ECONOMIST ENTERPRISE

Healthy foundations: The hidden economics of women's prevention



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Contents

3 About this report

5 Executive summary

8 The hidden opportunity: reframing women's prevention

12 Quantifying the opportunity

15 Why we still have an economic accounting problem

19 Build the evidence decisions require

20 Design women's health strategies to close the gaps

22 Appendix: Methodology note

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About this report

Healthy foundations: The hidden economics of women's prevention is the first report in Economist Enterprise's *The Women's Health Dividend*, a three-year research programme supported by Merck KGaA, Darmstadt, Germany. Across three pillars—Healthy Foundations, Healthy Families and Healthy Communities—the programme explores how interconnected factors shape women's health, wellbeing and opportunities across the life course, with consequences for families, communities and economies.

This report focuses on the first pillar, Healthy Foundations.* It examines why women's prevention—preventing illness where possible, detecting it earlier and limiting its progression and complications—represents one of the world's largest overlooked opportunities to improve health, keep women in the workforce and drive long-term economic growth. We consider prevention across women's lives and where action can change women's health trajectories. We explore how better prevention can improve health and advance health equity, while reducing costs and creating economic benefits for women, employers, health systems and economies.

Economist Enterprise reviewed and analysed existing data and research on women's prevention across more than 30 conditions and cross-cutting risks that affect women uniquely, disproportionately or differently. An advisory board of six experts in health economics, clinical care and health policy across Asia, Europe and North America helped to test and refine the research framework and analytical approach. We also developed a bespoke analytical model to begin quantifying the economic opportunity associated with stronger prevention.



Women's prevention—preventing illness where possible, detecting it earlier and limiting its progression and complication

*Healthy Foundations takes a prevention-first approach, examining opportunities across women's lives to prevent illness where possible, detect it earlier and limit its progression and complications. This focus on prevention represents one part of the broader foundations of women's health.

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Using hypertension and diabetes as proof points, the report quantifies one measurable part of this opportunity and makes the case for women's prevention as an urgent investment priority. These conditions show what becomes visible when the evidence is strong enough to quantify prevention's impact, and how much of the wider opportunity remains unmeasured.

Subsequent phases of the programme will build on this foundation through the Healthy Families and Healthy Communities pillars, exploring additional factors that shape health, wellbeing and opportunity across the life course.

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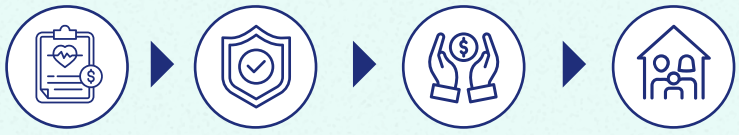
Executive summary

Around the world, a quiet economic crisis continues to unfold in plain sight. Consider a woman in the peak of her earning years, whose health begins to change the terms of her daily life. Pain and fatigue make her job and her responsibilities at home harder, yet she continues to manage both. Her symptoms go unrecognised or are dismissed as stress and tiredness. She works fewer hours, passes up opportunities, earns less or eventually leaves the workforce earlier than planned, with less time and energy for her family and herself. Some of these effects are visible: her employer records reduced output, the health system records appointments, the government records her retirement, and her family takes on more care as her health deteriorates. What remains largely unmeasured is what better health might have enabled—the earnings and financial security she might have built, the opportunities she might have pursued, and the value she might have created for herself, her family and the wider economy. Over a lifetime, that gap can compound.

Across billions of women, the gap between realised outcomes and unrealised potential becomes a tangible economic opportunity hiding in plain sight:

How does prevention create economic value?



keeping women healthier for longer. Prevention is how we begin to capture the opportunity. Prevention creates economic gains in two connected ways: it avoids health-care costs and protects women's contributions to paid and unpaid work. It preserves healthier trajectories that enable women to remain in work, advance, earn and build financial security over time, supporting household wellbeing with benefits that extend to future generations.

However, much of prevention's economic value is hidden and difficult to estimate. A legacy of neglect has left many costs and lost opportunities beyond direct health-care costs poorly measured. What evidence exists is dispersed across conditions, institutions and stages of women's lives, and estimates tend to capture immediate, measurable consequences rather than the full value prevention could generate.

Economist Enterprise's *The Women's Health Dividend* programme, supported by Merck KGaA, Darmstadt, Germany, begins to make the economic opportunity presented by women's prevention more visible. Drawing on a synthesis of more than 30 conditions and cross-cutting risks* that uniquely or disproportionately affect women, our research applies a broad definition of prevention across conditions and the life course: preventing illness where possible, detecting it earlier and limiting its progression and complications. We examined where prevention could change women's health trajectories, what health improvements and economic gains could follow, and modelled a defined portion of this opportunity for hypertension and diabetes. The result is an economic case that reinforces what the health and equity case already makes clear: prevention is an investment worth making.

*The selected conditions illustrate the breadth of the women's prevention opportunity across the life course, spanning conditions that are unique to women, disproportionately affect women, are experienced differently by women or arise from cross-cutting risk factors. The list of conditions explored in this report is illustrative rather than exhaustive, but we have tried to capture a wide range of conditions to demonstrate the size of the opportunity.

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Almost US$780bn

from two conditions is not the full economic opportunity. It is just the tip of the iceberg.



By reducing the prevalence of just two conditions, economies stand to gain more than US$2bn a day and save over a half a million lives each year.

Three key findings stand out:

- **Women's prevention is increasingly recognised as an important opportunity, but it is still not a coherent investment category**. Prevention remains fragmented by disease, intervention and life stage. Its economic consequences are fragmented too, spread across health systems, employers, households and women themselves, who may absorb many of these costs across both paid work and unpaid care. No single decision-maker sees the full opportunity. Until prevention is defined and examined across conditions and women's lives, governments and health systems will continue to miss what they are failing to protect—and fail to invest accordingly.
- **Prevention pays dividends. By reducing the prevalence of just two conditions, economies stand to gain more than US$2bn a day and save over half a million lives each year**. Reducing the prevalence of hypertension and diabetes among women by 10%, while improving diagnosis and control, could generate almost US$780bn in annual economic gains—more than the size of Ireland's entire economy.[1] The same improvement can also save the lives of around 580,000 women each year, roughly the total number of deaths recorded annually across England and Wales.[2] And this US$780bn is not an estimate of the full value of women's prevention: it covers just two conditions, bounded improvements and only those economic consequences that available evidence allows us to estimate credibly. Its deliberately narrow scope makes the scale of the result more—not less—striking.
- **The value of women's prevention is hidden not only by missing data but also by incomplete economic accounting**. Existing estimates often value individual conditions and their consequences separately, rather than how prevention's health and economic effects interact and compound across women's lives. The evidence available today reflects what medicine has historically recognised, studied and measured in women. Conditions with complete evidence pathways are more readily recognised as investment opportunities; those with incomplete evidence remain economically obscured. Historical neglect therefore has an economic legacy: what has been studied least remains hardest to value.

