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PREVENTIVE HEALTH READINESS INDEX

Measuring how prepared countries are to prevent disease



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1. FOREWORD

Health systems are historically measured by what they deliver and how they react to illness, whether that is through spending, hospital capacity, clinical outcomes or waiting times. However, these metrics say very little about whether countries and health systems are equipped to stop illness from occurring in the first place.

Chronic disease, infectious threats and injuries place a rising and largely preventable burden on health systems, and the cost of managing that burden is growing faster than most health budgets can absorb. The ambition to shift toward prevention is well established in global commitments, but turning that ambition into capability has proved more challenging.

The Preventive Health Readiness Index measures the systems that make prevention possible. It assesses the policy architecture, the funding structures, the data infrastructure and the delivery capacity that together determine whether a country can prevent disease at scale.
One finding that runs through the whole index is that no country has finished building. Every country here, including those at the top, has substantial ground left to cover. Additionally, wealth alone does not determine prevention readiness, as we see several middle-income countries outperforming richer nations. Prevention is fundamentally a question of system design and investment priorities, rather than resources alone.

For investors, the index highlights where the prevention systems still have room to develop. But that opportunity isn't something to tackle alone; it takes partnership. Governments set the policy and hold the data, while much of the infrastructure, technology and delivery capacity is built with external partners. The returns then run three ways, with better health for populations, lower long-term costs for systems and commercial return for those who are doing the building. For policymakers, the index is a diagnostic and provides a practical tool for identifying where their prevention systems are weaker and showcases what higher performing countries have done differently.

We built this index because prevention is where health spending and economic return meet most directly. This is not just a ranking or a list. It is a map of which countries are building the foundations of healthier populations and where future investment and policy action can have the greatest impact.

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2. Executive Summary

Health systems are typically measured by how they treat disease. Far less attention is paid to whether they are equipped to prevent it. The Preventive Health Readiness Index addresses that gap by measuring the policy, financing, data and delivery systems to determine just how prepared countries are to prevent disease, rather than how well they treat it.

The index evaluates and scores 114 countries across four readiness dimensions: Policy & Governance, Funding & Incentives, Digital & Data, and Access & Capacity that when taken together showcase the level of prevention readiness. Twenty-seven indicators drawn from established international sources are combined into an overall readiness score. Health outcomes are assessed separately as a complementary lens, allowing for further examination on how readiness relates to health outcomes.

The United Kingdom leads the index overall, followed by Finland and Australia. Countries are grouped into four readiness tiers: 16 are Advanced, 20 Established, 28 Developing and 50 Emerging. The United States records the strongest Digital & Data performance, Finland leads on Policy & Governance, the Republic of Korea ranks first for Funding & Incentives and Australia leads when it comes to Access & Capacity. The spread of results highlights that countries build prevention readiness in different ways and that overall performance depends on how effectively policy, financing, data and delivery work together as a system.

What the index reveals:

- **Prevention readiness is unfinished everywhere.** Even the highest-ranked countries show material gaps across all four dimensions. Prevention readiness is not a destination but a continuous process of strengthening policy, financing, data and delivery capabilities. This is an agenda for every country in the index.

- **Readiness is not determined by income alone.** While readiness broadly follows income, the index identifies several countries that outperform wealthier peers. Thailand reaches the Advanced tier, and Chile, Malaysia and Brazil come in ahead of a number of higher-income countries. Prevention readiness reflects decisions about how health systems are designed and financed, and those decisions are accessible across a wide range of income levels.

- **Readiness and outcomes move together.** Outcomes reflect decades of accumulated decisions, while readiness reflects the systems countries have built today. Readiness is positively associated with population health outcomes and may provide a forward-looking signal of future performance.

- **Prevention measurement itself needs strengthening.** The index draws on a large and growing body of internationally comparable data, but building it also revealed important gaps in how prevention is measured globally. Areas such as how well policy is implemented and enforced, how far preventive services actually reach and how much spending arrives at prevention remain difficult to assess consistently. Better measurement is a precondition for directing investment and policy effort well.

Taken together, the findings show that prevention readiness is not predetermined. The index gives policymakers, investors and global health institutions a practical tool for seeing where each country's system is weakest and where effort is likely to count most.

3. Understanding Preventive Health Readiness

Why measurement matters

The FII Institute's Healthy Humanity Blueprint positions prevention as a foundational pillar of long-term health improvement.[1] World Health Organization ("WHO") Member States endorsed the Global Action Plan for the Prevention and Control of Non-Communicable Diseases, setting a roadmap to reduce premature mortality.[2] The International Health Regulations place binding obligations on countries to build core public health capacities for detection and response[3] and the UN Sustainable Development Goals put universal coverage and preventable mortality at the center of the global agenda.[4]

What has been missing is a way to tell whether those commitments have translated into capability. Our whitepaper Silent Systems, Loud Burden set out the case for measuring prevention readiness and proposed the conceptual framework.[5] This index applies that framework and produces the measurement.

The need is straightforward. Global health measurement is built around outcomes and service delivery, focused on mortality, disease burden, coverage and expenditure metrics. These are essential measures and the index draws on several of them. They only describe what has already happened. A country that strengthens its prevention systems today may not see the effect in its disease burden for a decade or more. Judging prevention by outcomes alone means judging every country by the decisions taken a generation ago.

What the index measures

Prevention is not a single activity. It operates across a continuum, from shaping the conditions that give rise to risk in the first place, through to preventing disease onset and detecting it early, to managing established illness to prevent complications. The whitepaper set out four analytical levels: primordial, primary, secondary and tertiary prevention. The taxonomy is condition-agnostic and applies to non-communicable disease, infectious disease and injuries alike.[5]

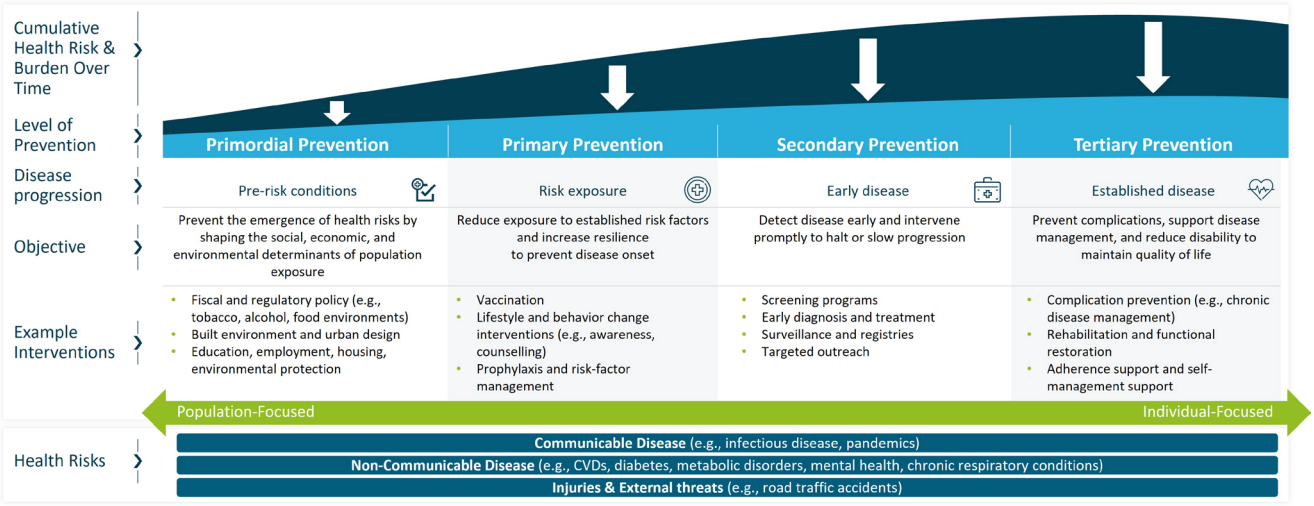


Figure 1. Defining prevention – an analytical taxonomy

Health outcomes are shaped by genetics, behavior, social and economic conditions as well as environmental exposure, much of which sits outside any system's direct control. Readiness focuses on what can be deliberately built, including the capabilities that determine whether proven prevention can actually be delivered equitably and at scale. Some of these capabilities, such as primary care workforce, essential medicines, financial protection and emergency response, are also characteristics of broader healthcare system capacity and are included because prevention cannot reach people without them. Capacity that serves treatment alone, such as hospital beds or specialist care, does not meet that condition and sits outside the index. The framework identifies four enabling dimensions and recognizes health outcomes and impact as a complementary lens to contextualize system readiness over time.

