Unlocking the Value of Cardiovascular Health Checks

Appendix

May 2026

Appendix 1. Overview of CVHCs across the EU

Table 1 Overview of CVHCs across the EU (PwC analysis, updated December 2025).

Programme name	Geographic scope	Recruitment	Targeting	Delivery setting	Frequency	Funding source	Integration in care pathway
Austria **National Preventive Health Check**	National	Systematic (non-CV-specific)	Broad (all adults)	Primary care	Annual	Public (National Social Security)	Yes
Bulgaria **National Preventive Examinations and Medical Check-ups**	National	Systematic (non-CV-specific)	Broad (all adults)	Primary care	Annual	Public (National Health Insurance)	Yes
Croatia **Preventive Health Check-up Programme**	National	Systematic (non-CV-specific)	Age-based (≥ 40 years)	Primary care	One-off	Public (National Health Insurance)	Yes
Czech Republic **National Adult Preventive Check-ups**	National	Systematic (non-CV-specific)	Broad (all adults)	Primary care	Every two years	Public (National Health Insurance)	Yes
France **My Preventive Check-up**	National	Systematic (non-CV-specific)	Broad (all adults)	Primary care	Regular intervals (once per age bracket, i.e. 18-25, 45-50, 60-65, 70-75 years)	Public (National Health Insurance)	Yes
Germany **Health Check-up**	National	Systematic (non-CV-specific)	Broad (all adults)	Primary care	Once between 18 and 34 years; then every 3 years	Public (National Health Insurance)	Yes
Greece **I prevent**	National	Systematic by invitation (CV-specific)	Age-based (30-70 years)	Primary care	One-off	EU funds	Yes
Hungary **Comprehen-sive Health Protection Screening Program**	Local (selected locations across the country)	Opportunistic	Broad (all adults)	Mobile units	Ad-hoc (different locations every year)	Public (nationally funded, 2010-2030)	Partially
Ireland **Structured Chronic Disease Management Programme**	National	Systematic (CV-specific)	Risk-based (hyper-tension or high CVD risk)	Primary care	Twice a year	Public	Yes

Programme name	Geographic scope	Recruitment	Targeting	Delivery setting	Frequency	Funding source	Integration in care pathway
Italy **Cardio50**	Regional (Veneto)	Systematic (CV-specific)	Age-based (50-51 years)	Primary care & community-based	One-off	Public (regional authorities)	Yes
Latvia **National Preventive Health Check-up**	National	Systematic (CV-specific)	Age-based	Primary care	Regular intervals (at 40, 45, 50, 55, 60 and 65)	Public (National Health Service)	Yes
Lithuania **Lithuanian High Cardio-vascular Risk**	National	Systematic (CV-specific)	Age-based (40-60 years)	Primary care	Annual for very high-risk; every 2 years for high-risk; every 4 years for all the others	Public (National Health Insurance)	Yes
The Netherlands **Check@Home**	Regional (Breda, Utrecht, Arnhem, Eindhoven)	Systematic by invitation (CV-specific)	Age-based (50-75 years)	Online & Primary care	One-off	Public-private partnership	Yes
Poland **My Health**	National	Systematic (non-CV-specific)	All adults (≥ 20 years)	Online & Primary care	Every 5 years between age 20 and 50, then every 3 years	Public	Yes
Slovenia **Together for Health**	National	Systematic (non-CV-specific)	Age-based (≥ 30 years)	Primary care	Annual or every 5 years if high risk	EU funds	Yes
Sweden **Väster-botten Intervention Programme**	Regional	Systematic (non-CV-specific)	Age-based	Primary care	Regular intervals (2 visits at 40, 50, 60 years)	Public (regional authorities)	Yes

Appendix 2. Methodology

This report draws on a structured approach for evidence synthesis, combining a non-exhaustive systematic literature review with targeted screening, grey literature assessment and thematic analysis to evaluate the most relevant clinical, economic and societal value associated with CVHCs. An overview of the methodological approach is outlined below.

a. Approach to data search and analysis

Population, Intervention, Comparison and Outcomes (PICO) framework

The scope of the review was defined using an adapted PICO framework to ensure a structured and transparent assessment of the value of CVHCs. Given the nature of the available evidence, the framework primarily focused on Population, Intervention and Outcomes, as explicit comparators are not consistently reported across the literature.