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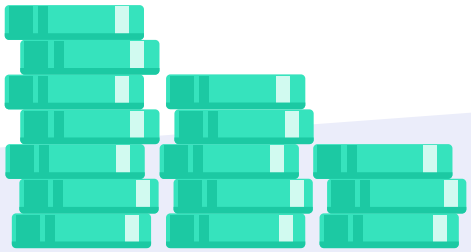
These conclusions expose a fundamental distortion: governments and health-care systems might see estimates of what prevention will cost, but lack a coherent account of the prosperity it enables across health systems, workplaces, households and women's lives. Prevention consequently is perceived as expenditure, and preventable ill health is dispersed across institutions and absorbed into the economy as business as usual.

This matters because preventive care already commands a small share of health budgets: across OECD countries, roughly 3% of health spending goes to preventive care.[3] The result can be a self-reinforcing cycle: what is poorly measured is easier to under-invest in, and what is under-invested in remains poorly understood.

Governments and health-system leaders do not need a perfect estimate of the entire opportunity before acting. They should apply a coherent definition of prevention across conditions and the life course; measure where women are missed, not merely the burden that follows; and assess returns across health care, paid work, unpaid contributions and longer-term financial security. They should act on established prevention pathways whose health benefits are already clear, while building the evidence needed to reveal their wider economic value.

Almost US$780bn from two conditions is not the full economic opportunity.[4] It is just the tip of the iceberg and a clear signal of how much value remains hidden because no one is responsible for seeing the whole picture.



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The hidden opportunity: reframing women's prevention

Women live longer than men, but they are not healthier: they spend about 25% more of their lives in poor health.[5] Behind those years of poor health lies a major prevention opportunity. Prevention—or preventing illness, detecting it earlier and limiting its progression— represents a major, still under-measured economic opportunity for women.[6] Our research takes a deliberately broad view of prevention, encompassing risk reduction, earlier recognition and diagnosis, effective treatment, and sustained control and action to prevent progression and complications.

Table 1. Prevention spans the disease pathway: definitions and examples[7,8,9,10]

	Primary prevention *"Reduce risk"*	**Secondary prevention** *"Detect earlier"*	**Tertiary prevention** *"Prevent progression"*
Definition	Reduce exposure to risk factors and delay or prevent disease where possible	Detect disease earlier so treatment can begin sooner	Manage disease effectively to prevent complications, disability and premature mortality
Examples			
Osteoporosis	Physical activity and adequate calcium and vitamin D	Fracture-risk assessment and bone-density testing	Pharmacological treatment and coordinated post-fracture care to prevent further fractures
Cervical cancer	Prophylactic HPV vaccination	HPV testing and cervical screening	Early treatment of pre-cancerous lesions and cervical cancer to improve survival and prevent complications

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Just 5% of global health R&D spending is directed towards women's health conditions.

Yet these opportunities are rarely considered together. Prevention for women is too often studied, funded and delivered condition by condition and life stage by life stage, rather than as a continuum across the life course.[11,12] Policymakers can see individual interventions and disease-specific opportunities, but not how their value connects and compounds across women's lives.

This fragmentation is no accident. Decades of gender bias in medicine have shaped what is recognised, researched, measured and ultimately valued, creating an evidence base that systematically understates both the burden of women's ill health and the value of preventing it.[13,14]

Five interconnected legacies within medicine, research and measurement have created this blind spot:

1 **Women's health has been narrowly defined**. For decades, women's health has been treated largely as reproductive health, leaving broader physical and mental health needs overlooked across the life course.[15] This has had far-reaching consequences for care delivery, research, measurement and funding: just 5% of global health research and development (R&D) spending is directed towards women's health conditions.[16,17]

2 **Medicine has treated men as the default**. Men's biology has long provided the baseline for research and care, leaving women under-represented in research and too often overlooked in clinical care.[18,19] Women of child-bearing age, for example, were routinely excluded from early-phase clinical trials in the US until federal guidelines changed in the 1990s.[20] Even heart disease, which kills more women than all cancers combined, has historically been understood through male patterns of disease.[21,22] Female-specific conditions have received less attention still: outside of cancer, they receive just 1% of health-care R&D and innovation funding.[23,24,25,26,27,28] The result is predictable: overlooked or misattributed symptoms, missed opportunities for prevention, later diagnosis and, ultimately, poorer health outcomes.[29,30,31]

3 **Women's health has been organised around diseases, not women**. Women's health is shaped across the life course, as biological, behavioural and social factors interact and accumulate over time.[32] Risks arising at one stage may affect health much later. Yet services and policies frequently treat reproductive health, non-communicable diseases, mental health and ageing as separate concerns.[33] Prevention, therefore, remains organised by individual diseases and life stages, fragmenting care and obscuring its cumulative value.[34,35,36]

4 **Evidence has accumulated one condition at a time, not across prevention as a whole**. The health and economic value of preventing individual diseases is well established.[37] But much of the evidence stops there. Prevention is measured one condition at a time rather than across women's lives.[38] This fragmented approach extends to measurement. Mortality and disability are widely tracked, but comparable measures of prevention, such as screening and early diagnosis, are often unavailable or inconsistent.[39] The result is that prevention remains harder to measure, and easier to undervalue.

5 **Economic measures have treated paid work as the work that counts**. Women perform 76% of unpaid care work globally, yet the economic consequences of this are often considered separately from paid employment and health-care costs.[40,41,42,43] When poor health reduces a woman's capacity for unpaid work, that work may go undone or shift to others in the household. This creates another economic blind spot: costs move through households without becoming fully visible in conventional measures of ill health or prevention.

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Why doesn't prevention reach more women?[44,45,46,47,48,49,50,51]

Women can face barriers at every stage of the prevention pathway:

Symptoms can be missed. Differences in women's risk and symptoms, compared to men, are not always recognised, and stigma can prevent some symptoms from being raised or discussed, contributing to missed opportunities for prevention and diagnosis.

Access can be constrained. Financial barriers, gender norms, caregiving responsibilities and other social factors can affect women's ability to seek and remain engaged with care.

Care can be fragmented. Unequal access, diagnostic bias and gaps between services can delay diagnosis, treatment and follow-up.

These barriers continue to shape how the prevention opportunity is understood today. Existing analyses quantify disease burden, health outcomes, workforce impacts and broader economic gains, but few examine prevention as a connected opportunity across women's lives. Table 2 illustrates how those silos are reflected within women's health.

These biases have obscured the prevention opportunity, but they need not define how we approach it today. There is ample evidence to begin viewing women's prevention holistically and approaching it differently.

To do so, our research examined more than 30 conditions and cross-cutting risks that affect women uniquely, disproportionately or differently. Table 3 illustrates how applying a prevention lens across women's lives reveals opportunities to improve both health and economic outcomes. It does not rank conditions or interventions.