Preventive health readiness is the intersection of the prevention analytical levels and the four readiness dimensions. Accordingly, the index produces a readiness score, but its more useful output is the dimension profile underneath each score. The rank tells you where a country stands. The dimension profile tells you what to do next. Two countries with the same overall score can face entirely different constraints and the action each needs to take is different. The index allows every country to be examined dimension by dimension and indicator by indicator.

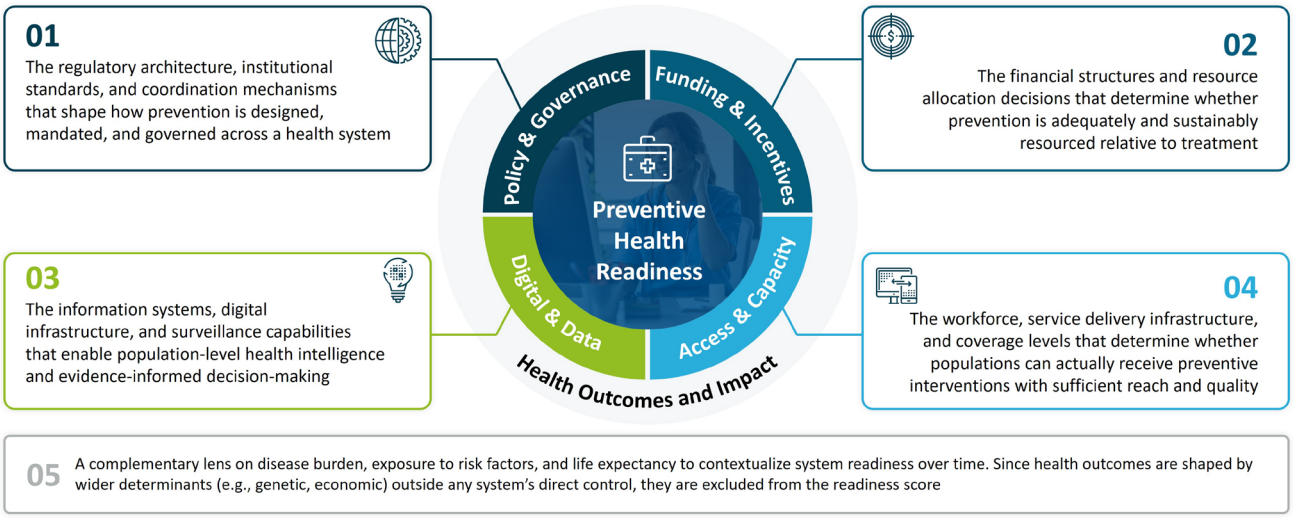


Figure 2. Preventive health readiness measurement dimensions

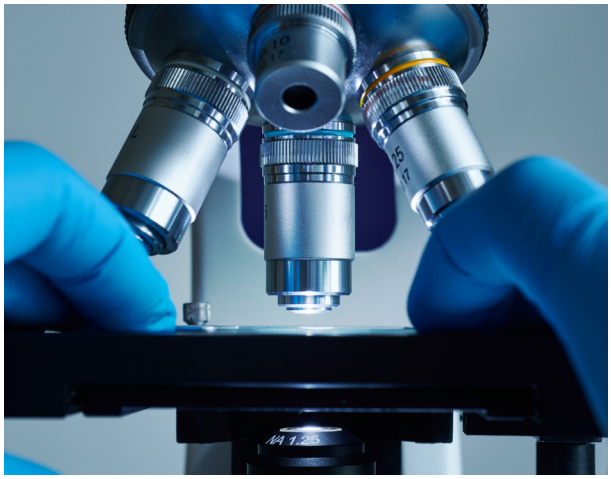


4. Methodology

The index scores 27 indicators across the four readiness dimensions: Policy & Governance, Funding & Incentives, Digital & Data and Access & Capacity. Indicators were selected to address all aspects of the prevention taxonomy and readiness dimensions, to ensure global comparability and are drawn from established international sources including WHO, the Global Health Security Index and the UN Sustainable Development Goals. Full indicator detail and sources are set out in Appendix A.

- **Normalization:** Each indicator is converted to a common 0 to 100 scale so that measures expressed in different units can be compared. Scores are capped at the upper (97.5th) and lower (2.5th) percentiles of each indicator's full source distribution, covering every country the dataset reports, so that extreme values do not distort scores for other countries. Sources already published on a comparable 0 to 100 basis are used as reported, rather than rescaled again.

- **Weighting:** Indicators are weighted by the richness of the underlying dataset and assessed on three criteria: granularity (whether the data is continuous, categorical or binary); assessment method (whether it is externally assessed; internationally validated; or self-reported); and timeliness (how recent the data is). Each is assigned a score of 1–3 to produce an overall data richness score of 3 to 9. For example, an indicator that contains continuous data, is independently verified and updated within the last two years would score 9, while a self-reported yes or no survey response from five years ago would score 3. Accordingly, an indicator with a higher data richness score would carry more relative weight in the aggregate index score. This is because prevention readiness is measured unevenly across sources, and weighting by richness keeps better-evidenced measures from being diluted by weaker ones.



- **Aggregation:** The 27 weighted indicator scores are combined into the relevant four dimension scores, and the dimension scores into an overall readiness score between 0 and 100. A higher score indicates stronger preventive health readiness relative to other countries.

- **Missing data:** Missing values are excluded from the calculation rather than counted as zero, and the weights of the remaining indicators in that dimension are rescaled proportionally, so countries are not penalized for gaps in international datasets, and no values are estimated. A country is only scored where it meets the minimum threshold of at least 70 percent of the weighted content of an indicator, and of the indicators making up a dimension. Countries below that threshold are not scored and are excluded from the index.

- **Outcomes:** Three outcome measures are assessed separately: risk factor exposure, total disease burden and life expectancy. These do not enter the readiness score and are used as a complementary lens in this report.

5. Index Results

5.1 Overall results

The United Kingdom leads the index, followed by Finland and Australia. The Advanced tier is dominated by Northern and Western Europe, together with Australia, Canada, the Republic of Korea, the United States and Thailand.

No country surpasses a score of 80. Although the countries at the top have mature institutions, long-established public health functions and decades of sustained investment, each still shows material gaps across the four dimensions. Readiness is best read as a spectrum rather than a set of distinct groups and small differences between adjacent countries should not be over-interpreted.