- **Population:** Adult population living in the European region (EU Member States and associated countries), assessed across healthcare settings.
- **Intervention:** CVHC programmes, defined as interventions that include an initial structured assessment designed to identify individuals at elevated risk of cardiovascular or cardiometabolic disease through the measurement of multiple risk factors and to initiate appropriate follow-up activities.
- **Outcomes:** Quantitative outcomes capturing the clinical, economic and societal value of CVHCs.

Research questions

Based on this framework, three overarching research questions were formulated:

- Which health outcomes (e.g. risk factor modification, CVD events averted, cardiovascular mortality) are associated with CVHC programmes?
- Which economic outcomes (including healthcare resource use, cost savings, cost-effectiveness and return on investment) are associated with CVHC programmes?
- Which societal outcomes (e.g. productivity, equity and quality-adjusted life years gained) are associated with CVHC programmes?

Additionally, programme design and implementation characteristics were captured and described where relevant to contextualise and interpret reported outcomes.

Search terms

Guided by the adapted PICO framework focusing on three elements, a non-exhaustive list of search terms was developed to support a literature search in PubMed (**Table 5**).

Literature search

A comprehensive search strategy was employed, combining structured searches in PubMed with a targeted review of relevant Cochrane Reviews. In addition, targeted grey literature searches were conducted, including government evaluations, programme and institutional websites, clinical and policy guidelines, and reference tracking of relevant studies. Results from all sources were then systematically documented and mapped out using a PRISMA flow diagram.

Evidence screening

Each value-evidence source was reviewed using a dual-reviewer process. Titles were screened first, with abstracts and full texts assessed where eligibility was unclear. All abstracts were available in English; where full-text publications were not available in English, screening was conducted using automated translations.

Inclusion and exclusion criteria

Eligibility criteria were defined to ensure a consistent and transparent selection of evidence relevant to the objectives of the review and are summarised in **Table 2**.