Table 2. Illustrative examples of how women's prevention is organised in silos[52,53,54,55,56,57,58,59]

Women's prevention domain	What is commonly measured	What is inconsistently connected
Cardiometabolic health *(eg, hypertension, diabetes)*	Risk factors, disease control, cardiovascular events and mortality	How reproductive health, pregnancy history and menopause influence later cardiometabolic risk
Reproductive and gynaecological health *(eg, endometriosis, polycystic ovary syndrome, fibroids)*	Symptoms, fertility rate, quality of life and disease management	Links to later chronic disease risk and women's broader health trajectory
Maternal health *(eg, gestational diabetes, hypertensive disorders of pregnancy, postpartum haemorrhage)*	Maternal and neonatal outcomes and pregnancy complications	Women's long-term cardiovascular, metabolic and mental health after pregnancy
Mental health *(eg, depression, perinatal mental health)*	Symptoms, diagnosis, treatment and quality of life	Connections with reproductive, maternal and chronic physical health across women's lives
Healthy ageing *(eg, menopause, osteoporosis, dementia)*	Symptoms, fractures, cognitive decline and health-care use	Earlier-life prevention opportunities and long-term health trajectories

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Table 3: The women's prevention opportunity landscape*[60,61,62,63,64,65,66,67,68,69]

Nature of women-specific impact of health issue			
			
Unique to women	**Disproportionately affects women**	**Affects women differently**	**Cross-cutting risks**
Why a women-specific lens matters			
Arises from female biology or life stages, but has consequences that extend well beyond reproduction.	Women experience greater burden or systematic under-recognition.	Risk, symptoms, diagnosis, treatment or outcomes differ for women because of sex or gender.	Risk exposure and prevention opportunities differ for women.
Conditions and risks examined			
Maternal mortality and morbidity; hypertensive disorders of pregnancy; gestational diabetes; pregnancy loss; unsafe abortion; endometriosis; adenomyosis; fibroids; polycystic ovary syndrome; menstrual disorders; infertility; menopause; pelvic-floor disorders; cervical, ovarian and endometrial cancers	Autoimmune diseases; osteoporosis; migraine; depression and anxiety; thyroid disease; iron-deficiency anaemia; chronic pain; urinary incontinence; dementia; obesity	Cardiovascular disease (including hypertension and stroke); diabetes and pre-diabetes; chronic kidney disease; asthma; chronic obstructive pulmonary disease; lung and colorectal cancers; HIV and other infectious diseases; musculoskeletal conditions; sleep disorders	Obesity; nutrition; physical inactivity; tobacco and alcohol use; pollution; occupational exposures; gender-based violence; poverty; unequal access to resources and care

*This table is meant to illustrate the breadth of the prevention opportunity; categories are not necessarily mutually exclusive and collectively exhaustive.

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Quantifying the opportunity

The full economic value of women's prevention remains unmeasured. Evidence remains fragmented across conditions, life stages and prevention pathways. Yet even the part we can measure makes a compelling case for action. To illustrate that opportunity, we modelled hypertension and diabetes, two major drivers of death and disability among women that together affect almost 1.9bn women worldwide, including those that are undiagnosed.*[70]



WHY HYPERTENSION & DIABETES?*

- Represent high-burden, prevention-responsive conditions.
- Demonstrate well-established opportunities across the prevention pathway, from reducing disease prevalence to earlier diagnosis and better control.
- Have strong evidence linking earlier detection to improved health outcomes for women.
- Have comparable international data that allows consistent modelling across countries.

*See the accompanying methodology note for further details on pathway selection.

A 10% reduction in the prevalence of hypertension and diabetes could prevent...

390,000 cases of stroke and ischaemic heart disease every year

60m reduction in the number of women living with diabetes

580,000 deaths among women averted every year

Together, these conditions cost the global economy more than US$4.3trn each year, more than double total EU health expenditure in 2023.[71] But the current burden tells only part of the story. Our analysis shows that, of the 1.3bn women living with hypertension and 580m living with diabetes, nearly half remain undiagnosed across both conditions, leaving millions without treatment until preventable complications emerge. Under-diagnosis therefore represents a major missed opportunity to prevent complications and their economic consequences.

Even modest improvements could deliver substantial gains. In our modelled scenario, reducing the prevalence of hypertension and diabetes by 10%, while improving diagnosis and control to the standard achieved by the world's best-performing countries,** could:

- prevent almost 390,000 cases of stroke and ischaemic heart disease every year;
- reduce the number of women living with diabetes by around 60 million; and
- avert around 580,000 deaths among women annually.

* Rather than examining individual interventions in isolation, the analysis takes a continuum approach to prevention, spanning risk reduction, earlier diagnosis and better control of existing conditions.
** "Best-performing countries" refers to the countries with the highest-observed rates of diagnosis and disease control for women in the underlying dataset (Kazakhstan for hypertension diagnosis, South Korea for hypertension control, Colombia for diabetes diagnosis, and Belgium for diabetes control). The term best-performing is not meant to imply that these countries do not have room to improve their rates of diagnosis and disease control. The model estimates the potential gains if all countries achieved these benchmark levels while reducing disease prevalence by 10%. The 10% scenario represents an ambitious but plausible global improvement, informed by the WHO's goal to halt the rise in diabetes and evidence from diabetes prevention programmes.

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KAZAKHSTAN
Earlier hypertension diagnosis through routine screening[72,73]



Highest diagnosis rate for women in model

Free national screening: Hypertension screening has been embedded in primary care since 2008.

Multiple detection opportunities: Hypertension screening programmes have extended blood-pressure measurement beyond clinics to workplaces, pharmacies and homes in rural Kazakhstan, creating more opportunities for detection.

Structured referral: Patients with raised blood pressure are referred for physician assessment through primary care.

SOUTH KOREA
Better hypertension control through sustained treatment[74,75,76]



Highest control rate for women in the model

High treatment coverage: Hypertension awareness and treatment have expanded substantially, with almost three-quarters of adults with hypertension receiving treatment.

Sustained treatment: The number of people adhering to antihypertensive treatment rose from 0.6m in 2002 to 8.1m in 2022, supporting consistent blood-pressure control.

Combination therapy: Treatment commonly combines antihypertensive medicines to help patients to achieve blood-pressure control.

Table 4. Breakdown of annual economic savings for women by cost category, hypertension and diabetes*

Cost category	Hypertension	Diabetes
Direct health-care costs	73%	33%
Absenteeism	17%	23%
Presenteeism	8%	28%
Informal care and domestic work	2%	16%
Mortality	~1%	0.5%
Early retirement	~0%	0.5%

*The model assumes a 10% reduction in the prevalence of hypertension and diabetes, alongside improvements in diagnosis and control to rates observed in the highest-performing countries. It captures only those impacts that can be measured consistently across countries over one year. Longer-term consequences, including mortality, early retirement and unpaid work, are likely to be understated, particularly as their impacts compound over time.