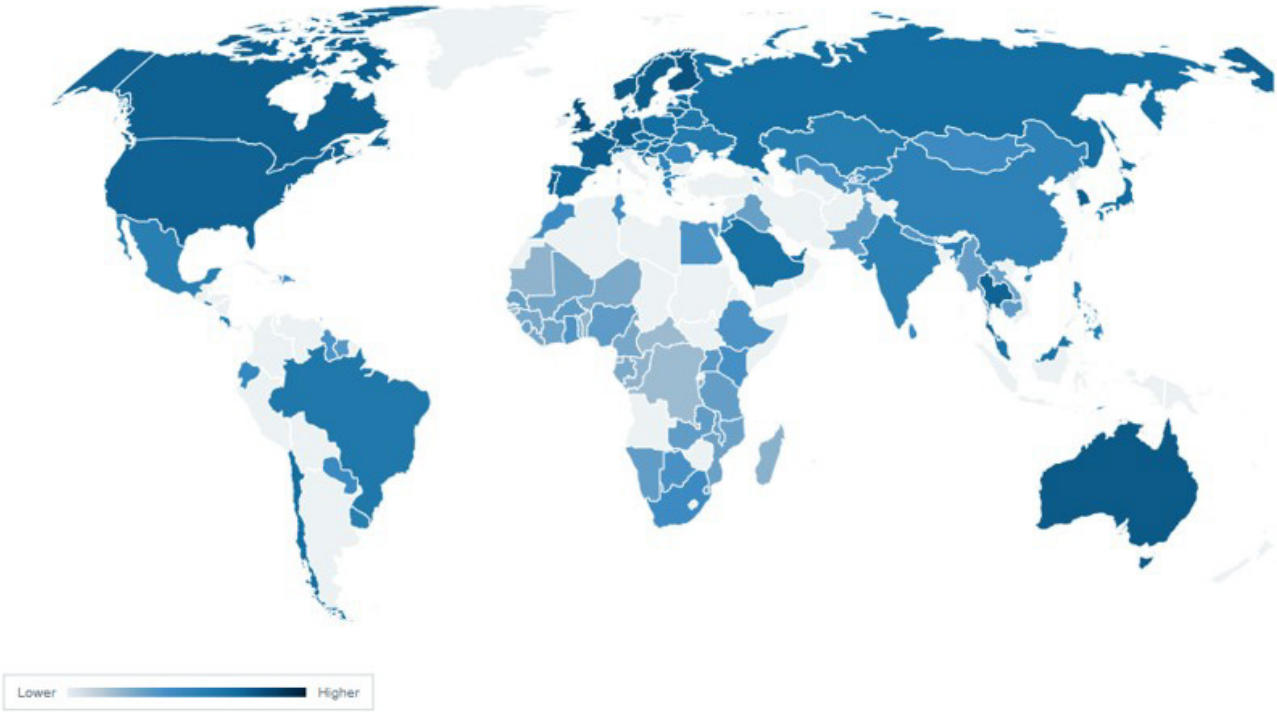


Figure 3. Preventive health readiness score by country

Readiness tiers

Countries are grouped into four tiers by score, so that those with broadly comparable readiness are read together.

Tier	Score	# Countries	Characteristics
Advanced	70+	16	Comprehensive capability across all four dimensions, with policy, funding, data and delivery working together. Remaining gaps are specific rather than structural.
Established	60 to 69	20	Strong foundations with one or two dimensions lower. Most have the policy architecture and data infrastructure in place, with delivery reach often the more common constraint.
Developing	50 to 59	28	Prevention systems are partially built. Policy commitments frequently exist but without the financing or workforce to deliver them consistently.
Emerging	Below 50	50	Capability is limited across most dimensions. These countries carry a high preventable disease burden but with the least system capacity to address it.

Half of the countries sit in the Emerging tier, which is the clearest statement the index makes about the global distribution of prevention capacity.

Regional patterns broadly follow income. Europe and Central Asia have the highest average readiness, followed by East Asia and the Pacific, then Latin America and the Caribbean and the Middle East and North Africa. Sub-Saharan Africa is lowest. The exceptions matter more than the pattern. Thailand reaches the Advanced tier and Chile, Malaysia and Brazil all sit in the Established tier, ahead of several higher-income countries.

Readiness and outcomes

Outcomes are assessed separately from the readiness score, across risk factor exposure, total disease burden and life expectancy. Readiness and outcomes are closely associated across the countries scored (R^2 = 0.62). Countries that have built prevention systems show measurably better population health.

The relationship is strong without being complete and the divergences are informative. Outcomes reflect decisions taken over decades, alongside demography, income and factors outside the health system entirely. Readiness reflects the systems in place now. Where readiness runs ahead of current outcomes, the index may be picking up investment that has not yet shown through. Several middle-income countries sit in this position, such as Sri Lanka, Jordan and Armenia.

The United States is the most instructive case in the other direction. It ranks first in the index on Digital & Data, with surveillance, laboratory and registry infrastructure among the strongest anywhere, and it ranks well on Access & Capacity. Its overall position is held back by Policy & Governance and Funding & Incentives, where fiscal and regulatory prevention levers are applied less consistently and a high level of health spending is directed largely toward treatment. At the same time, its health outcomes sit below those of countries with comparable readiness. The pattern illustrates the central argument of the index: readiness is not the sum of spending or of any single capability, and strength in one dimension does not compensate for weakness in another.

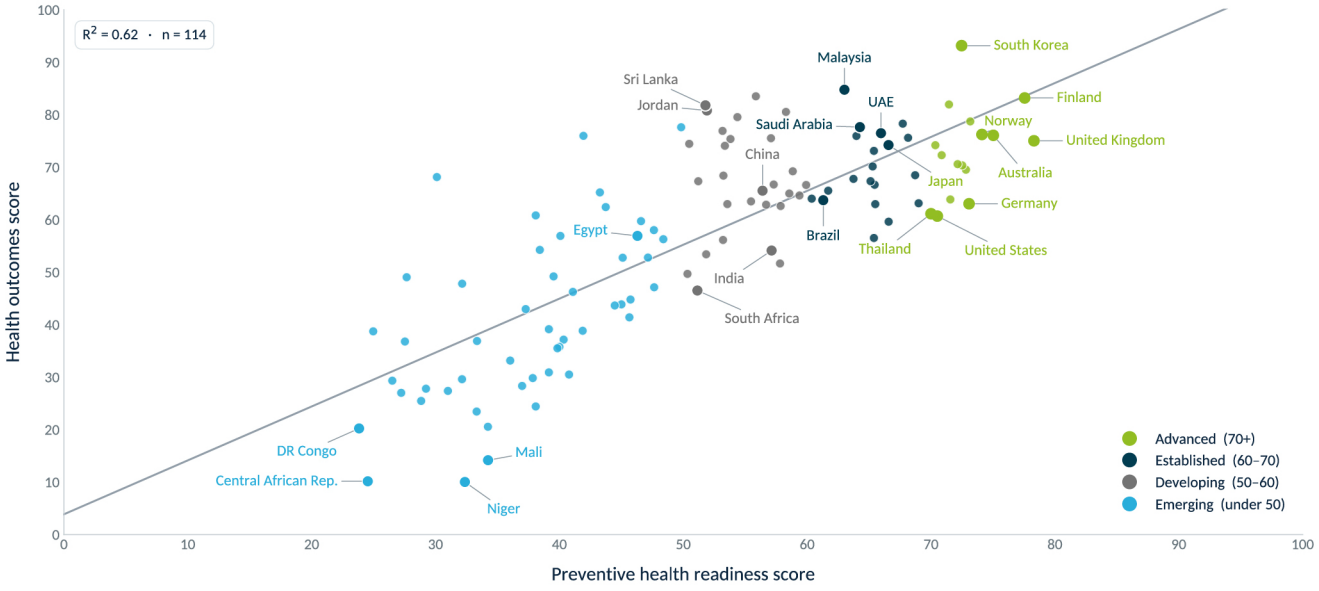


Figure 4. Preventive health readiness vs. health outcomes



Four takeaways

1. Prevention readiness remains unfinished everywhere: The countries leading the index have mature institutions and decades of sustained investment yet each still shows material gaps across the four dimensions.