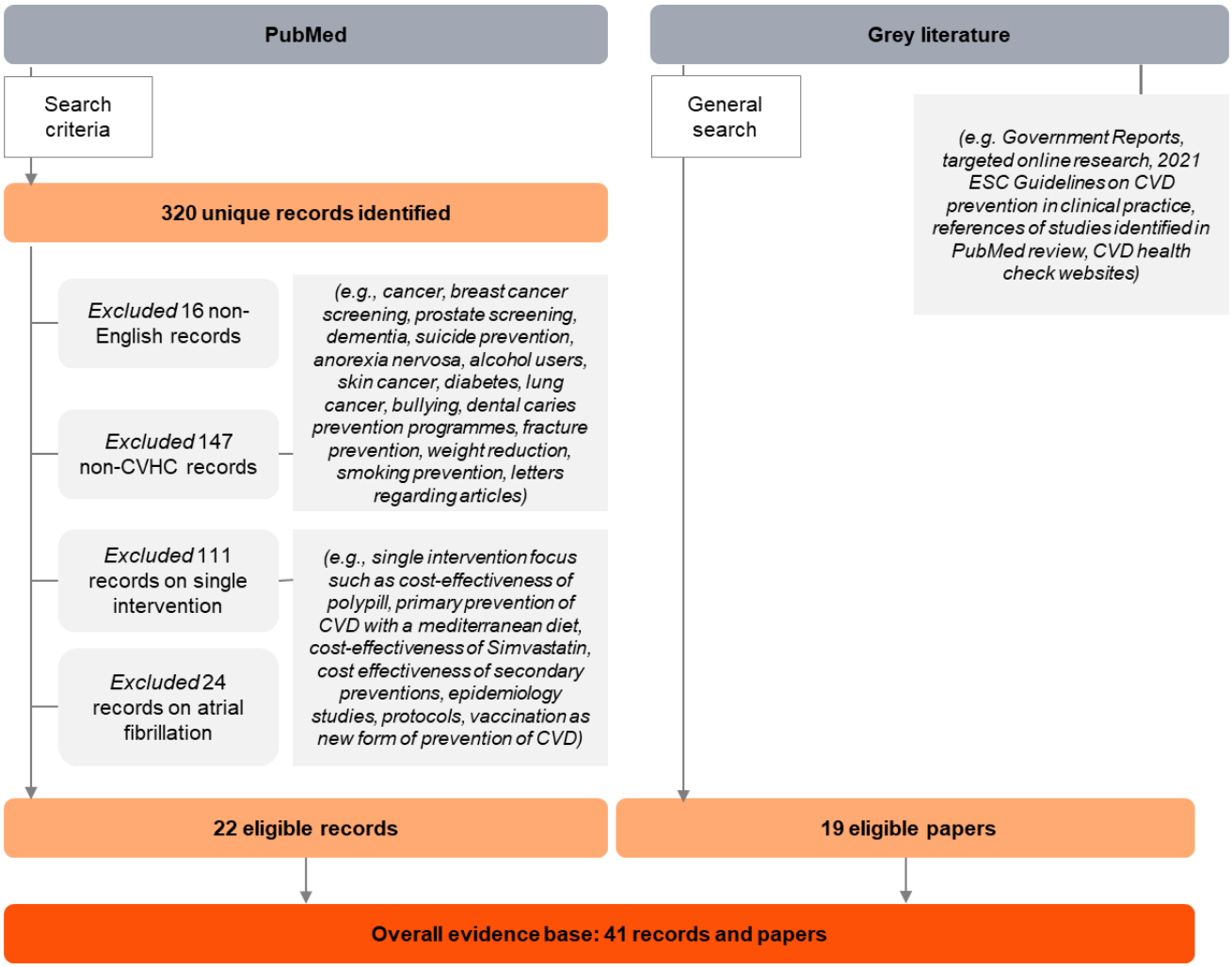
Table 2 Inclusion and exclusion criteria.

Inclusion criteria (all must apply)
• Studies reporting quantitative data (outcomes) related to a structured health check assessing multiple cardiometabolic parameters in the adult population, including biological risk factors and/or assessment of health behaviours, lifestyle factors or relevant personal and family medical history. • Studies reporting data from the European region, including EU Member States and associated countries (UK, Norway, Switzerland). • Studies published between 2015 and 2025. • For systematic literature reviews, studies including data from at least one EU country.
Exclusion criteria
• Studies focused mostly or exclusively on non-cardiovascular screening programmes (e.g. breast, cervical or prostate cancer screening). • Studies examining single preventive or therapeutic interventions only (e.g. cost-effectiveness of statins, polypill or individual medications) without a structured health check component. • Research protocols or editorials without reported outcome data.

Evidence base identification

The identification, screening and inclusion of evidence sources are summarised in **Table 3**.

Table 3 PRISMA flow diagram of study selection. The diagram summarizes the identification, screening, eligibility assessment, and inclusion of studies in the review, with reasons for exclusion at each stage.



The initial search of PubMed yielded 320 unique records, which were screened against the predefined inclusion and exclusion criteria. In parallel, additional relevant studies were identified through targeted searches of the grey literature and other sources. Following eligibility assessment, 22 PubMed-sourced papers and 19 externally identified studies were retained, resulting in a total of 41 included studies. This evidence base forms the foundation for assessing the value of CVHCs.

Data extraction

For each of the three value domains – clinical, economic and societal – relevant sub-value dimensions were identified (e.g. *risk factor detection and diagnosis* for the clinical domain; *cost-effectiveness* for the economic domain). Data were extracted from shortlisted full-text publications and mapped accordingly to these value areas, as illustrated in **Table 4**.