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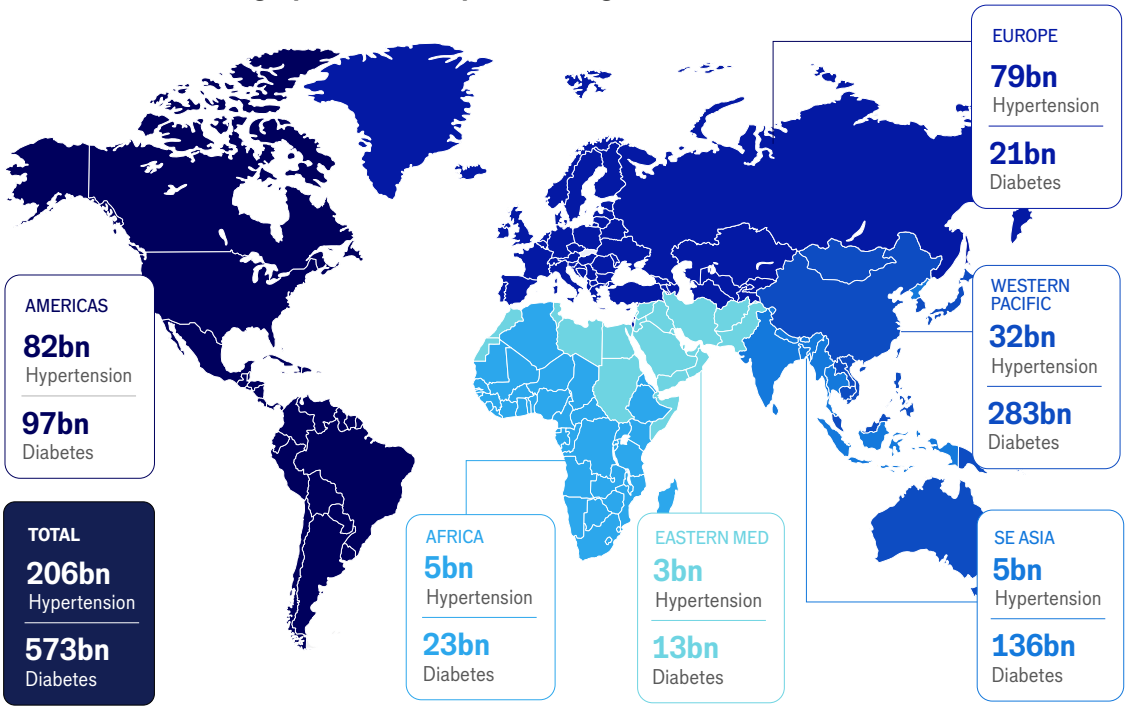
Table 5. Annual savings, per condition, per WHO region*



*Differences reflect variation in the underlying burden and economic inputs used in the model; the analysis was not designed to explain country- or region-specific drivers.

What this means for one woman

The longer-term cost of premature retirement:

Diabetes: modelled average early retirement age 58 (7 years early) | **~US$50,000 lost**

Ischaemic heart disease: modelled average early retirement age 52 (13 years early) | **~US$130,000 lost**

Stroke: modelled average early retirement age 45 (20 years early) | **~US$200,000 lost**



*The model assumes a general retirement age of 65.

These modelled estimates capture only one part of the longer economic trajectory and do not fully reflect forgone career progression, lifetime earnings or financial security.

The economic gains would also be substantial. Our economic modelling shows that earlier diagnosis and better management of hypertension and diabetes alone could generate almost US$780bn in annual economic savings worldwide—more than US$2bn every day. Most of these measurable gains come from lower health-care costs, together with reductions in absenteeism and presenteeism.

The opportunity is global, with substantial measurable gains across every WHO region.

Diabetes drives the most measurable savings in the Western Pacific and South-East Asia, whereas hypertension accounts for a greater share of the measurable opportunity in the Americas and Europe.

These figures do not even capture the full economic opportunity, but they do not need to. If preventing and managing two common chronic conditions generates almost US$780bn in annual savings, the wider opportunity across women's health is likely to be measured in trillions, if not more. Prevention is an investment in women's health and equity. It is also an investment in future economic capacity.

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Why we still have an economic accounting problem

The almost US$780bn estimate is possible because hypertension and diabetes have relatively strong evidence pathways: defined improvements in diagnosis and control can be connected to changes in health outcomes and, in turn, to measurable economic gains. Even then, the analysis excludes outcomes where causal links cannot yet be established or consistently measured, as well as benefits beyond the model's one-year time horizon.

Revealing the wider opportunity for women is therefore not simply a matter of expanding the analysis to include more conditions. It requires evidence connecting three elements: the burden women experience; the points at which prevention and care could change health trajectories; and the health and economic gains that would follow. Our review across more than 30 conditions and cross-cutting risks found that these pathways frequently break down, as Table 6 illustrates.



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Table 6. Missing data linkages across the economic argument for women's prevention*[77,78,79,80,81,82,83,84,85,86,87,88,89,90,91,92,93,94,95,96,97,98]

Evidence gap	What is missing	Illustrative conditions	
Global burden is only partly visible	Estimates may miss undiagnosed disease, symptom severity and duration, and variation across life stages or multimorbidity.	**Endometriosis:** Long diagnostic delays mean that the diagnosed burden may underestimate the true burden of the condition.	**Thyroid disease:** Underdiagnosis means prevalence and impacts are incompletely captured.
Health-care delivery, including screening, is poorly measured	Comparable evidence on prevention, screening, diagnosis, treatment, adherence and effective control is frequently absent.	**Chronic kidney disease:** Gaps remain in understanding how sex and gender affect women's detection, monitoring, referral and management of chronic kidney disease.	**Hypertensive disorders of pregnancy:** Systematic screening and long-term follow-up remain gaps in care and measurement.
The effects of action are not traced	Health-care and productivity losses may be documented without showing what earlier diagnosis or better management would avert.	**Fibroids:** Health-care and productivity burdens are well documented, but the benefits of treatment remain incompletely quantified.	**Pre-diabetes:** Interventions can reduce progression to diabetes, but their broader effects on work and productivity are less well quantified.
Women's economic losses are only partially captured	Effects on education, employment, work hours, earnings, advancement, unpaid work and caregiving are inconsistently captured.	**Rheumatoid arthritis:** Studies document losses in earnings, paid work and household activities, but rarely capture these impacts together.	**Stroke:** Women's work loss, unpaid care and caregiver impacts remain incompletely measured.
Evidence cannot be easily combined	Studies use different definitions, populations and time horizons and are concentrated in select countries and workplaces.	**Menopause:** Evidence is concentrated in high-income countries and uses inconsistent outcome measures.	**Perinatal mental health:** Intervention and economic evidence remains fragmented across countries and study designs.

Individual studies make important contributions to different parts of the economic pathway. Estimating the wider value of prevention, however, often requires connecting those findings with evidence from other studies. Table 7 illustrates the kinds of connections such an estimate requires.

Connecting these pieces requires reconciling different populations, definitions, comparators and time horizons. Historical biases in women's health make that task even harder.

Why the full prevention opportunity remains difficult to estimate

Even where evidence from different studies can be connected, estimating the wider value of women's prevention remains methodologically challenging.

* The examples illustrate how evidence from different studies can be connected. They do not imply that the relevant evidence is absent, nor do they represent a complete assessment of the evidence for each condition.

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Three issues make it difficult to produce a credible estimate: attribution, accumulation and aggregation. These challenges are compounded by the breadth of prevention itself. Different points along the prevention pathway create different health and economic gains, realised over different time horizons and across women, families, employers, health systems and governments. No single estimate captures this full picture.