2. System design matters more than national wealth: Thailand reaches the Advanced tier. Chile, Malaysia and Brazil sit in the Established tier, ahead of a number of wealthier countries. What separates them from their income peers is design. They each have dedicated prevention financing, delivery platforms built to carry preventive services and national data systems.

3. Stronger systems, healthier populations: Countries with stronger prevention capability record better population health. The association is strong without being complete, which is what makes readiness worth measuring alongside outcomes.

4. What gets measured gets improved: The index draws on a large and growing body of internationally comparable data. Building it also showed where the gaps sit and how to improve measurement going forward, including how well policy is enforced, how far preventive services actually reach and how much spending arrives at prevention. Better measurement is a precondition for directing investment and policy effort well.

5.2 Policy & Governance

KEY TAKEAWAY

The countries that lead on prevention policy treat prevention as a whole-of-government responsibility rather than as a single part of a health portfolio, combining fiscal, regulatory and legislative levers across sectors to apply a "health in all policies" approach.

This dimension covers the regulatory and fiscal architecture behind prevention. It spans policies regulating tobacco, alcohol and sugary drinks, nutrition and physical activity policy, road safety and environmental protection, urban design, immunization mandates, clinical guidelines and health security governance.

What the data shows

The indicators measure the strength of policy, rather than its presence. Most countries in the index have a tobacco control policy and a national nutrition strategy. The dimension rewards the countries that have set those policies at levels intended to change behavior and applied them consistently across sectors. Scores run from 23 to 78, and the dimension's average of 50 is the lowest of the four.

Fiscal policy is where countries separate most clearly. Taxation of tobacco, alcohol and sugary drinks sits among the WHO's "Best Buys", the interventions WHO identifies as the most cost-effective available to governments, and it is one of the most direct prevention levers a government can reach for.[2] It is also where practice varies most widely. For policymakers, this is the most accessible starting point: fiscal and regulatory levers rely on legislation more than on large budgets, evidenced by several middle-income countries appearing in the top 15 of this dimension alongside high-income systems.

The dimension is notable for how far it reaches beyond health. Environmental standards, urban design, road safety legislation and food regulation all sit here, and the top performers treat prevention as a cross-government responsibility rather than a health portfolio.

Top 15: Policy & Governance

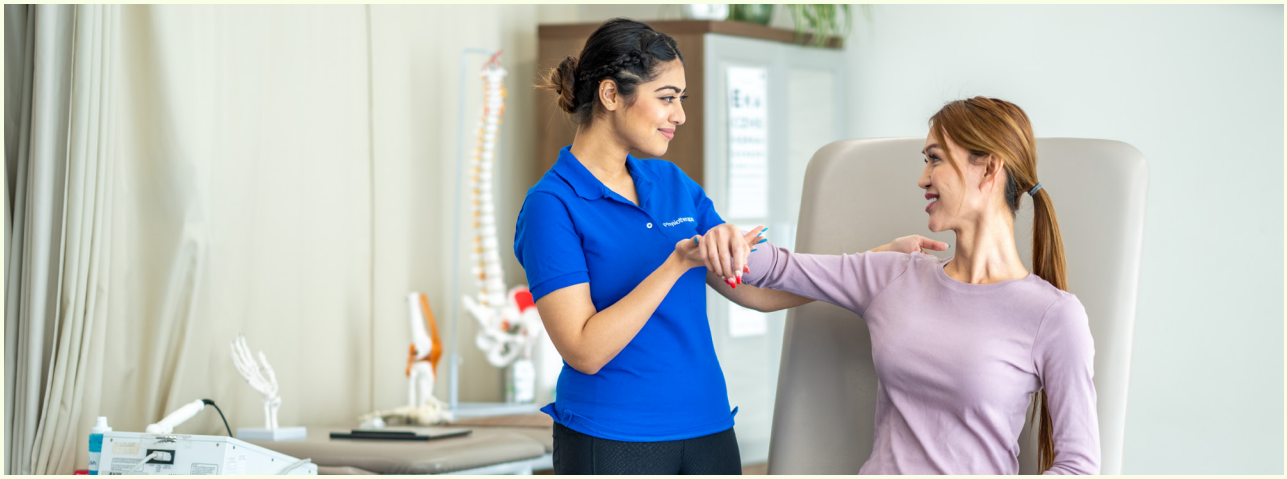
#	Country	Score	#	Country	Score
1	Finland	77.9	2	United Kingdom	75.4
3	Norway	72.8	4	Croatia	72.5
5	France	72.4	6	Australia	69.6
7	Sweden	68.8	8	Netherlands	68.0
9	United Arab Emirates	68.0	10	Estonia	67.9
11	Chile	67.5	12	Portugal	67.4
13	Montenegro	67.1	14	North Macedonia	66.8
15	Poland	66.6			

Case studies: Finland, United Kingdom and Saudi Arabia

Finland leads this dimension. Its distinguishing feature is “Health in All Policies”, an approach it pioneered and which is now written into its Health Care Act, requiring municipalities to involve every sector in their health plans.[6] Finland has also put a tobacco endgame into law. The Tobacco Act sets a statutory objective of ending the use of tobacco and nicotine products by 2030 and the Ministry of Social Affairs and Health has published a roadmap of the measures needed to reach it.[7] What matters is the mechanism, which turns a policy aspiration into a standing legal obligation with a roadmap to deliver it.

The United Kingdom ranks second. Its Soft Drinks Industry Levy is the clearest example of designing a tax to change industry behavior, rather than to raise revenue. Because the levy is tiered by sugar content, manufacturers had a direct financial reason to reformulate and the government's own review found a 46 percent average reduction in sugar in the drinks within scope between 2015 and 2020.[8] The same design logic runs through the wider UK approach. The United Kingdom ranks first in the index on tobacco policy and taxation and full marks on nutrition and physical activity policy, alongside an organized national standard of adult health checks.[9]

Saudi Arabia, which ranks 18th on this dimension, shows rapid institutional change over recent years. It has introduced a 50 percent excise on carbonated and sweetened drinks and 100 percent on energy drinks, mandatory calorie labeling across restaurants and food stores and the elimination of industrial trans fats.[10] Around those measures it has been assembling the governance to make prevention a whole-of-government matter. A Ministerial Committee for Health in All Policies brings health considerations into decisions taken outside the health ministry and standing cross-sector committees do the same for specific causes of preventable death.[10] Saudi Arabia also now hosts the region’s first WHO Collaborating Centre for Healthy Cities.[11] The same approach extends to delivery. The Sehhaty national health app reaches more than 24 million users and now carries an AI health coach built with commercial partners.[10] Despite these reforms, the full impact is unlikely to be reflected in current scores for several years.



5.3 Funding & Incentives

KEY TAKEAWAY

Most health budgets are dominated by treating illness, leaving relatively little funding available for prevention. The countries that lead this dimension have given prevention and primary care a strong claim on the budget. Several go even further and fund prevention from prevention-aimed fiscal policies, meaning funding self-generates from the harm it is meant to reduce.

This dimension covers how prevention is paid for. It spans domestic preventive health spending, primary care financing, the capacity to finance health security functions and the extent to which populations face financial hardship from out-of-pocket health costs.

What the data shows

Prevention competes against treatment for funding in almost every system. Treatment need is immediate, visible and politically unavoidable, while prevention need is less tangible and the impact isn't seen until later. What separates the countries at the top of this dimension is a higher and steadier commitment to prevention and primary care within the health budget. The dimension also has the lowest ceiling of the four, with a top score of 76.5 against 99 for Digital & Data.