Table 4 Overview of evidence domains covered by studies evaluating CVHCs. For illustrative purposes, the table maps how individual studies can contribute evidence across clinical, economic and societal domains.

Domain	Sub-dimension	Study A	Study B	Study C	Study D	Study E
Clinical evidence	*Risk factor detection and diagnosis*	☑	☑	☑		
	Treatment initiation and diagnosis			☑		
	Risk factor mgm't and behaviour change					☑
	Non-fatal and fatal CVD events	☑				☑
Economic evidence	*Healthcare resource utilisation*					
	Cost-effectiveness				☑	☑
	Return on investment				☑	
	Healthcare system sustainability					☑
Societal evidence	*Equity*				☑	
	Productivity				☑	
	Quality of life				☑	

In addition, study characteristics extracted from each publication included study design, data sources, population size, jurisdiction, follow up duration, comparator (where applicable), healthcare setting and reported limitations.

For studies evaluating the cost-effectiveness of CVHCs, additional data elements were extracted, including population characteristics, analytical perspective, programme coverage (where reported), estimated uptake (where reported), time horizon, categories of data sources used, key findings and willingness-to-pay thresholds.

Data analysis

Evidence was synthesised narratively by consolidating results across multiple studies within each value domain and respective sub-dimensions.

Differences in value-related findings (e.g. effects on mortality) were explored descriptively by comparing key programme and study characteristics, including target population age, intervention type (e.g. multifactorial vs. single-component approaches), follow-up duration and population size. As outcome estimates and measures of statistical significance were not consistently reported across the literature, no quantitative comparison was conducted.

A thematic analysis aligned to the value sub-dimensions was undertaken. Within each, evidence was examined to identify recurring drivers of value and factors associated with limited or diminishing impact, supporting a structured narrative synthesis across heterogeneous study designs. Generally, the analysis focused on primary outcomes measures.

b. Overview of search terms for the literature review

Search queries were structured using Boolean logic, combining population and intervention concepts with outcomes and value dimensions according to the following formulation:

(Population terms) AND (Intervention terms) AND (Clinical outcomes terms) OR Economic outcomes terms OR Societal outcomes terms).

Table 5 presents the search terms derived from the adapted PICO framework and used to identify relevant studies.

Table 5 Search strategy and key terms used to identify relevant evidence.

Populations	"EU" [title/abstract] OR "Europe" [title/abstract] OR "UK" [title/abstract] OR "United Kingdom" [title/abstract] OR "England" [title/abstract] OR "Europe" [Mesh] OR "Greece" [title/abstract] OR "France" [title/abstract] OR "Italy" [title/abstract] OR "Germany" [title/abstract] OR "Sweden" [title/abstract] OR "Austria" [title/abstract] OR "Belgium" [title/abstract] OR "Bulgaria" [title/abstract] OR "Croatia" [title/abstract] OR "Cyprus" [title/abstract] OR " Czechia" [title/abstract] OR "Denmark" [title/abstract] OR "Estonia" [title/abstract] OR "Finland" [title/abstract] OR "France" [title/abstract] OR "Hungary" [title/abstract] OR "Ireland" [title/abstract] OR "Italy" [title/abstract] OR "Latvia" [title/abstract] OR "Lithuania" [title/abstract] OR "Luxembourg" [title/abstract] OR "Malta" [title/abstract] OR "Netherlands" [title/abstract] OR "Poland" [title/abstract] OR "Portugal" [title/abstract] OR "Romania" [title/abstract] OR "Slovakia" [title/abstract] OR "Slovenia" [title/abstract] OR "Spain" [title/abstract]
Interventions	"Health Check" [title] OR "Cardi* Health Check" [title] OR "Screen" [title] OR "cardi* screening" [title] OR "Cardi* prevention*" [title] OR "vascular screening" [title] OR "prevention program*" [title] OR "general health checks" [title] OR "cardi* risk communication" [title] OR "cardio* risk assessment" [title] OR "primary prevention" [title] OR "systematic screen*" [title] OR "opportunistic screen*" [title] OR "NHS Health Check" [title]
Clinical outcomes	"patient outcomes" [title] OR "outcomes" [title] OR " benefits" [title] OR "health outcomes" [title] OR "value" [title] OR "mortality" [title] OR "morbidity" [title] OR "cardio* events" OR "heart failure" [title] OR "transient ischaemic attack" [title] OR "atrial fibrillation" [title] OR "cerebral vascular" [title] OR "ischaemic heart disease" [title] OR "effectiveness" [title¨] or "clinical outcomes" [title] or "ASCVD" [title]
Economic outcomes	"cost effective*" [title] OR "budget impact" [title] OR "cost savings" [title] OR "cost utility" [title] OR "cost benefit" [title] OR "return on investment" [title] OR "ROI" [title] or "economic evaluation" [title] or "efficiency" [title] or "resource utilisation" [title]
Societal outcomes	"societal value" [title/abstract] OR "holistic value" [title/abstract] OR "societal" [title/abstract] OR "social value" [title/abstract] OR "public value" [title/abstract] OR "equity" [title/abstract] or "trust" [title/abstract] OR "productivity" [title/abstract]