Table 7. Connecting the evidence for women's prevention*

Condition or health issue	What the study shows	Additional action needed to estimate the wider economic pathway
Menstrual disorders[99]	Links heavy or prolonged menstrual bleeding and severe menstrual pain during adolescence with increased school absence and lower educational attainment.	Connect earlier identification and effective treatment with educational outcomes, and any resulting improvements in later employment, lifetime earnings and financial security.
Endometriosis[100]	Links longer time to diagnosis with greater health-care use and higher health-care costs before diagnosis.	Connect earlier diagnosis and treatment strategy with subsequent changes in health, health-care use and long-term economic outcomes.
Menopause[101]	Documents associations between menopausal symptoms and work impairment, absence, productivity and career decisions.	Connect clinical or workplace interventions with improved symptoms, then quantify effects on employment, lifetime earnings, career progression and financial security.
Iron-deficiency anaemia[102]	Synthesises evidence that iron supplementation improves physical performance among women of reproductive age, with evidence suggesting potential benefits for work capacity and productivity.	Connect feasible improvements in identification and treatment at scale with sustained gains in health, employment and productivity across settings and over time.
Asthma[103]	Estimates productivity losses associated with uncontrolled asthma, many of which could be avoided through better clinical control.	Connect defined prevention and disease-management strategies with sustained control at scale, and quantify health-care, productivity and long-term gains.
Uterine fibroids[104]	Documents symptom burden, reduced quality of life and effects on work productivity.	Connect earlier diagnosis and treatment with changes in symptoms, productivity, employment, career progression and long-term economic outcomes.
Thyroid disease[105]	Links thyroid disease with sick leave, reduced work ability, lower income and disability pension.	Connect disease severity, earlier diagnosis and effective management with employment, productivity and earnings over time.

*The examples illustrate how evidence from different studies can be connected. They do not imply that the relevant evidence is absent, nor do they represent a complete assessment of the evidence for each condition.

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From fragmented evidence to corrective investment

This accounting problem is not neutral. Economic analysis necessarily begins with the evidence available, and the completeness of that evidence can be mistaken for the scale of the opportunity.

Conditions with measurable burden, established intervention pathways and economic consequences are more readily recognised as investment opportunities. Those characterised by under-investment, under-diagnosis, fragmented care, poorly measured effects on unpaid care and domestic work or consequences that unfold over many years can appear less consequential—not because their preventable value is necessarily smaller, but because less of it is visible.

Historical neglect can therefore become self-reinforcing: weaker evidence constrains investment, and limited investment leaves the evidence pathway incomplete. Governments should not allow the evidentiary consequences of past neglect to become the justification for its continuation.

Table 8. Methodological challenges to estimating the value of women's prevention[106,107,108,109]

Methodological challenge	Why it matters
Attribution *(linking action to outcomes)*	The burden of disease is not the same as the value of preventing it. Estimating prevention's value requires a defined intervention and a credible counterfactual showing how much health and economic loss that intervention would avert.
Accumulation *(capturing compounding effects over time)*	Annual and condition-specific estimates may not capture how health disruptions compound across education, employment, earnings, unpaid work and financial security—or how multiple conditions interact over women's lives.
Aggregation *(combining evidence)*	Existing estimates cover different populations, outcomes, assumptions and time horizons, and often overlap. Simply adding them together may in some cases produce a larger number, but not a credible estimate of prevention's value.

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Build the evidence for better decisions

Our call to action, however, is not to produce a single speculative estimate of the global economic gains from women's prevention. It is instead to build the evidence needed to make better decisions: to identify where women are being missed, what earlier action would change, how those changes improve health and economic outcomes, and who benefits. Table 9 outlines the minimal data needed to answer these questions.

This evidence pathway should become part of how women's health strategies set priorities, design delivery and measure success—capturing what better health protects inside and outside the labour market.

Table 9. Building the evidence to support women's prevention

Decision to make	Minimum data needed
Who is affected, when and for how long?	Sex- and age-disaggregated prevalence, symptoms, severity, duration, disability and multimorbidity
Where are women being missed?	Coverage of prevention, screening where appropriate, diagnosis, treatment, adherence and effective disease control, disaggregated across population groups and care settings
What difference would earlier action make?	Effects of earlier or improved intervention on functioning, progression, complications and survival
What does better health protect?	Education, work capacity, career progression, labour-force participation, earnings, financial security, unpaid care and domestic work over time
Who pays, who benefits and when?	Costs and benefits across health systems, employers, governments, households and women
How do benefits accumulate across life stages and conditions?	Linked health, education, employment and household data

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Design women's health strategies to close the gaps

Women cannot benefit from prevention while evidence and systems continue to overlook their needs. Women's health strategies must identify where women's risks, symptoms and responses remain poorly understood; where diagnostic delays or barriers leave preventable burden unaddressed; and where incomplete evidence obscures opportunities for investment. Investment and implementation should then be targeted to close those gaps.



Governments and health-care systems must translate this approach into four actions:

- **Build prevention around women's lives, not diseases alone**. Governments and health systems should organise prevention around women's lives rather than individual diseases, using a consistent life-course approach across conditions that affect women uniquely, disproportionately or differently. Disease-specific action remains essential, but programmes operating in isolation cannot address the overlapping risks, gaps and transitions women experience throughout their lives. Prevention should connect risk reduction, screening, earlier diagnosis, treatment and long-term disease management throughout the life-course, while prioritising conditions where biological differences, diagnostic bias or historical evidence gaps contribute to poorer outcomes for women.
- **Make women's prevention a whole-of-government priority**. No single ministry can deliver the full benefits of women's prevention. Governments should establish shared priorities, co-ordinated investment and joint accountability across health, education, employment, finance and other relevant ministries so women's prevention becomes a shared responsibility across government.
- **Set targets where women are being missed**. National women's prevention strategies should establish time-bound, sex-disaggregated goals

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for prevention coverage, screening, diagnosis, treatment initiation and effective disease control—not merely report disease and disability that follow when these pathways fail. These indicators should identify where women are being lost along the prevention pathway, target investment where the gaps are greatest and hold health systems accountable for prevention, not just treatment.

- **Prevent historical evidence gaps from delaying action**. Where burden is established but the economic pathway is incomplete, governments and health systems should implement proven interventions while embedding evaluation into delivery, using real-world data to strengthen the evidence base rather than delaying action until it is complete.

Prevention should reflect the realities of women's health. Women need prevention strategies that reflect where their biology, health risks and experiences of care differ, and where historical gaps in research, diagnosis and measurement have left preventable needs unmet. Addressing those gaps is not preferential treatment. It is evidence-based prevention. Doing so is also central to realising prevention's full health and economic potential.

An uplift of US$780bn from two conditions, although compelling in itself, more importantly exposes the limits of how our system currently recognises prevention's value. The question is no longer whether women's prevention has value. It is whether governments, health systems and others will act early enough to protect the health, opportunities and economic potential that poor health in women can quietly take away.

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Appendix: Methodology note

Introduction

This methodology note describes the analytical approach, assumptions and principal data inputs used to estimate the health and economic benefits of improving prevention, early diagnosis and disease management for women. The quantitative analysis focuses on two illustrative conditions: hypertension and diabetes mellitus. Together, these case studies demonstrate how strengthening prevention pathways can improve women's health outcomes while also generating wider economic benefits through lower health-care expenditure, improved productivity and reduced losses in unpaid care.

