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Annex: Macroeconomic Analysis Assumptions

For the purposes of the model used in the accompanying paper, the following assumptions were made.

POPULATION COVERAGE AND SCOPE OF ROLLOUT

1. The model proposed by the Tony Blair Institute for Global Change (TBI) assumes that a population of 26.65 million adults in the UK with a body mass index (BMI) of 27 or more[1] could access anti-obesity medications (AOMs). The NHS model is based on, the NHS England rollout of AOMs, which in turn is based on NICE guidelines of tirzepatide rollout. This includes an initial rollout to 220,000 individuals between 2024 and 2027, followed by a gradual scaleup to reach a total of 3.4 million people over a 12-year period.[2,3] The model for NHS rollout includes the eligible population for England and is not a four-nations model.

2. Under TBI's proposed rollout, the model assumes that 14.75 million of the 26.65 million adults in the UK (56 per cent) would want to and would be able to access the medication (and the inverse: that not everyone in the population with a BMI of 27 and over would want to or would be able to take the medication):
    a. No data are currently available to show what percentage of the obese or overweight population actively wants to start treatment with AOMs, so we have estimated 60 per cent. This reflects voluntary-uptake patterns observed for other interventions: for example, flu-vaccine rates are between 32.1 and 77.8 per cent in the vulnerable population,[4] 71.7 per

[1] Prevalence data was extrapolated from HSE population data: National Centre for Social Research, University College London, Department of Epidemiology and Public Health, Health Behaviour Unit (2024). Health Survey for England, 2021 [data collection]. UK Data Service. SN: 9319, DOI: http://doi.org/10.5255/UKDA-SN-9319-1
[2] https://www.theguardian.com/society/2024/dec/05/nhs-to-restrict-new-weight-loss-drug-mounjaro-to-220000-patients-in-england-initially
[3] https://www.nice.org.uk/news/articles/nice-describes-how-weight-loss-drug-tirzepatide-will-be-rolled-out
[4] https://www.gov.uk/government/statistics/seasonal-influenza-vaccine-uptake-in-gp-patients-winter-season-2023-to-2024/seasonal-influenza-vaccine-uptake-in-gp-patients-in-england-winter-season-2023-to-2024

cent were willing to get vaccinated against Covid-19[5] and 20 per cent of people would take AOMs if they were free on the NHS.[6]

b. We set 93.5 per cent as the estimate of people who can access AOMs without risks because it accounts for:
    - Thyroid cancer being approximately 13.6 cases per 100,000, or 0.014 per cent.[7]
    - The prevalence of chronic pancreatitis being about 50 cases per 100,000 (0.05 per cent) and the annual incidence of acute pancreatitis being 13 to 45 per 100,000 (0.045 per cent).[8]
    - Chronic liver disease affecting 1.5 to 1.8 per cent of the European population.[9]
    - Severe chronic kidney disease affecting 2.6 million adults,[10] or approximately 4.8 per cent of the total adult population.

Disease prevalence calculations in the model include the general population and do not account for increased risk of disease in individuals with obesity or overweight, or who have type-2 diabetes. Notably, both models account for projected population growth through to 2050 and this is reflected across all aspects of the modelling, both in terms of costs and benefits.

3. For the proposed TBI model, it is assumed that AOM rollout would occur within two years and that that factors such as pharmacy capacity and medication availability would not limit the rollout.