What the index measures is the result of that commitment, how much a country spends on prevention and primary care from its own resources and how far that spending reaches. How countries get there varies. Some have made prevention partly self-funding by financing it from the risks it exists to reduce, such as through levies on tobacco and alcohol. Others have written prevention spending into law as an obligation on insurers or built preventive services into universal coverage as an entitlement rather than an optional extra. The case studies below set out examples of these approaches.

Financial protection is the second half of the dimension. Preventive services that carry a cost at the point of care are used least by the populations that need them most, so the share of the population facing hardship from health payments is itself a measure of whether prevention can reach people.

For investors, this is where the gap between commitment and capability is widest. Prevention financing mechanisms, delivery infrastructure and services that reduce downstream cost are under-built in most markets, including high-income ones.

Measuring prevention financing proves challenging, and the index reflects this as a deliberate design choice. Absolute spend favors high-income countries, where a high cost of care is not in itself a sign of strong prevention. Prevention as a share of health spending favors countries that run prevention as standalone programs, because systems delivering prevention inside routine primary care record much of it as ordinary care instead. The index uses both measures together, so that neither bias dominates and country positions on this dimension are best read alongside the other three dimension scores, not as a standalone.



Top 15: Funding & Incentives

#	Country	Score	#	Country	Score
1	Republic of Korea	76.5	2	Seychelles	74.9
3	Trinidad and Tobago	74.0	4	Germany	73.4
5	United Kingdom	72.9	6	Guyana	72.8
7	Finland	71.4	8	Denmark	69.2
9	Sweden	68.9	10	Thailand	68.4
11	United Arab Emirates	68.0	12	Japan	67.9
13	Norway	66.9	14	Botswana	66.7
15	Netherlands	66.2			

Case studies: Republic of Korea, Germany and Thailand

The Republic of Korea leads this dimension. Its National Health Insurance covers effectively the entire population and preventive services reach people as an entitlement through a national health screening program and the National Cancer Screening Program.[12] Health promotion is financed separately through the National Health Promotion Fund, which draws on a dedicated charge on tobacco and so has its own revenue source.[13] Korea raised tobacco taxation to around 70 percent of retail price in 2015 and used the proceeds in part to fund national cessation services.[12]

Germany ranks fourth. The 2015 Prevention Act placed a statutory obligation on health insurance funds to spend a defined minimum per insured person each year on prevention and health promotion, with specified shares directed to workplaces and to community settings such as schools and day-care centers. The Act also created a National Prevention Conference bringing statutory health, pension, accident and long-term care insurance together with federal, state and municipal government under a shared national prevention strategy.[14] Because the obligation is statutory and per insured person, providers of workplace and community prevention services face a predictable, recurring volume of work rather than a discretionary budget line.

Thailand ranks 10th on this dimension and sits in the Advanced tier overall, ahead of many high-income countries on prevention financing. The Thai Health Promotion Foundation, created by the Health Promotion Foundation Act in 2001, is an autonomous body funded by a 2 percent surcharge on tobacco and alcohol excise, giving prevention a revenue stream drawn from the risk factors it exists to address and growing independently of the health budget.[15] WHO recognized the foundation with the Nelson Mandela Award for Health Promotion in 2021.[16] Combined with universal coverage delivered through a primary care platform, Thailand brings clear evidence in the index that this dimension is a design question before it is a resource question.

5.4 Digital & Data

KEY TAKEAWAY

Data infrastructure is what makes prevention targetable. Good data systems help countries identify who is at risk, where the risks are, and who should receive preventive care. The countries that lead this dimension do not simply collect population health data, instead they connect it to how preventive services are identified, delivered and followed up.

This dimension covers the information infrastructure behind prevention, the capacity to use health data in policy and planning, population health intelligence, disease surveillance systems, national digital health maturity and chronic disease registries.

What the data shows

Digital & Data has both the widest spread of the four dimensions, from 11 to 99, and the highest average, at 59. The countries leading this dimension have built three things at once, surveillance that reports close to real time, registries that record who has been screened, vaccinated or diagnosed and the analytical capacity to act on both.

The distinction that separates the leaders is between collecting data and connecting it. Many countries run population health surveys and maintain surveillance systems. Fewer link them to delivery, so that a person who is due for a screening test or a vaccination is identified, contacted and followed up.

This is also the fastest-moving element of prevention readiness. Interoperable records, digital identity and population health analytics are being built now in countries at different income levels. Today, continuous data from wearables and remote monitoring, genomic risk profiling and large-scale health datasets are shifting prevention work from population averages toward individual risk. For investors, population intelligence systems and analytics layers are among the clearest near-term opportunities in the index.

Top 15: Digital & Data

#	Country	Score	#	Country	Score
1	United States	99.0	2	Australia	96.2
3	United Kingdom	95.8	4	Republic of Korea	94.1
5	Sweden	92.9	6	Denmark	92.9
7	Spain	90.7	8	Latvia	89.8
9	Germany	87.9	10	Finland	86.9
11	Norway	86.0	12	France	85.6
13	Czechia	85.0	14	Slovenia	81.5
15	Portugal	80.0			



Case studies: United States, Australia and Republic of Korea

The United States records the highest single dimension score in the index. Its position rests on surveillance and laboratory infrastructure and on population-based cancer registration that is more complete than its fragmented delivery system would suggest. The CDC's National Program of Cancer Registries funds central registries covering 97 percent of the U.S. population and, together with the National Cancer Institute's SEER program provides population-based cancer data for the country as a whole.[17]

Australia ranks second and its distinguishing feature is that its data systems are built into delivery, rather than alongside it. The Australian Immunization Register records vaccines given to people of all ages across Australia, and providers can query it for reports to identify patients who are due or overdue.[18] The National Cancer Screening Register consolidated eight separate state and territory cervical registers and a paper-based bowel screening register into a single national record, issuing invitations and reminders and giving clinicians direct access through practice software.[19,20] The register itself is a commercial contract, the government sets the policy and owns the data, while a private provider builds and operates the infrastructure, under an agreement originally valued at up to AUD220 million over five years.[20]

The Republic of Korea ranks fourth. Its national insurance claims database and national screening records together cover effectively the whole population over two decades, giving it a fairly complete longitudinal picture of population health.[12] The capability was visible during the COVID-19 response and its more durable value is in chronic disease, where population-level data allows risk to be identified before it presents clinically.

5.5 Access & Capacity

KEY TAKEAWAY

The countries that lead in prevention access and capacity have made preventive services something that the system delivers by default, rather than something individuals have to know to seek out.

This dimension covers whether populations actually receive the preventive services that have been set up. It spans vaccination coverage, universal health coverage, screening programs, preventive mental health provision, essential medicines availability, disease detection capacity, emergency response capability and the primary care workforce.

What the data shows

Because the dimension is measured across eight distinct services, it rewards breadth. Scores range from 15 to 83. A country with excellent immunization coverage but no organized screening programs, or with strong detection capacity but limited medicines availability, does not score well here. The leading countries deliver consistently across the range.

Coverage of preventive services is not simply a function of spending. Several middle-income countries achieve immunization and screening coverage comparable to high-income systems and several high-income countries do not convert their spending into consistent coverage.

Workforce is the slowest of these to change. Generalist physician density varies widely across the index and no policy or financing decision closes that gap quickly, which makes it the constraint most worth planning against early. For global health institutions, this is where support is most needed and slowest to take effect. Workforce and service coverage cannot be built quickly, which makes early and sustained investment in the lowest tiers more valuable than later, larger interventions.