Hypertension and diabetes were selected for the analysis because they are among the most prevalent non-communicable diseases globally, impose substantial health and economic burden, and are amenable to prevention, earlier diagnosis and effective long-term management. Their selection was informed by the following criteria:

- Presence of a sex- or gender-specific dimension, recognising that women may experience distinct risk factors and barriers to diagnosis and treatment;
- Scale of impact, including the size of the affected population and the potential impacts on health and economic outcomes;
- Strength of evidence, with robust evidence linking prevention, diagnosis and disease management to health and economic outcomes; and
- Availability of standardised and internationally comparable data, enabling consistent modelling across countries.

The models of the two diseases differ slightly in scope. The diabetes model focuses on the direct health and economic burden associated with diabetes mellitus, and the benefits of reducing its prevalence and improving diagnosis and disease management. The hypertension model uses a broader disease pathway, because hypertension is a major modifiable risk factor for cardiovascular disease. In addition to estimating the burden directly associated with hypertension, the model also captures downstream reductions in cases of stroke and ischaemic heart disease (IHD) resulting from improved hypertension prevention and management.

Although the quantitative analysis focuses on these two conditions, they are intended to be illustrative rather than exhaustive. The broader report makes the case for strengthening prevention across women's health more generally. Hypertension and diabetes therefore serve as case studies demonstrating the scale of the health and economic benefits that can be achieved through investment in prevention.

The models estimate impacts separately for women and men to capture differences in disease burden and outcomes by sex. However, the primary focus of the analysis is on women, reflecting evidence that women often face distinct barriers to prevention, diagnosis and treatment. In addition to formal labour

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market impacts, the analysis also incorporates losses in unpaid care and domestic work, recognising that these activities are typically disproportionately undertaken by women. Including both formal and informal economic activity provides a more comprehensive estimate of the value of prevention.

Overview of the analysis

The analysis estimates the health and economic burden associated with two illustrative disease pathways:

- Hypertension, including downstream cardiovascular outcomes (stroke and IHD); and
- Diabetes mellitus.

The analysis is conducted separately for men and women across 194 countries, before being aggregated to regional and global levels. The scope of the modelling exercise is summarised in Table 1.

The model first estimates the baseline disease burden for each condition, translated into health-care costs and formal and informal productivity losses. The baseline represents the current health and economic burden of each disease based on observed rates of prevalence, diagnosis and disease management.

The model then measures a series of scenarios for each disease representing improvements in prevention, diagnosis and disease management. The first scenario assumes either a 5% or 10% reduction in disease prevalence. The second scenario builds on these reductions by also assuming improvements in diagnosis and treatment, with rates set to those observed in the highest-performing countries in the model dataset. The difference between the baseline and each scenario represents the estimated reduction in disease burden and the corresponding annual health and economic benefits (Table 2).

The assumed 5% and 10% reductions in prevalence were selected as evidence-informed scenarios that represent realistic and achievable improvements in prevention rather than forecasts of future outcomes.* The benchmark diagnosis and treatment rates are similarly intended to represent ambitious but achievable levels of performance based on the highest country-specific values observed in the model dataset for each condition.** Together, these scenarios provide an evidence-informed range for illustrating the potential health and economic benefits of strengthening prevention, diagnosis and treatment.

Table 1. Scope of the analysis

Attribute	Description
Geographic scope	194 countries, with country-level estimates aggregated globally and regionally across the six defined WHO regions:[110] Africa, Americas, South-East Asia, Europe, Eastern Mediterranean and Western Pacific.
Population	The model covers the entire population. Disease burden and associated health outcomes are estimated using sex-disaggregated population data from the UN World Population Prospects.[111] Productivity impacts are estimated for the working-age population (18-65 years) only.
Time horizon	Static, one-year analysis estimating annual health burden and annual health and economic benefits. Lifetime impacts are not modelled.
Model outputs	Cases diagnosed and managed; cardiovascular events and deaths; direct medical costs; formal productivity losses; and informal productivity losses through loss of unpaid work.

*For hypertension, a 5% reduction was selected as a conservative scenario and a 10% reduction as an ambitious scenario. These assumptions are informed by historical evidence showing that several high-income countries achieved declines in hypertension prevalence exceeding 12 percentage points between 1990 and 2019. (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01688-3/abstract). For diabetes, the 5% and 10% reductions are informed by previous modelling studies that evaluated a 10% reduction in diabetes incidence as a plausible outcome of strengthened primary-care interventions (https://pmc.ncbi.nlm.nih.gov/articles/PMC3537737/).
**For hypertension, the highest diagnosis and control rates in the model dataset are observed in Kazakhstan and South Korea respectively. For diabetes, the corresponding benchmark countries are Colombia (diagnosis) and Belgium (control).

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Table 2. Baseline and modelled scenarios

Scenario	Low estimate	High estimate	Difference from baseline
Baseline	Current burden		Current health and economic burden
Scenario 1	5% lower prevalence	10% lower prevalence	Benefits associated with reduced prevalence of hypertension and diabetes mellitus
Scenario 2	Scenario 1 plus diagnosis and treatment rates equivalent to the highest-performing country*	Scenario 1 plus diagnosis and treatment equivalent to the highest-performing country*	Additional benefits from combining prevention with improved diagnosis and treatment

*For hypertension, the benchmark diagnosis and control rates are drawn from Kazakhstan and South Korea respectively. For diabetes, the benchmark diagnosis and control rates are drawn from Colombia and Belgium.

Analytical approach

This section describes the analytical approach used to estimate the health and economic burden associated with each disease pathway and the potential benefits under the modelled scenarios.

Figures 1 and 2 illustrate the analytical frameworks for the hypertension and diabetes pathways.

The hypertension pathway (Figure 1) captures both the direct burden associated with hypertension and its downstream cardiovascular consequences, specifically stroke and IHD. Hypertension is modelled more broadly because it is a major modifiable risk factor for cardiovascular disease, allowing the analysis to estimate some of the wider health and economic benefits that arise from preventing and effectively managing hypertension.