4. For both the TBI and NHS rollout scenarios, treatment persistence was modelled based on real-world data on GLP-1 discontinuation rates, including published persistence studies[11,12,13] and pharmacy data.[14] The following assumptions were applied:
    a. Of those patients receiving the treatment, 52.5 per cent are expected to remain on it for at least two years. Although there is no published data on what long-term treatment with AOMs will look like, for the purposes of this model we have made the following assumptions regarding this group: one-third will complete a two-year course and then stop treatment; one-third will complete two years and subsequently cycle on and off

[5] https://www.cambridge.org/core/journals/psychological-medicine/article/covid19-vaccine-hesitancy-in-the-uk-the-oxfordcoronavirus-explanations-attitudes-and-narratives-surveyoceans-ii/C30FDB5C3D87123F28E351FDAAD5351A
[6] https://www.theguardian.com/society/2024/dec/28/one-in-five-britons-weight-loss-drug-free-nhs-poll#:~:text=The%20polling%20firm%20Ipsos%20surveyed%20a%20representative,if%20they%20were%20provided%20by%20the%20NHS
[7] https://seer.cancer.gov/statfacts/html/thyro.html?
[8] https://pmc.ncbi.nlm.nih.gov/articles/PMC3662544/
[9] https://pmc.ncbi.nlm.nih.gov/articles/PMC7007353/
[10] https://assets.publishing.service.gov.uk/media/5a82c379e5274a2e8ab593af/ChronickidneydiseaseCKDprevalencemodelbriefing.pdf
[11] https://link.springer.com/article/10.1007/s13300-021-01053-7#Sec13
[12] https://www.jmcp.org/doi/epdf/10.18553/jmcp.2024.23332
[13] https://onlinelibrary.wiley.com/doi/full/10.1002/oby.23952
[14] https://www.forbes.com/sites/joshuacohen/2024/07/11/study-shows-85-of-patients-discontinue-glp-1s-for-weight-loss-after-2-years/

treatment (modelled as three months of treatment per year); and one-third will remain on treatment for life. Of those patients,12.5 per cent are assumed to interrupt or pause treatment for one year. Of these, one-third will be treated for one year only and then discontinue with maintenance of benefits, one-third will resume treatment intermittently (modelled as three months of treatment per year) and one-third will also be treated for one year only but will not accrue significant long-term benefits.

b. Within the first six months of initiation, 35 per cent of patients are expected to discontinue treatment.

Currently there is no published research, clinical evidence or anecdotal input indicating what the successful cycling on and off GLP-1 therapy would entail, nor any evidence demonstrating the long-term success of such an approach. In the TBI and NICE models used in the accompanying paper, the cost of treatment for patients assumed to cycle on and off therapy is proxied as the equivalent of three months of treatment per year at the standard dose. While the optimal duration of therapy required to achieve and sustain health benefits remains uncertain, assumptions were made to enable fiscal modelling. Specifically, fiscal benefits were assumed to accrue only to patients who remained on treatment for a minimum of two years – including those cycling on and off – and to two-thirds of the population who received treatment for at least one year. This is under the assumption that these individuals would maintain sufficient health improvements to yield fiscal gains.

TBI models a rollout in which, for benefits to accrue, patients must continue treatment at the full dose to which they were originally titrated on an ongoing basis for the rest of their lives. Once treatment stops, the associated benefits are assumed to cease. In this case, the original discontinuation rates were used: 52.5 per cent of patients being expected to remain on treatment for life, 12.5 per cent assumed to interrupt or pause treatment for one year and 35 per cent expected to discontinue treatment within the first six months of initiation.

KEY ASSUMPTIONS FOR THE MICROECONOMIC MODELLING OF AOM COST

1. The monthly cost of AOMs was modelled to align with the current NHS list price:
   a. Under the NHS-proposed rollout, after the initial titration period this cost stabilises at £122 per month.[15] However, under TBI modelling it is assumed that an eight-year deal with major

[15] https://www.nice.org.uk/guidance/ta1026/resources/tirzepatide-for-managing-overweight-and-obesity-pdf-2973528337587397

pharmaceutical companies could be made, reducing the cost of the medication to 50 per cent of the current NHS price (£61 a month).