Top 15: Access & Capacity

#	Country	Score	#	Country	Score
1	Australia	83.3	2	Portugal	82.0
3	Canada	79.9	4	Netherlands	77.3
5	Slovenia	76.1	6	United Kingdom	76.1
7	Finland	75.7	8	Germany	75.1
9	United States	75.1	10	Japan	75.0
11	France	74.8	12	Belarus	74.7
13	Lithuania	74.5	14	Thailand	74.4
15	Norway	73.5			

Case studies: Portugal, Canada and Costa Rica

Portugal ranks second on this dimension, seventh overall and first in the index on generalist primary care workforce. Its national health service is organized around family health units, small multi-professional teams responsible for a registered list of patients, whose remit covers health promotion and disease prevention explicitly and who work to contracted indicators on preventive activity.[22] The effect is that screening and vaccination coverage becomes a function of the system, rather than of patient initiative.

Canada ranks third. Its strength is breadth, with universal coverage, high generalist workforce density, strong immunization performance and organized cancer screening programs operating across provinces and territories. The Canadian Partnership Against Cancer coordinates nationally, publishing comparable data across jurisdictions and convening programs on recruitment and follow-up.[23] Nine provinces run organized cervical screening programs and twelve jurisdictions run organized breast screening, with national work underway on lung screening and the transition to HPV primary screening.[23]

Costa Rica ranks 22nd on this dimension, but significantly ahead of considerably wealthier countries and well ahead of its overall position at 41. Its Equipos Básicos de Atención Integral de Salud are multidisciplinary teams, each serving a defined population of roughly 4,000 people, comprising a physician, nurse, pharmacy and data staff and a community health technician who conducts household visits.[24] Costa Rica also placed public health and health care delivery under a single national social security agency.[24] It reaches coverage levels above those of several considerably wealthier countries at a fraction of the spending, making it a transferable model for countries in the Developing and Emerging tiers.[25]



6. The Path Forward

What this index means

For policymakers

The dimension profile as a whole matters more than the rank itself. A country constrained by financing needs a different intervention from one constrained by workforce or by data. The approaches that produce high scores are specific and transferable, whether that is dedicated prevention financing, delivery platforms with an explicit preventive mandate, fiscal policy designed to change behavior or data systems connected to service delivery. Prevention readiness is a system design challenge before it is a spending one. Countries at similar income levels reach very different scores, and the difference is usually a specific structural choice. The index identifies which capability is holding a country back, which is the question of where to act first for policymakers across geographies.

For investors

The policy commitment to prevention exists in most countries and interest in the technologies that could deliver it is growing quickly. Wearables, remote monitoring, population health data platforms and AI-driven risk analytics have advanced rapidly and attracted growing attention as tools for prevention.[26] What is broadly missing are the systems and partnerships to deliver prevention at scale. The index does not size a market. It shows where the gap between that commitment and the capability to act on it sits, and the gap takes a different form in each country. Some lack the financing mechanisms to sustain prevention, some the data infrastructure to target it, some the workforce and service coverage to deliver it. Closing those gaps takes partnership, and the strongest ones will return value across three aspects: better health for populations, lower long-term cost for governments and a commercial return for those building the capability. A country's prevention capability profile shows which gap is holding back progress, which tells investors where to look and what kind of partnership is likely to be needed.

The biggest shift ahead is in prevention itself. AI, genomic risk profiling and continuous monitoring make it possible to identify risk in an individual, rather than a population, and to then act on it before the disease appears. Several of these tools are already in routine clinical use, such as continuous glucose monitoring and AI-assisted screening for diabetic eye disease.[27] What can still be improved is their integration within health systems. These tools sit outside of day-to-day clinical practice in many countries, and building, scaling and embedding them alongside governments and providers is a defining opportunity for the next decade of prevention. Where it happens first isn't necessarily about income. Countries with connected records, registries and analytics can adopt AI, genomic risk profiling, continuous monitoring and other innovative prevention technologies quickly, and countries building their data systems now can design for these uses from the start rather than retrofitting later.

For global health institutions

Half the countries in the index sit in the lowest readiness tier, carrying high preventable burden with the least capacity to address it. Countries with similar health outcomes often face very different readiness constraints. The index helps identify which bottleneck matters most: financing, workforce, data or delivery to direct support and resources where they can have the largest impact. Readiness also complements outcome measurement. Outcomes show what past investment achieved, while readiness shows whether the capacity for future prevention is being built. Tracking both distinguishes countries whose results are improving from those whose systems are, which is what determines whether support addresses a symptom or a cause.

Taking the index forward

This index aims to bring together the best globally comparable data currently available on prevention readiness. Assembling it also revealed how much of prevention is not yet measured consistently; that finding is useful in its own right. Where international datasets capture whether a policy exists, they do not always capture how well it is enforced. Where they capture national totals, they rarely show variation between regions and populations within a country. Several areas that are central to prevention, such as health literacy and the use of predictive analytics to identify population risk early, have no comparable global dataset at all. Prevention spending itself remains difficult to trace with precision across most national accounts.

Country coverage can expand as data becomes available for countries currently below the data threshold. Implementation and enforcement measures can be added as credible sources emerge. Subnational analysis becomes possible where national statistical systems develop. As the index is repeated, change over time becomes measurable, which is ultimately the most useful output. It's not only where a country stands, but whether it is building. The index is intended to develop alongside the measurement base it depends on and to highlight where that base most needs strengthening.



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8. Appendix

A. Indicator directory & how scores are calculated

The index is built from 27 indicators across the four readiness dimensions, with a further three indicators measuring health outcomes as a complementary lens. Each indicator is drawn from an established international source and selected for global coverage, repeatability and relevance to prevention. Where an indicator draws on more than one dataset, each is listed and contributes to a single score.

How the score is calculated

- **Indicator weights.** Each indicator is weighted by its data richness score (3 to 9, combining granularity, assessment method and timeliness). The resulting weight is shown for each indicator in the tables below.

- **Dimension weights.** Each dimension is weighted by the combined richness of its indicators: Policy & Governance 38 percent, Access & Capacity 32 percent, Funding & Incentives 15 percent and Digital & Data 15 percent.

- **Combining datasets.** Some indicators draw on several datasets or international indicators (for example, WHO self-assessments alongside the Global Health Security Index, or WHO and IHME coverage estimates) to give a more complete view of the capability where data allows. Each is normalized separately and the results are averaged with equal weight.

- **Normalization reference.** Percentile caps are calculated across each indicator's full source distribution, covering every country the dataset reports.

- **Missing data.** Where an indicator is unavailable for a country, its weight is redistributed proportionally across the remaining indicators in that dimension.

- **Eligibility.** A composite indicator is scored only where at least 70 percent of its components are reported, and a dimension only where the indicators a country holds account for at least 70 percent of its weight. A country enters the index only where all four dimensions meet this threshold.

Weights shown in the tables below apply where all indicators in a dimension are reported.