Figure 1. Hypertension pathway

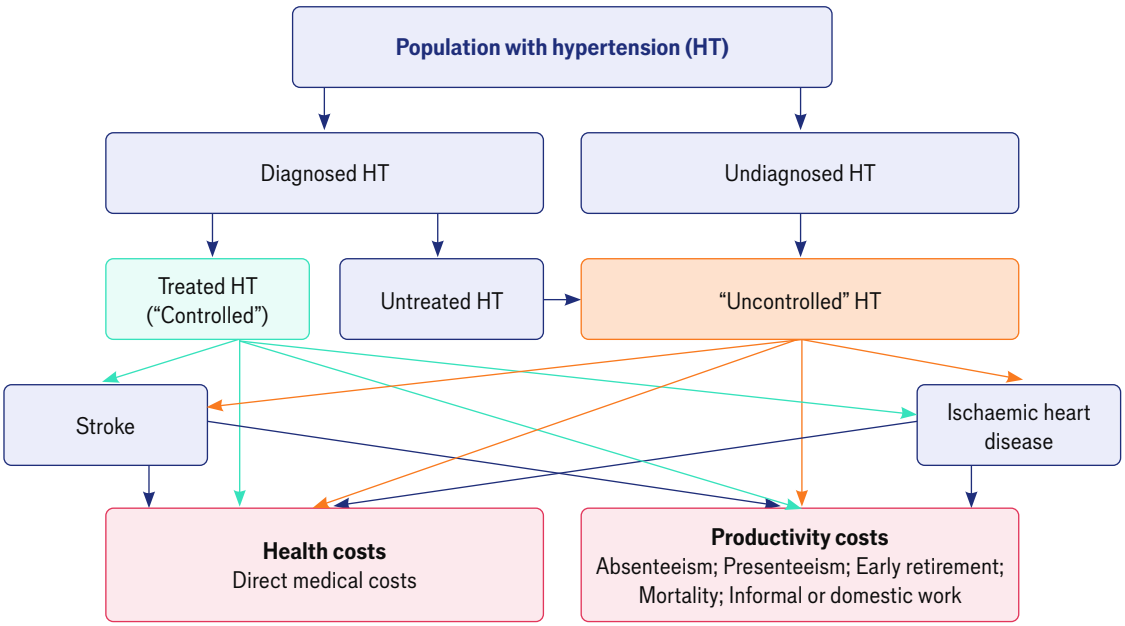

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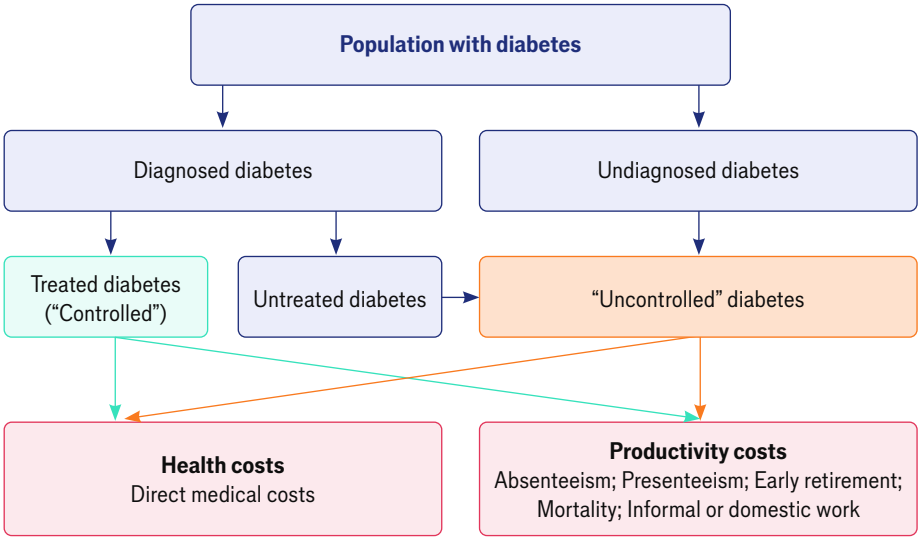
Figure 2. Diabetes pathway



By contrast, the diabetes pathway (Figure 2) focuses on the direct burden associated with diabetes mellitus. Although diabetes has numerous long-term complications, robust and internationally comparable evidence linking improvements in prevention and disease management to downstream outcomes is less consistently available. Restricting the pathway to diabetes therefore provides a robust and conservative estimate of the benefits associated with improved prevention, diagnosis and disease management.

Although the two pathways differ in scope, the same broad analytical approach is applied to each and separately for women and men across all countries.

For each disease pathway, the analysis estimates:

1. **Disease burden**: Estimates the number of people living with the condition, including those who are diagnosed and undiagnosed, and controlled and uncontrolled.
2. **Direct medical costs**: Translates health outcomes into direct medical costs.
3. **Productivity costs**: Translates health outcomes into productivity costs, including formal and informal costs.
4. **Health and economic benefits**: Compares the baseline with the modelled scenarios to estimate the annual health and economic benefits associated with improved prevention, diagnosis and disease management.

Estimating disease burden and health outcomes

The analysis first estimates the number of women and men living with each condition across countries. Country-specific prevalence estimates from the WHO are applied to population data from the UN World Population Prospects to estimate the total number of people living with hypertension and diabetes mellitus.

Individuals are then classified according to their disease status. First, they are divided into those who have been diagnosed and those who remain undiagnosed using country-specific diagnosis rates. Among those diagnosed, individuals are further classified according to whether their condition is effectively managed (controlled) or not effectively managed (uncontrolled) using country-specific disease-management rates. It is assumed that all undiagnosed cases of each disease are uncontrolled. These estimations provide the baseline distribution of disease burden that underpins all subsequent health and economic burden calculations.

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For the hypertension pathway, the distribution of controlled and uncontrolled hypertension burden is then used to estimate the burden of two major cardiovascular outcomes: stroke and IHD. Individuals with controlled and uncontrolled hypertension are assigned different risks of experiencing stroke and IHD based on published epidemiological evidence, reflecting the reduced cardiovascular risk associated with effective hypertension management. This allows the analysis to estimate the number of hypertension-attributable stroke and IHD cases under both the baseline and each modelled scenario.

Under scenario 1, reductions in disease prevalence decrease the total number of people living with each condition. Under scenario 2, improvements in diagnosis and treatment rates then shift individuals from undiagnosed to diagnosed status and from uncontrolled to controlled disease, reflecting strengthened prevention pathways and more effective long-term management. For hypertension, these changes also reduce the estimated number of stroke and IHD cases attributable to hypertension, allowing the model to capture the wider health and economic benefits of preventing hypertension and improving its management.

The epidemiological inputs and assumptions used across each disease pathway are summarised in Table 3.

Table 3. Epidemiological inputs and assumptions used to estimate disease burden and health outcomes*

	Hypertension pathway			Diabetes pathway
	Hypertension	Hypertension-related stroke	Hypertension-related IHD	
Prevalence	Country-specific prevalence from WHO[112]	Estimated from hypertension prevalence and published relative risks of stroke from hypertension. Assumed that the risk of stroke from controlled hypertension is 0.73 times the risk from uncontrolled[113]	Estimated from hypertension prevalence and published relative risks of IHD from hypertension. Assumed that the risk of stroke from controlled hypertension is 0.83 times the risk from uncontrolled[114]	Country-specific prevalence from WHO[115]
Diagnosis rate	Country-specific diagnosis rates from WHO[116]	Not applicable	Not applicable	Country-specific diagnosis rates from the International Diabetes Federation[117]
Treatment rate	Country-specific treatment rates from WHO[118]	Not applicable	Not applicable	Country-specific treatment rates from WHO[119]
Case-fatality rate (CFR)	Assumed no hypertension-related deaths within one year	Country-specific estimates calculated using The Institute for Health Metrics and Evaluation (IHME) incidence and mortality data[120]	Country-specific estimates calculated using IHME incidence and mortality data	Country-specific estimates calculated using IHME prevalence and mortality data

*Missing country values are replaced with a geographically or economically comparable proxy.

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2. Estimating direct medical costs

After estimating the disease burden, direct medical costs are estimated for each disease pathway using published evidence and country-specific health-care data.

For hypertension and diabetes, published cost estimates are generally reported as average costs per case rather than separately for individuals with controlled and uncontrolled disease. Average direct medical costs are therefore disaggregated using published evidence on differences in health-care utilisation between effectively managed and unmanaged disease, before being applied to the corresponding case estimates.