b. While the exact patent expiry date for AOMs such as semaglutide and tirzepatide remains uncertain, it is projected to occur around 2033. Accordingly, both models assume a significant reduction in drug costs following this date, reflecting the anticipated entry of generic competitors. A revised monthly cost of £50 was applied post-2033, in line with typical patterns observed following loss of exclusivity, where drug prices often decline by more than 80 per cent.[16] However, due to the complexity of manufacturing peptide-based therapies and the fact that current AOMs require injection pens, the cost of production for these medicines is expected to remain higher than for conventional oral generics. Estimated manufacturing costs range from £13 to £30 per month, driven by the expense of synthesising large peptide molecules and the cost of the injector device. Therefore, the assumed 80 per cent price reduction was applied only to the portion of the original price not attributable to manufacturing. For example, based on a branded cost of £122 per month and a manufacturing floor of £30, the modelled price becomes: £30 + (122-30) × 0.2 = £48.40, rounded to £50 for simplicity.

2. The cost of AOM delivery was modelled as follows:
   a. Under the NHS-proposed rollout, the total first-year cost of AOM treatment, including associated delivery and support services, is estimated to be £1,239.21. In subsequent years, ongoing costs are projected to decline to £355.18 per year, reflecting reduced support intensity after the initiation phase. These figures are based on current NHS clinical and reimbursement guidelines.[17] Notably, recent announcements suggest that rollout will not be restricted to primary care but potentially shared with community-care providers.[18] However, these changes have not been finalised and it is unclear how cost will be impacted. Therefore current modelling includes the most up-to-date cost released by the NHS instead.
   b. Under the TBI-proposed "lighter-touch" digital rollout, delivery costs were modelled at £43 per month (equivalent to £519.60 per year) for the first year, based on the average cost of private wraparound support.[19,20,21] For subsequent years, a reduced annual cost of £355.18 was applied, aligned with NHS pricing assumptions. This reduction reflects the assumption that patients will require less intensive support after the first year, having titrated to their

[16] https://www.medicinesuk.com/uploads/off-patent-savings-watch-h1-2025.pdf
[17] https://www.nice.org.uk/guidance/ta1026/documents/supporting-documentation-3
[18] england.nhs.uk/wp-content/uploads/2025/03/PRN01879-interim-commissioning-guidance-implementation-of-the-nice-technology-appraisal-ta1026-and-the-NICE-fu.pdf
[19] https://www.myjuniper.co.uk/glp-medication
[20] https://www.secondnature.io/guides/lifestyle/glp1s/boots-wegovy
[21] https://www.roczen.com/en-gb/pricing

optimal dose, established drug tolerability and completed a structured programme of exercise, dietary education and coaching. This assumption is consistent with existing NHS modelling. However, it is based on private providers adjusting their pricing to reflect the reduced intensity of ongoing support, which is not currently happening.

In the TBI model we assume that 50 per cent of the adult population will contribute to the cost of AOMs and associated wraparound support, while the remaining 50 per cent – considered to be on lower incomes – will be fully covered by the government. This split approximates the share of the population that would be unable to access the medication without public support, based on eligibility for free prescriptions under the current NHS scheme (estimated at 53 to 58 per cent of the population from official UK government data and reasonable assumptions).[22,23,24] Notably, this estimate is adjusted to exclude individuals who, while eligible for free prescriptions, are excluded from this model as they are not eligible for AOM under current licensing – specifically those under the age of 18 and pregnant.[25,26]

KEY ASSUMPTIONS FOR THE PROPOSED MACROECONOMIC MODELLING

The macroeconomic modelling results should be interpreted with these key assumptions in mind:

1. It is important to note that the model does not directly assess the impact of obesity on macroeconomic or labour-market outcomes. Instead, it quantifies the economic effects of reducing the incidence of six chronic diseases – cardiovascular disease (CVD), musculoskeletal conditions (MSK), diabetes, chronic obstructive pulmonary disease (COPD), cancer and mental-health conditions – that are all driven by obesity. In this way, while obesity serves as a critical underlying factor, the model's primary focus is on the macroeconomic benefits achieved through mitigating these six chronic diseases.
2. While the model used for this report focuses on capturing the macroeconomic impact achieved through the reduction of chronic diseases, there is an important evidence gap. Directly quantifying how obesity affects labour-market outcomes – such as workforce participation, productivity and earnings – is critical for developing a more comprehensive