Policy & Governance

Indicator	Source	Description	Rationale	Weight (richness)
1.1 Tobacco policy	Economics for Health: Cigarette Tax Scorecard	Assesses a country's cigarette tax system against internationally recognized best practice, covering the level of excise as a share of retail price, affordability relative to income, and the structure of the tax itself.	Tobacco taxation is a WHO-recommended cost-effective NCD 'Best Buy'.	4.97% (9)
1.2 Alcohol policy	WHO Global Health Observatory	Measures excise tax as a share of the retail price of alcoholic beverages, assessed separately for beer and spirits and averaged. Normalized across countries.	Alcohol taxation is a WHO-recommended cost-effective NCD 'Best Buy'.	4.42% (8)
1.3 Sugary drinks policy	WHO Global Health Observatory	Measures excise tax as a share of the price of a standard unit of sugar-sweetened beverage. Countries with no national excise are recorded as zero rather than as missing data. Normalized across countries.	Taxation of sugar-sweetened beverages is a WHO-recommended cost-effective NCD 'Best Buy'.	4.42% (8)

Indicator	Source	Description	Rationale	Weight (richness)
1.4 Nutrition and physical activity policy	WHO Country Capacity Survey on Noncommunicable Diseases	Measures the share of eight national policy instruments in place, covering salt reduction, trans-fat elimination, marketing of food to children, national diet and physical activity plans, and public awareness campaigns.	Diet and physical inactivity are two of the largest modifiable NCD risk factors, and population-level policies addressing them are priorities under the WHO Global NCD Action Plan.	2.76% (5)
1.5 Road safety policy and legislation	WHO Global Status Report on Road Safety	Assesses national legislation against evidence-based best practice across five behavioral risk factors: speed, impaired driving, motorcycle helmet use, seatbelt use and child restraints.	Road traffic injury is a leading cause of preventable death, and halving road traffic deaths is a target under the Sustainable Development Goals and the UN Decade of Action for Road Safety 2021–2030.	3.87% (7)
1.6 Environmental protection policy	Yale University: Environmental Performance Index	Measures how closely countries are meeting established environmental policy targets across environmental health, air and water quality, pollution control and ecosystem vitality. Published as a 0–100 index and used without further rescaling.	Air, water and soil pollution are major drivers of preventable disease, and reducing the resulting deaths and illnesses is a target under the Sustainable Development Goals (3.9).	4.97% (9)
1.7 Health-promoting urban environments	UN Sustainable Development Goals	Measures the urban conditions that shape population health, including access to open and green space, housing quality, urban transport and social inclusion. Normalized across countries.	Urban design and the built environment directly influence physical activity and exposure to risk factors, reduction of which is a core Sustainable Development Goal (SDG11).	3.87% (7)
1.8 Health security governance	WHO States Parties Self-Assessment Annual Report; Global Health Security Index	Measures self-assessed national capacity on the policy, legal and coordination arrangements for health security, alongside independently assessed indicators of governance, coordination and risk communication.	A core capacity under the International Health Regulations (2005).	3.87% (7)
1.9 Immunization policy mandates	Our World in Data	Measures the legal status of childhood immunization requirements, distinguishing countries where vaccination is mandated, required for school entry, or recommended only.	National mandates are a prerequisite for sustained coverage and central to the Immunization Agenda 2030, endorsed by the World Health Assembly.	2.21% (4)
1.10 Chronic disease clinical guidelines	WHO Country Capacity Survey on Noncommunicable Diseases	Measures the share of nine national evidence-based clinical guidelines in place, covering management of cardiovascular disease, diabetes, cancer and chronic respiratory disease, and of the main behavioral risk factors.	Clinical guidelines underpin tertiary prevention by supporting standardized, evidence-based management of established disease.	2.76% (5)

Funding & Incentives

Indicator	Source	Description	Rationale	Weight (richness)
2.1 Health security financing	WHO States Parties Self-Assessment Annual Report; Global Health Security Index	Measures self-assessed capacity to finance health security functions and emergency response, alongside independently assessed indicators of health security financing preparedness.	Sustained financing is a core capacity under the International Health Regulations (2005) and is essential to operational readiness.	3.87% (7)
2.2 Preventive health financing	WHO Global Health Expenditure Database	Measures domestically financed preventive spending per capita (PPP) and the share of domestic health spending it represents. Preventive care covers immunization, screening, health promotion, surveillance and emergency preparedness. Externally financed spending is excluded from both measures.	Preventive spending signals the degree to which a health system prioritizes prevention in how it allocates resources.	3.87% (7)
2.3 Primary care financing	WHO Global Health Expenditure Database	Measures domestically financed primary health care spending per capita (PPP) and the share of domestic health spending it represents. Externally financed spending is excluded from both measures.	Primary health care is the main platform for delivering prevention, and adequate financing for it was a core commitment of the Declaration of Astana (2018).	3.87% (7)
2.4 Financial protection in health	WHO Global Health Observatory	Measures the share of the population facing financial hardship from out-of-pocket health payments, covering both large household spending on health and spending that pushes households into poverty. Normalized and reversed, so lower hardship scores higher.	Financial protection is an explicit target under the Sustainable Development Goals (3.8.2) and a condition of universal health coverage.	3.31% (6)

Digital & Data

Indicator	Source	Description	Rationale	Weight (richness)
3.1 Health data use for policy	WHO SCORE Assessment of Health Data Systems	Measures national capacity to translate health data into policy and action, covering data analysis, communication of findings and institutional use of evidence. Reported on a five-point capacity scale and expressed on the index's 0–100 scale.	The capacity to act on data determines whether surveillance systems achieve their purpose of informing prevention.	1.66% (3)
3.2 Population health intelligence	WHO SCORE Assessment of Health Data Systems	Measures whether countries maintain routine population data systems, assessed on the presence of regular population-based health and risk-factor surveys and a current national census. Reported on a five-point capacity scale and expressed on the index's 0–100 scale.	Routine population data is the foundation for monitoring health trends and targeting prevention where it is most needed.	1.66% (3)

Indicator	Source	Description	Rationale	Weight (richness)
3.3 Disease surveillance systems	Global Health Security Index	Measures capacity to detect and monitor disease, covering laboratory systems and supply chains, real-time surveillance and reporting, and case-based investigation. Published as a 0–100 score and used without further rescaling.	A core capacity under the International Health Regulations (2005).	4.42% (8)
3.4 Digital health adoption	Global Digital Health Monitor	Measures the maturity of national digital health systems, covering strategy, infrastructure, standards and interoperability, and the extent of deployment at scale. Reported on a five-point maturity scale and expressed on the index's 0–100 scale.	Digital infrastructure is recognized in the WHO Global Strategy on Digital Health as an enabler of scalable prevention.	2.76% (5)
3.5 Chronic disease registries	International Agency for Research on Cancer; WHO Country Capacity Survey on Noncommunicable Diseases	Measures the coverage and quality tier of national population-based cancer registries (IARC), alongside the presence of a national diabetes registry (WHO).	Registries are the primary means of monitoring disease burden and evaluating whether early detection is working.	4.42% (8)

Access & Capacity

Indicator	Source	Description	Rationale	Weight (richness)
4.1 Vaccination coverage	WHO and UNICEF Immunization Coverage Estimates	Measures coverage rates for routine childhood and adult immunization across a set of tracer vaccines, from estimates triangulating administrative reporting with survey data. Normalized across countries.	Routine immunization is among the most effective preventive interventions available and is tracked under the Sustainable Development Goals.	4.97% (9)
4.2 Mental health preventive service provision	WHO Mental Health Atlas	Measures the availability of preventive and promotive mental health service types provided nationally, across seven categories including school and workplace programs, suicide prevention and early childhood interventions.	The WHO Comprehensive Mental Health Action Plan identifies promotion and prevention as priorities for all countries.	2.76% (5)
4.3 Universal health coverage	WHO Universal Health Coverage Service Coverage Index; IHME effective coverage estimates	Measures population coverage of essential health services, based on tracer interventions spanning reproductive and child health, infectious disease, noncommunicable disease, and service capacity and access, averaged with IHME's effective coverage index.	Universal health coverage is an established commitment under the Sustainable Development Goals (3.8).	4.97% (9)
4.4 Disease detection capacity	Global Health Security Index	Measures capacity to detect and investigate disease events, covering laboratory systems, laboratory supply chains, case-based investigation, and epidemiology workforce. Published as a 0–100 score and used without further rescaling.	Epidemiological and investigation capacity underpins outbreak detection and evidence-based prevention planning.	4.42% (8)