For hypertension-related stroke and IHD, direct medical costs are applied uniformly to all estimated cases. These conditions represent acute cardiovascular events that incur treatment costs irrespective of the hypertension treatment pathway. Although hypertension management influences the likelihood of experiencing these events, once they occur, average treatment costs are assumed to be the same.

The assumptions and data sources used to estimate direct medical costs are summarised in Table 4.

Table 4. Direct medical costs assumptions*

	Hypertension pathway			Diabetes pathway
	Hypertension	**Hypertension-related stroke**	**Hypertension-related IHD**	
Cost applied by disease management status (controlled and uncontrolled)?	Yes - separate costs for controlled and uncontrolled hypertension	No - average cost per event	No - average cost per event	Yes - separate costs for controlled and uncontrolled diabetes
Primary data source	Published literature on hypertension care costs[121] and country-specific health expenditure per head[122]	Country-specific health expenditure per head[123]	Published literature and country-specific GDP per head data[124]	International Diabetes Federation estimates of annual cost per person of diabetes[125]
Costing approach and assumptions	Average annual cost per person is estimated based on an assumption that the annual cost of care is 0.68 times the health expenditure per head.[126] Costs are then disaggregated between controlled and uncontrolled disease using a weighted average approach, assuming uncontrolled hypertension incurs 1.11 times higher costs than controlled hypertension[127]	Average annual cost per stroke event is estimated as 1.7% of country-specific health expenditure per head.[128] Event costs are assumed to be independent of hypertension management status.	Average annual cost per IHD event is estimated using published evidence, assuming costs are equivalent to 21.7% of GDP per head.[129] Event costs are assumed to be independent of hypertension management status.	Average annual cost per person is taken from International Diabetes Federation estimates. Costs are disaggregated between controlled and uncontrolled disease using a weighted average approach, assuming individuals with HbA1c <7%** incur 1.7% lower health-care costs than those with HbA1c ≥7%.[130]

*Missing country values are replaced with a geographically or economically comparable proxy.
**Standard cutoff for diagnosing diabetes is HbA1c > 6.5%; the study uses 7% as the glycaemic-control target for those already with diabetes.

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3. Estimating productivity costs

The analysis estimates the wider economic consequences of each disease by quantifying productivity losses among working-age adults through different formal and informal channels. Table 5 summarises each productivity measure included in the analysis, which, together, capture both formal labour market impacts and losses in unpaid economic activity.

Productivity impacts are estimated separately for women and men using country-specific and sex-specific labour market data, and disease-specific estimates of productivity loss.

The analysis first estimates the number of people living with each condition who are of working age (18-65 years). Country-specific employment rates are then applied to estimate the number of those individuals participating in the labour market.[131] For each disease pathway, published evidence is used to estimate the effects of disease on productivity through absenteeism, presenteeism, early retirement, premature mortality and loss of unpaid caregiving. The resulting losses in time are valued using country-specific earnings data to estimate the associated market productivity costs.[132]

Table 6 summarises the disease-specific assumptions applied across each productivity channel.

4. Estimating health and economic benefits of prevention

The final stage of the analysis combines the estimated health outcomes, direct medical costs and productivity impacts to calculate the total annual health and economic burden associated with each disease pathway under both the baseline and each modelled scenario.

The difference between the baseline and each scenario represents the estimated annual health and economic benefits associated with strengthening prevention, improving diagnosis and enhancing disease management.

Limitations of the analysis

This analysis provides a simplified, cross-country framework for estimating the potential health and economic benefits of strengthening prevention, early diagnosis and disease management for women. By focusing on two illustrative disease pathways, it demonstrates how improvements in prevention can reduce disease burden and generate economic gains through lower health-care expenditure, improved productivity and reduced unpaid care. The findings are intended to illustrate the direction and potential scale of these benefits rather than provide comprehensive estimates of the value of prevention across all health conditions affecting women.

Table 5. Productivity measures and definitions

Productivity measure	What the model captures
Absenteeism	Paid working time lost through sickness-related absence
Presenteeism	Reduced productivity while remaining at work in ill health (estimated in days)
Early retirement	Loss of labour market participation resulting from ill health
Mortality	One year of lost economic production due to premature death
Unpaid work	Lost non-market activity (unpaid care, household and domestic activity) associated with illness

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Table 6. Productivity assumptions by disease pathway*

	Hypertension pathway			Diabetes pathway
	Hypertension	**Hypertension-related stroke**	**Hypertension-related IHD**	
Absenteeism (days lost per year)	Controlled: 2.28[133] Uncontrolled: 4.39[134]	62.1[135]	39.8[136]	Controlled: 5.4[137] Uncontrolled: 18.1[138]
Presenteeism (days lost per year)	Controlled: 4.13[139] Uncontrolled: 4.52[140]	10.1[141]	16.3[142]	Controlled: 12.0[143] Uncontrolled: 26.3[144]
Early retirement	Not modelled - assumed not to result directly in early retirement within the one-year time horizon of the model	Average retirement age: 45 years[145] Proportion retiring early: 36.8%[146]	Average retirement age: 52 years[147] Proportion retiring early: 18.9%[148]	Average retirement age: 58.3 years[149] Proportion retiring early: 30% higher rate of exit than those without diabetes[150]
Premature mortality	Not modelled - assumed not to result directly in premature mortality within the one-year time horizon of the model	Based on country-specific case-fatality rates (Table 3) applied to estimated working-age population with condition	Based on country-specific case-fatality rates (Table 3) applied to estimated working-age population with condition	Based on country-specific case-fatality rates (Table 3) applied to estimated working-age population with condition
Unpaid care and domestic work	Assumed the same number of days lost in unpaid care and domestic work as days lost in formal employment through absenteeism, applied to baseline country- and sex-specific time spent on unpaid care and domestic work (UN Women)[151]			

*Parameter values are informed by relevant literature. Where a directly applicable estimate was unavailable, the parameter was derived from related estimates or assumptions based on the available evidence.

The analysis adopts a static, one-year framework so benefits that accrue over longer periods, including some downstream health effects and longer-term impacts on employment, earnings and financial security, are not fully captured. It does not account for future changes in population demographics, disease epidemiology or health-care systems. The modelled scenarios should therefore be interpreted as illustrative, evidence-informed estimates of the potential annual benefits rather than forecasts of future outcomes.

The analysis also uses a standardised methodology across 194 countries to enable international comparability. As a result, it relies on generalised assumptions and internationally available data sources and does not explicitly account for country-specific differences in health-care systems, treatment quality, population characteristics or wider social determinants of health. Furthermore, it does not capture sources of heterogeneity within countries, such as differences by age, socioeconomic status or ethnicity.

Finally, although the hypertension pathway incorporates selected downstream cardiovascular outcomes, not all downstream complications, comorbidities or wider societal benefits of prevention can be robustly quantified using internationally comparable evidence. Similarly, although the analysis includes losses in unpaid care and domestic work, it does not capture all broader social and economic impacts of improved health, including effects on quality of life, educational attainment or intergenerational outcomes. The estimates presented are therefore likely to understate the full value of strengthening prevention, particularly for women, and should be interpreted as conservative approximations of the potential health and economic benefits.

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