[22] https://www.gov.uk/government/publications/census-2021-first-results-england-and-w[...]opulation-and-household-estimates-england-and-wales-census-2021
[23] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebir[...]hsummarytablesenglandandwales/2022/pdf
[24] https://www.ons.gov.uk/peoplepopulationandcommunity/educationandchildcare/bulletins/educationenglandandwales/census2021/pdf
[25] https://www.gov.uk/government/publications/census-2021-first-results-england-and-wales/population-and-household-estimates-england-and-wales-census-2021
[26] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebir[...]hsummarytablesenglandandwales/2022/pdf

economic perspective. Rigorous, data-driven research using high-quality administrative records from the UK would offer valuable insights into these causal links.

3. The model includes the potential impact of AOMs on reducing health- and social-care costs associated with CVDs. These savings were estimated using the "Cardiovascular Disease Prevention for people at high risk: Return on Investment Tool V1.0",[27] developed by the University of Sheffield. It is important to note that these estimates represent potential additional savings and should be interpreted with caution. They are included to illustrate the broader fiscal benefits that may arise from improved cardiovascular health, rather than to serve as definitive cost offsets. Furthermore, the tool models cost savings for England only, not the entire UK population, and is based on cost structures available at the time of the tool's development. As such, these figures may not fully reflect current or future service costs across the UK health system. Notably, the CVD-related benefits included in the model are based solely on the initial treatment population. The model does not account for population growth, which could lead to an increase in the number of individuals eligible for AOMs. While this consideration has been incorporated into all other aspects of this model, the potential impact of this increase on CVD-related hospitalisation savings has not been modelled in this analysis.
4. In this model, no additional health-care costs have been included that could be associated with patients presenting to the emergency department or primary care due to adverse events from using AOMs. While the model captures direct treatment costs and associated fiscal benefits, it does not account for potential side effects that may require medical attention. It is possible that some of these costs are implicitly reflected in existing health-service utilisation estimates or in other components of NHS cost modelling. However, they are not explicitly modelled here and as such, the overall cost projections should be interpreted as conservative with respect to potential costs related to adverse events.
5. When it comes to the treatment of the broader population, there is a possibility that some individuals – particularly those who are younger and relatively healthy – might re-enter the workforce as a result of improved health outcomes. However, in the paper *Prosperity Through Health: The Macroeconomic Case for Investing in Preventative Health Care in the UK,* we previously showed that it is generally more difficult for individuals who are already out of work to return to employment compared to retaining individuals currently in the workforce. Therefore, while this effect is likely to be relatively limited, it is still important to acknowledge that this dynamic is not explicitly captured in the current model.
6. It is anticipated that the rollout of AOMs will lead to improved health outcomes and increased life expectancy. As a result, a greater proportion of the population is expected to remain in good health for longer. This includes both an extension in the number of years individuals are

[27] https://cvd-prevention.shef.ac.uk/

able to remain in the workforce and an increase in the number of people reaching state pension age. The model incorporated both of these dynamics. The projected increase in the number of individuals eligible for the state pension was included with pension expenditure estimated using the 2024/2025 weekly state pension rate of £221.20.[28]

The macroeconomic modelling input was based on key targeting and treatment-effect assumptions:

7. To account for variation in population reach and drug efficacy, the model incorporates a matrix of targeting and treatment-effect scenarios:
    a. Targeting scenarios (Optimistic, Plausible and Pessimistic) represent different levels of success in reaching individuals affected by obesity-related conditions. These conditions include CVD, MSK, mental-health issues, cancer, diabetes and COPD. The Optimistic scenario assumes high coverage of the target population, Plausible reflects the most likely level of reach and Pessimistic assumes lower-than-expected uptake or access.
    b. Treatment-effect scenarios (Optimistic, Baseline and Pessimistic) reflect uncertainty around the real-world effectiveness of AOMs. The Optimistic scenario assumes outcomes exceeding current trial expectations, the Baseline scenario is aligned with efficacy observed in clinical trials and the Pessimistic scenario assumes reduced effectiveness in practice. A detailed breakdown of affected populations is provided in Figure 1, below.