Indicator	Source	Description	Rationale	Weight (richness)
4.5 Screening coverage	WHO Country Capacity Survey on Noncommunicable Diseases	Measures reported cervical cancer screening coverage among women aged 30 to 49, the existence of a national breast cancer screening program, and the general availability of NCD diagnostics and risk assessment in primary care.	Cervical cancer screening is a WHO-recommended 'Best Buy'; early detection is a core pillar of the WHO Global Breast Cancer Initiative; and NCD screening/risk assessment identifies high-risk individuals the Global NCD Action Plan targets for treatment.	3.31% (6)
4.6 Primary care workforce	Population Reference Bureau	Measures generalist medical doctors per 10,000 population, as the workforce indicator most directly associated with first-contact and preventive care. Normalized across countries.	Primary care is the recommended platform for preventive and first-contact services, a global commitment first made in the Declaration of Alma-Ata (1978) and renewed in the Declaration of Astana (2018).	3.87% (7)
4.7 Essential medicines availability	WHO Country Capacity Survey on Noncommunicable Diseases	Measures the share of 20 essential medicines for noncommunicable disease reported as generally available in the public sector, spanning cardiovascular, diabetes, respiratory, cancer pain relief and tobacco cessation.	Reliable access to medicines determines whether health systems can sustain long-term disease management and prevent complications.	3.31% (6)
4.8 Emergency response capacity	Global Health Security Index	Measures preparedness to respond to public health emergencies, covering response planning, medical countermeasure deployment, supply chains and stockpiling, and infection control practices. Published as a 0–100 score and used without further rescaling.	Response capacity determines whether health threats are contained early or escalate into wider population harm.	4.42% (8)



Outcomes & Impact

Health outcomes are measured separately and do not form part of the readiness score. They are used as a complementary lens, allowing readiness to be compared against results achieved.

Indicator	Source	Description	Rationale
5.1 Risk factor exposure	Institute for Health Metrics and Evaluation: Global Burden of Disease Study	Measures population exposure to modifiable risk factors, expressed as the prevalence of exposure weighted by the risk each factor carries, on a scale where zero indicates no excess risk. Age-standardized and reversed so lower exposure scores higher.	Captures the risk a population carries before disease occurs, distinct from harm already realized.
5.2 Disease burden	Institute for Health Metrics and Evaluation: Global Burden of Disease Study	Measures total health loss as disability-adjusted life years per 100,000 population, across communicable, maternal, neonatal and nutritional conditions; noncommunicable diseases; and injuries. Age-standardized and reversed so lower burden scores higher.	Captures the full fatal and non-fatal health loss a population sustains.
5.3 Life expectancy	United Nations World Population Prospects	Measures the average number of years a newborn would live if current age-specific mortality rates were to hold throughout its lifetime. Normalized across countries.	Reflects the cumulative effect of prevention, health system performance and wider determinants.

B. Country Scores

#	Country	Score	Tier	#	Country	Score	Tier
1	United Kingdom	78.3	Advanced	2	Finland	77.6	Advanced
3	Australia	75	Advanced	4	Norway	74.1	Advanced
5	Sweden	73.2	Advanced	6	Germany	73.1	Advanced
7	Portugal	72.8	Advanced	8	France	72.5	Advanced
9	Republic of Korea	72.5	Advanced	10	Netherlands	72.1	Advanced
11	Denmark	71.6	Advanced	12	Canada	71.4	Advanced
13	Slovenia	70.9	Advanced	14	United States	70.5	Advanced
15	Croatia	70.3	Advanced	16	Thailand	70	Advanced
17	Latvia	69	Established	18	Lithuania	68.7	Established
19	Spain	68.1	Established	20	Belgium	67.7	Established
21	Czechia	66.6	Established	22	Japan	66.6	Established
23	United Arab Emirates	66	Established	24	Chile	65.5	Established

#	Country	Score	Tier	#	Country	Score	Tier
25	Switzerland	65.5	Established	26	Russian Federation	65.4	Established
27	Poland	65.4	Established	28	Estonia	65.3	Established
29	Hungary	65.1	Established	30	Saudi Arabia	64.3	Established
31	Slovakia	64	Established	32	Austria	63.7	Established
33	Malaysia	63	Established	34	Belarus	61.7	Established
35	Brazil	61.3	Established	36	Ukraine	60.4	Established
37	Malta	59.9	Developing	38	El Salvador	59.4	Developing
39	Kazakhstan	58.8	Developing	40	Uruguay	58.6	Developing
41	Costa Rica	58.3	Developing	42	Mexico	57.9	Developing
43	Philippines	57.8	Developing	44	Montenegro	57.3	Developing
45	India	57.1	Developing	46	Greece	57.1	Developing
47	North Macedonia	56.7	Developing	48	China	56.4	Developing
49	Armenia	55.9	Developing	50	Serbia	55.5	Developing
51	Mauritius	54.4	Developing	52	Cyprus	53.8	Developing
53	Romania	53.6	Developing	54	Trinidad and Tobago	53.4	Developing
55	Ecuador	53.2	Developing	56	Seychelles	53.2	Developing
57	Kyrgyzstan	53.2	Developing	58	Jordan	51.9	Developing
59	Paraguay	51.9	Developing	60	Sri Lanka	51.8	Developing
61	Mongolia	51.2	Developing	62	South Africa	51.1	Developing
63	Morocco	50.5	Developing	64	Timor-Leste	50.3	Developing
65	Tunisia	49.8	Emerging	66	Dominican Republic	48.4	Emerging
67	Kenya	47.7	Emerging	68	Uzbekistan	47.6	Emerging
69	Botswana	47.1	Emerging	70	Guyana	46.6	Emerging
71	Egypt	46.3	Emerging	72	Fiji	45.7	Emerging
73	Ethiopia	45.6	Emerging	74	Ghana	45.1	Emerging
75	Eswatini	45	Emerging	76	Nepal	44.5	Emerging
77	Tajikistan	43.7	Emerging	78	Suriname	43.3	Emerging
79	Cabo Verde	41.9	Emerging	80	Uganda	41.9	Emerging

#	Country	Score	Tier	#	Country	Score	Tier
81	Cambodia	41.1	Emerging	82	Nigeria	40.8	Emerging
83	Burkina Faso	40.3	Emerging	84	Namibia	40.1	Emerging
85	Zambia	40	Emerging	86	Pakistan	39.8	Emerging
87	Myanmar	39.5	Emerging	88	United Republic of Tanzania	39.1	Emerging
89	Malawi	39.1	Emerging	90	Iraq	38.4	Emerging
91	Sierra Leone	38.1	Emerging	92	Senegal	38.1	Emerging
93	Lao People's Democratic Republic	37.9	Emerging	94	Gambia	37.3	Emerging
95	Mozambique	37	Emerging	96	Côte d'Ivoire	36	Emerging
97	Mali	34.2	Emerging	98	Liberia	34.2	Emerging
99	Cameroon	33.3	Emerging	100	Guinea	33.3	Emerging
101	Niger	32.4	Emerging	102	Gabon	32.1	Emerging
103	Togo	32.1	Emerging	104	Burundi	31	Emerging
105	Comoros	30.1	Emerging	106	Haiti	29.2	Emerging
107	Madagascar	28.8	Emerging	108	Mauritania	27.7	Emerging
109	Congo	27.5	Emerging	110	Benin	27.2	Emerging
111	Equatorial Guinea	26.5	Emerging	112	Guinea-Bissau	25	Emerging
113	Central African Republic	24.5	Emerging	114	Democratic Republic of the Congo	23.8	Emerging

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