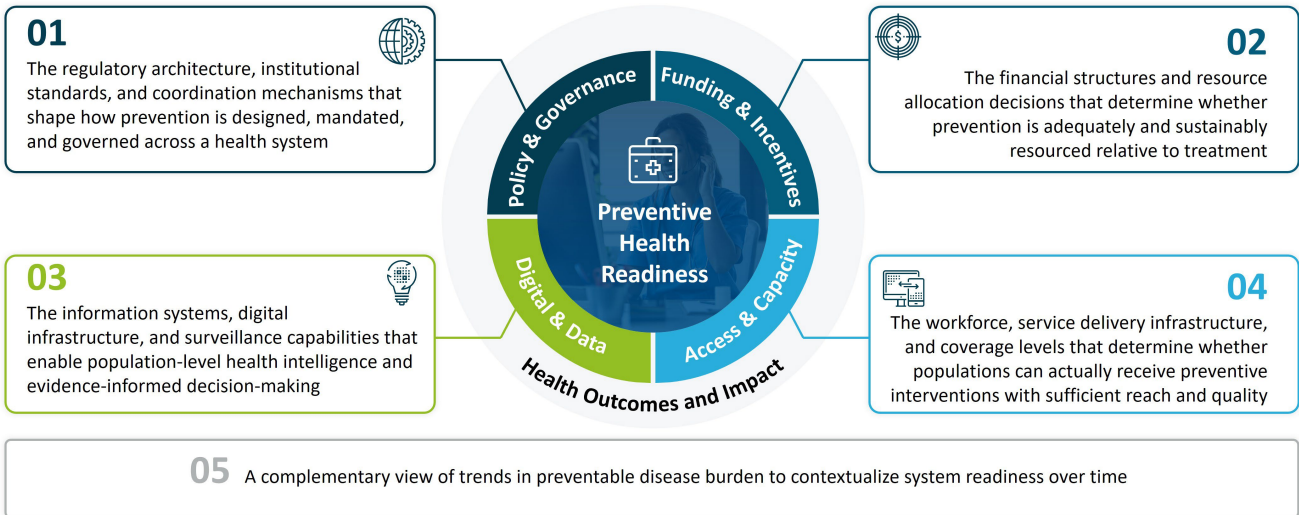


Figure 3. Preventive health readiness measurement dimensions

These dimensions are designed to be universally applicable, not because every country faces the same prevention challenges, but because every system requires these foundational enablers regardless of its specific burden of disease, income level, or health system design. A country with strong tobacco policy but weak surveillance infrastructure faces a different readiness profile than one with robust data systems but inadequate primary care coverage. The framework's value lies precisely in making these distinct profiles visible and comparable.

### The Questions That Matter

At the intersection of prevention analytical levels and prevention readiness dimensions emerges a structured set of questions that can guide a standard measurement approach.

These questions ground measurement in practical terms. They also reveal an important structural reality at the core of the measurement approach: effective prevention cannot rely on strength in any single dimension.

Prevention Readiness Dimensions		PREVENTION LEVELS			
		Primordial Prevention	Primary Prevention	Secondary Prevention	Tertiary Prevention
ENABLERS	1 Policy & Governance	Do governance and regulatory mechanisms address the <b>upstream conditions</b> that drive population health risk?	Are prevention priorities translated into clear, enforceable policies and standards that <b>guide actors' roles</b> for reducing risk exposure?	Do governance and standards support <b>systematic early detection</b> of health conditions and risks?	Are standards in place to support long-term <b>disease management and complication prevention</b> ?
	2 Funding & Incentives	Is financing structured to sustain public health and prevention functions that operate <b>upstream of clinical care</b> ?	Is financing structured to prioritize <b>risk reduction</b> and maintaining health, rather than primarily paying for downstream illness?	Is financing structured to support <b>sustained early detection and follow-through</b> ?	Do funding mechanisms support <b>care continuity and access to essential services</b> for established health conditions?
	3 Digital & Data	Can the system generate population-level health intelligence to <b>monitor upstream risks and inform prevention priorities</b> ?	Can the system use data and digital tools to support prevention delivery and reach <b>high-risk populations</b> ?	Does the system have the surveillance and information infrastructure to <b>detect health threats and monitor disease occurrence</b> ?	Can the system support <b>longitudinal tracking</b> of established health conditions and outcomes?
	4 Access & Capacity	Does the population have access to <b>infrastructure that supports health-protective conditions</b> before individual risk factors emerge?	Can the population reliably access <b>core preventive services</b> that reduce risk exposure?	Is there sufficient access and system capacity to <b>ensure eligible populations receive timely early detection services</b> ?	Can people with established health conditions <b>access the support</b> needed for effective <b>long-term management</b> ?
		5 HEALTH OUTCOMES & IMPACT <i>Do population outcomes reflect sustained progress in reducing preventable disease burden over time?</i>			