These combined assumptions enable the model to generate a range of fiscal outcomes that reflect realistic variation in both delivery reach and drug performance. They also allow us to account for the high degree of uncertainty inherent at this early stage of the rollout, with robust real-world evidence still emerging.

Figure 1, below, presents the input matrix of scenarios used to model variation in both population reach and treatment efficacy for AOMs within the macroeconomic framework. Targeting scenarios (Optimistic, Plausible and Pessimistic) represent different levels of success in reaching individuals affected by obesity-related conditions, including CVD, MSK, mental-health conditions, cancer, diabetes and COPD. Treatment-effect scenarios (Optimistic, Baseline and Pessimistic) reflect uncertainty in real-world drug performance, ranging from outcomes exceeding trial expectations to those falling below anticipated levels.

[28] https://www.legislation.gov.uk/uksi/2024/242/memorandum/contents

FIGURE 1 – TARGETING AND EFFICACY SCENARIOS MODELLED IN THE MACROECONOMIC ANALYSIS

	Percentage of disease-affected population that also has overweight or obesity and could therefore be targeted by the intervention			Data are expressed as hazard ratios or relative risk ratios		
CVD						
Includes	Optimistic targeting	Plausible targeting	Pessimistic targeting	Optimistic treatment effectiveness	Baseline treatment effectiveness	Pessimistic treatment effectiveness
Congestive heart failure, coronary heart disease, angina, heart attack, stroke	95%	85%	61.2%[29]	0.49[30]	0.80[31]	0.90
MSK						
SF-12 physical component above 3	75%	57.3%[32]	45%	0.30	0.44[33]	0.70
Cancer						
Cancer or malignancy	40%	30%[34]	15%	0.35[35]	0.61[36]	0.75[37]
Mental health						
GHQ-12 score above 3	60%	45.9%[38]	30%	0.40	0.50[39]	0.60
Diabetes						
Diabetes	85%	69.8%[40]	60%	0.06[41]	0.67	0.85
COPD						
Asthma, chronic bronchitis, emphysema	65%	54.7%[42]	40%	0.60	0.70[43,44]	0.80

The targeting and efficacy values for each scenario and disease were further adjusted as follows:

a. For TBI rollout modelling we considered that 60 per cent of individuals with a BMI of 27 or more are expected to express interest in accessing treatment. Of these, 93.5 per cent are clinically