c. Methodological and evidence limitations

The findings of this review should be interpreted in light of both methodological limitations of the review approach and limitations inherent in the available evidence base. From a methodological perspective, the search strategy relied primarily on PubMed, supplemented by targeted searches of grey literature and key sources rather than a fully systematic search across multiple bibliographic databases. While this approach was chosen to prioritise policy-relevant and high-quality evidence, it may have resulted in the omission of some relevant studies. In addition, the scope of the review was deliberately focused on the European region, which may limit completeness of the findings.

At the same time, several limitations reflect the nature of the underlying literature. The available evidence is heterogeneous in terms of study design, outcomes reported, populations studied and follow up duration, constraining comparability across programmes. Furthermore, papers generally assessed selected clinical, economic or societal outcomes rather than the full spectrum of CVHC impacts, which may result in the under-representation of certain outcomes, including long-term system-level or social care impacts. Finally, evidence on programme design and implementation characteristics was reported descriptively, rather than systematically evaluated.

Appendix 3. Overview of studies included in the targeted literature review

Table 6 Overall evidence base. Overview of the studies included in the literature review, covering study design, CVHC characteristics, geographic scope and population age range. All cited studies are listed in the bibliography. RCT: randomised controlled trial

No.	Author, Year	Study type	CVHC programme or Study name	Country	Age eligibility (years)
1	Crossan et al. 2017	Cost-effectiveness study	NHS Health Check	UK	Various
2	Mistry H et al. 2022	Systematic literature review of cost-effectiveness studies	NHS Health Check	UK	Various
3	Kypridemos et al. 2018	Cost-effectiveness study	NHS Health Check	UK	40-74
4	Kennedy et al. 2019	Quasi RCT	NHS Health Check	UK	35-75
5	Debiec et al. 2023	Prospective analysis	NHS Health Check	UK	40-74
6	Gysan et al.2017	RCT	Germany Workplace Health Check: Ford Study	Germany	18+
7	Jousilahti et al. 2016	Population based observational study	North Karelia	Finland	25-64
8	Avanzini et al. 2015	Cohort study	N/A	Italy	64.0 ± 9.5
9	Patel et al. 2020	Cross-sectional study	NHS Health Check	UK	40-74
10	Krogsbøll et al. 2019	Systematic literature review	SLR	N/A	Various
11	McCracken et al. 2024	Matched-cohort study	NHS Health Check	UK	40-74
12	Tanner et al. 2022	Rapid review	NHS Health Check	UK	40-74
13	Vartiainen et al. 2018	Observational study	North Karelia	Finland	30-59
14	Robson et al. 2017	Observational-matched study	NHS Health Check	UK	40-74
15	Baumann et al. 2015	RCT	Inter99 Study	Denmark	30-60
16	HSE Ireland Report 2025	Observational study	Structured Chronic Disease Management Treatment Programme	Ireland	18+
17	NHS Annex E HE modelling 2021	Cost-effectiveness study and return-on-investment modelling	NHS Health Check	UK	40-74
18	Alageel et al. 2019	Matched-cohort study	NHS Health Check	UK	40-74
19	Thomas et al. 2020	Modelling (cost-savings analysis)	No programme specified	UK	40-74
20	Collins et al. 2020	Cost-effectiveness study	NHS Health Check	UK	16+
21	Meireles-Brandão et al. 2022	Retrospective study	Portugal (Porto) primary care programme	Portugal	18+