Figure 4. Mapping preventive health readiness questions

### 3. Requirements to Measure Preventive Health Readiness

A conceptual framework is a necessary starting point. But for it to drive action, it must be translated into credible, repeatable measurement. Any approach to measuring preventive health readiness across countries must navigate tensions between comprehensiveness, conceptual precision, and feasibility. A credible measurement approach must therefore adopt the following principles as a starting point:

- **Whole-of-prevention lens.** Measurement should reflect the full prevention continuum, from primordial through tertiary, recognizing that effective prevention requires capabilities that operate across the entire disease pathway, not only at the clinical point of care.
- **Readiness-first approach.** To measure readiness, we need to measure what systems can deliberately build. Health outcomes are an important contextual signal, but not the only measure.
- **Evidence-anchored focus.** What is measured should be grounded in established evidence on what drives effective and cost-effective prevention and maximizes population and system outcomes.

- **Comparability and transparency.** Measurement needs to rely on indicators that are globally comparable, repeatable, and based on clear definitions. Data gaps certainly exist, but the value of beginning to measure—even imperfectly—lies in establishing a baseline, providing an initial signal of where systems stand, and creating the foundation for improvement over time.

Based on these principles, we can distill an initial view of the types of measures that could anchor each readiness dimension across the prevention continuum. These measures are not prescriptive but are instead intended to show the breadth and structure of what a comprehensive measurement approach might look like. Different countries will show different strengths; some may score well on policy and governance but lag on data infrastructure, while another may have the opposite profile. The framework is designed to surface these differences in a consistent way, so that each country can see where its readiness is strongest and where it needs the most attention.

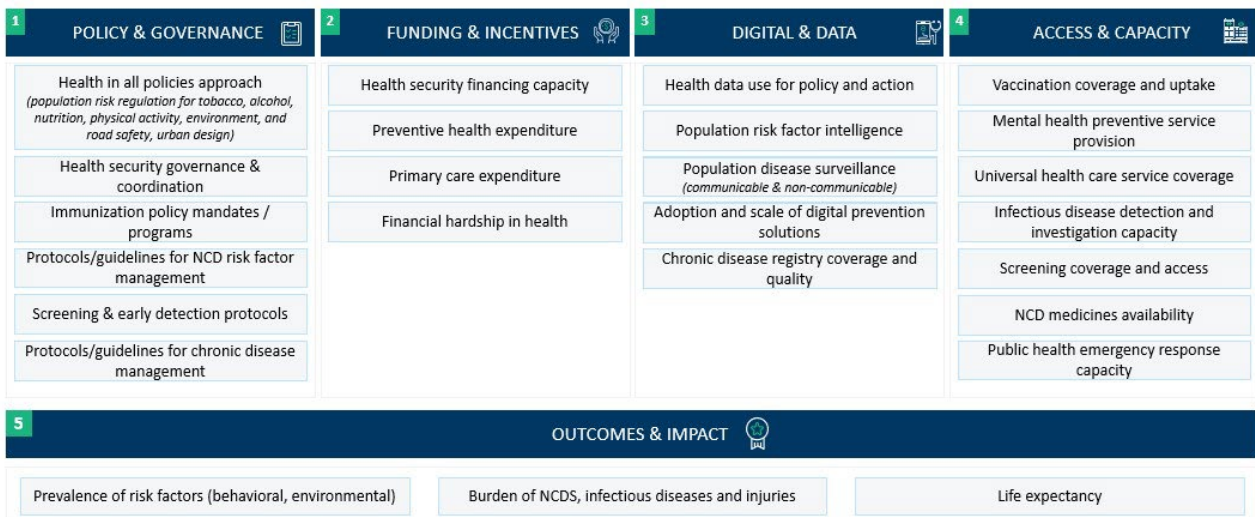


Figure 5. Illustrative measurement domains across the preventive health readiness framework

## Key Methodological Considerations

Translating a conceptual framework into a practical index that informs policy and investment requires careful methodological choices.