[29] Prevalence data was extrapolated from HSE population data: National Centre for Social Research, University College London, Department of Epidemiology and Public Health, Health Behaviour Unit (2024). Health Survey for England, 2021 [data collection]. UK Data Service. SN: 9319, DOI: http://doi.org/10.5255/UKDA-SN-9319-1
[30] https://www.nejm.org/doi/full/10.1056/NEJMoa1901118
[31] https://www.nejm.org/doi/full/10.1056/NEJMoa2307563
[32] Prevalence data was extrapolated from HSE population data: National Centre for Social Research, University College London, Department of Epidemiology and Public Health, Health Behaviour Unit (2024). Health Survey for England, 2021 [data collection]. UK Data Service. SN: 9319, DOI: http://doi.org/10.5255/UKDA-SN-9319-1
[33] https://www.nejm.org/doi/full/10.1056/NEJMoa2403664
[34] https://archive.cdc.gov/www_cdc_gov/media/releases/2017/p1003-vs-cancer-obesity.html
[35] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820833
[36] https://meetings.asco.org/abstracts-presentations/238997
[37] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820833
[38] Prevalence data was extrapolated from HSE population data: National Centre for Social Research, University College London, Department of Epidemiology and Public Health, Health Behaviour Unit (2024). Health Survey for England, 2021 [data collection]. UK Data Service. SN: 9319, DOI: http://doi.org/10.5255/UKDA-SN-9319-1
[39] https://pmc.ncbi.nlm.nih.gov/articles/PMC8864443/#trc212268-sec-0140
[40] Prevalence data was extrapolated from HSE population data: National Centre for Social Research, University College London, Department of Epidemiology and Public Health, Health Behaviour Unit (2024). Health Survey for England, 2021 [data collection]. UK Data Service. SN: 9319, DOI: http://doi.org/10.5255/UKDA-SN-9319-1
[41] https://www.nejm.org/doi/full/10.1056/NEJMoa2206038
[42] Prevalence data was extrapolated from HSE population data: National Centre for Social Research, University College London, Department of Epidemiology and Public Health, Health Behaviour Unit (2024). Health Survey for England, 2021 [data collection]. UK Data Service. SN: 9319, DOI: http://doi.org/10.5255/UKDA-SN-9319-1
[43] https://www.bmj.com/content/379/bmj-2022-071380
[44] https://link.springer.com/article/10.1186/s13098-023-01118-6

eligible to use the drug (and not at risk of severe side effects). Of those eligible, 65 per cent are expected to successfully complete at least one year of treatment.

b. For NICE rollout modelling. we considered that under NICE eligibility criteria, only 12.9 per cent of the overweight and obese population would have access to the medication (equivalent to the 3.4 million individuals who have access to the treatment). Of this group, around 65 per cent are expected to complete at least one year of treatment. Notably, while the scenario used in this analysis reflects the Plausible targeting assumption, the estimates are adjusted to account for 12.9 per cent of the eligible population receiving treatment. It is possible that this is a conservative estimate. This subgroup likely represents those with the highest unmet need and may therefore include a higher proportion of individuals affected by one or more of the six priority conditions described above. However, this macroeconomic model focuses on fiscal benefits linked to improved health and likelihood of remaining in work. Under current NHS England rollout criteria, the intervention is recommended for individuals with high BMI and multiple comorbidities, who are more likely to experience severe disease progression. While health outcomes for this group may improve significantly, it is expected that a large proportion are already out of work and would therefore not retain fiscal benefits under this model.

POTENTIAL FISCAL BENEFITS OF AOM ROLLOUT

Figure 2 presents the projected total fiscal benefits of a large-scale rollout of AOMs to 14.7 million individuals across the UK (expressed in £ billions in today's prices). The fiscal model assumes full enrolment at the beginning of Year 0, with benefits commencing from Year 1 onwards. Three targeting scenarios – Optimistic, Plausible and Pessimistic – represent different levels of success in reaching individuals affected by obesity-related conditions: high, most likely and low. These conditions include CVDs, MSKs, mental-health conditions, cancer, diabetes and COPD. In parallel, three treatment-effect scenarios – Optimistic, Baseline and Pessimistic – are modelled to capture variation in drug efficacy. They reflect a scenario where treatment yields above-expected health benefits, another aligned with randomised trial evidence and one where treatment confers less protection than anticipated. These combined scenario matrices allow for the evaluation of fiscal outcomes under a range of realistic and uncertain rollout conditions. For a detailed condition-specific breakdown, refer to the previous chapter: Macroeconomic Analysis Assumptions.