**Establishing a common scale.** Prevention indicators are measured in fundamentally different units—from binary policy adoption to continuous coverage rates to composite expert assessments. Any credible measurement approach must normalize these onto a comparable scale. First, the primary unit of analysis is the country: the framework is designed to produce national-level assessments that can inform domestic decision-making and enable cross-country comparison. However, a key consideration is whether to assess countries against absolute benchmarks (such as established policy targets or clinical thresholds), against observed global performance, or some combination. Each approach carries implications for how progress is recognized and how the measurement responds to shifts in global performance over time.

**Calibrating the weight of different signals.** Not all indicators carry equal informational value. A composite assessment evaluated externally across hundreds of dimensions provides a fundamentally different signal than a single binary survey item. The methodology must account for these differences, considering measurement granularity, independence of assessment, ability to differentiate between systems to ensure that stronger signals carry proportionate influence.

**Rewarding balance versus specialization.** When developing a composite assessment, the choice of aggregation approach has real consequences. Should strength in one area be allowed to compensate for weakness in another, or should the measurement reward balance?

**Balancing capability and implementation:** Where possible, credible measurement would capture not only whether a policy or capability exists on paper, but also whether it is being applied in practice. For instance, rather than only assessing whether a country has adopted national immunization policies, we can also examine actual vaccination coverage rates. This balance between de jure and de facto measurement strengthens the signal.

## Acknowledging What We Cannot Yet Measure (And Why it Matters)

No measurement framework can be stronger than the data that feeds it. Intellectual honesty requires acknowledging that global health data infrastructure, while advancing rapidly, has not kept pace with the full breadth of what prevention demands.

Some dimensions of prevention readiness are inherently harder to quantify at a global scale in a consistent way. Upstream, population-level capabilities such as health literacy, community-based prevention reach, and the conditions that shape whether risk factors emerge in the first place lack the standardized, comparable datasets that exist for clinical interventions. On the other hand, longitudinal tracking of how well health systems manage chronic conditions over time remains a significant gap in most countries. Furthermore, health threats are continuously evolving; emerging challenges such as antimicrobial resistance and climate-related health risks are reshaping what prevention needs to address, often faster than measurement systems can keep up.

These gaps are real, but they are not a reason to wait. The alternative to imperfect measurement is no measurement at all. A well-designed measurement framework can be built on what is available today, while explicitly earmarking gaps to inform future measurement efforts. The goal is not a perfect snapshot, but a credible, evolving tool that improves as the evidence matures.

## 4. Looking Ahead

A comprehensive measurement framework for preventive health readiness is sorely needed, but laying a proper conceptual foundation for what it should capture, open for stakeholder feedback, is also essential. Translating this framework into a living index will unlock significant value; not as an academic exercise, but as a practical tool designed to inform decisions, direct resources and drive accountability. Once released, the index will serve:

- **Policyholders and health system leaders:** to identify where prevention systems are strong, where they are exposed, and where reform and investment should be prioritized.
- **Investors:** to direct capital and resources toward the highest-impact gaps and opportunities that generate long-term savings and build the conditions for resilient and productive economies.
- **Global and regional health institutions:** to track whether international commitments are translating into actual system-level capability.
- **Employers, insurers, and the private sector:** to inform workforce health strategies,

market entry decisions, and long-term risk assessments.

- **Researchers:** to advance the science of prevention measurement, bridge data gaps, and evaluate the effectiveness of system-level interventions across countries.
- **Citizens and communities:** to mitigate the upstream conditions that drive disease burden, and enhance quality of life.

We believe the creation of a Prevention Health Readiness Index is both achievable and urgent. The conceptual framework presented here is a starting point: an invitation to refine, challenge, and build upon. In the months ahead, we will work with public health experts, policy-makers, and health system leaders to translate this framework into a practical measurement tool. We welcome that conversation because the ambition of a prevention-ready world will only be realized if we can see, clearly and comparably, how far we still have to go — and act before the burden arrives.



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