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FIGURE 2 – TOTAL FISCAL BENEFITS OF THE TBI-MODELLED AOM ROLLOUT TO 14.7 MILLION INDIVIDUALS ACROSS THE UK (£ BILLIONS)

Year from treatment	TBI optimistic targeting + optimistic treatment	TBI optimistic targeting + baseline treatment	TBI optimistic targeting + pessimistic treatment	TBI plausible targeting + optimistic treatment	TBI plausible targeting + baseline treatment	TBI plausible targeting + pessimistic treatment	TBI pessimistic targeting + optimistic treatment	TBI pessimistic targeting + baseline treatment	TBI pessimistic targeting + pessimistic treatment
0	0	0	0	0	0	0	0	0	0
1	2.00	1.46	0.98	1.56	1.14	0.75	1.11	0.80	0.52
2	3.68	2.69	1.79	2.87	2.09	1.38	2.04	1.47	0.96
3	5.09	3.71	2.47	3.97	2.88	1.90	2.81	2.02	1.32
4	6.25	4.55	3.03	4.88	3.54	2.33	3.45	2.48	1.61
5	7.22	5.25	3.49	5.63	4.08	2.69	3.99	2.86	1.86
10	10.15	7.33	4.86	7.92	5.69	3.74	5.59	3.98	2.58
15	11.43	8.20	5.43	8.91	6.37	4.18	6.27	4.45	2.88
20	12.11	8.65	5.73	9.45	6.72	4.41	6.64	4.69	3.03
25	12.62	8.97	5.92	9.86	6.97	4.56	6.92	4.86	3.13
30	13.24	9.30	6.12	10.36	7.24	4.72	7.25	5.03	3.24
35	13.93	9.64	6.31	10.94	7.52	4.88	7.63	5.21	3.34
40	14.73	10.03	6.53	11.59	7.84	5.06	8.06	5.41	3.45
45	15.67	10.49	6.80	12.37	8.22	5.28	8.56	5.65	3.59

Figure 3, below, presents the projected total fiscal benefits of AOM rollout to 3.4 million individuals across the UK according to the proposed NHS England rollout (expressed in £ billions in today's prices). It uses the same targeting scenarios and treatment-effect scenarios as Figure 2, outlined above. (For a detailed condition-specific breakdown, see Figure 1.)

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FIGURE 3 – TOTAL FISCAL BENEFITS OF THE NICE-MODELLED AOM ROLLOUT TO 3.4 MILLION INDIVIDUALS ACROSS THE UK (£ BILLIONS)

Year from treatment	NICE optimistic targeting + optimistic treatment	NICE optimistic targeting + baseline treatment	NICE optimistic targeting + pessimistic treatment	NICE plausible targeting + optimistic treatment	NICE plausible targeting + baseline treatment	NICE plausible targeting + pessimistic treatment	NICE pessimistic targeting + optimistic treatment	NICE pessimistic targeting + baseline treatment	NICE pessimistic targeting + pessimistic treatment
0	0	0	0	0	0	0	0	0	0
1	0.46	0.34	0.22	0.36	0.26	0.17	0.25	0.19	0.12
2	0.85	0.62	0.41	0.66	0.48	0.31	0.46	0.34	0.22
3	1.17	0.85	0.56	0.91	0.66	0.43	0.64	0.47	0.30
4	1.43	1.04	0.69	1.12	0.81	0.52	0.78	0.58	0.36
5	1.66	1.20	0.80	1.29	0.93	0.60	0.90	0.66	0.42
10	2.32	1.67	1.11	1.81	1.29	0.83	1.26	0.92	0.58
15	2.60	1.87	1.24	2.03	1.45	0.93	1.41	1.03	0.65
20	2.76	1.97	1.30	2.15	1.53	0.98	1.50	1.08	0.68
25	2.87	2.04	1.35	2.25	1.58	1.02	1.56	1.12	0.71
30	3.01	2.11	1.39	2.36	1.64	1.05	1.63	1.16	0.73
35	3.17	2.19	1.43	2.49	1.71	1.09	1.72	1.20	0.75
40	3.35	2.28	1.48	2.63	1.78	1.13	1.81	1.25	0.78
45	3.56	2.38	1.54	2.80	1.86	1.18	1.92	1.30	0.81