No.	Author, Year	Study type	CVHC programme or Study name	Country	Age eligibility (years)
22	Kuneinen et al. 2024	Prospective cohort study	Harmonica Project	Finland	45-70
23	Mytton et al. 2018	Microsimulation model	NHS Health Check	UK	40-45
24	Diederichsen et al. 2024	Post hoc study	Danish Cardiovascular Screening trial	Denmark	65-74
25	Journath et al. 2020	Longitudinal, prospective follow-up study	The Sollentuna Prevention Programme	Sweden	15+
26	Bordin et al. 2018	Cohort study	Cardio50	Italy	18+
27	Kievit et al. 2017	Cost-effectiveness study	N/A	Netherlands	50-70
28	Hinde et al. 2016	Cohort study	NHS Health Check	UK	40-74
29	Morton et al. 2025	Cost-effectiveness study	Interventional trial	UK, Australia	40-69
30	Krstačić et al. 2024	Cost-effectiveness study	N/A	Croatia	45+
31	Sogaard et al. 2022	RCT-based cost-effectiveness study	Danish Cardiovascular Screening trial	Denmark	65-74
32	Badenbroek et al. 2020	RCT	INTEGRATE	Netherlands	45-70
33	Stol et al. 2020	RCT	INTEGRATE	Netherlands	45-70
34	Atkins et al. 2020	Systematic review	N/A	UK	Various
35	IQWiG, 2023	Rapid review	Check Up	Germany	18+
36	Uppsala County report, 2025	Cost-effectiveness study	Uppsala County Targeted Health Consultations	Sweden	40
37	Webb et al. 2019	RCT	N/A	UK	40-75
38	Bernstorff et al. 2019	RCT	Ebeltoft Health Promotion Project	Denmark	30-49
39	Lindholt et al. 2022	RCT	Danish Cardiovascular Screening trial	Denmark	65-74
40	Laucevicius et al. 2019	Programme review	The LitHiR Programme	Lithuania	40-55 (men), 50-65 (women)
41	Vilacosta et al. 2023	Programme review	PreveCardio	Spain	50-75

Appendix 4. Overview of health economic studies

Table 7 Health economic evidence base. Overview of health-economic studies included in the literature review, covering study design, methodology and key findings. CVD: cardiovascular disease; NHSHC: NHS Health Check; QALY: quality-adjusted life year; WTP: willingness to pay.

No.	Author, year, title	Design	Methodology	Key findings (non-exhaustive)
1	Lagord C, et al, 2021 Review of the NHS Health Check: Annex E Health Economic Modelling	Age eligibility (years): 40-74 Coverage: 100%. Uptake (base case): 52.5% Perspectives: Health and social care Time horizon: 20 years	Data sources: NHSHC primary care dataset (2012–2017) and others Comparators: Current implementation, no implementation, invite from age 30, most deprived, increased uptake, improve follow up WTP threshold: 30,000GBP/QALY	The NHSHC programme is likely to reduce health inequalities and deliver a societal return on investment of about 2.93GBP per 1GBP spent by 2040. It is unlikely to be cost-effective at the NICE 30,000GBP per QALY threshold. Increasing the effectiveness or the size of the population benefiting from behavioural interventions is likely to improve the effectiveness of the current NHSHC
2	Kypridemos et al., 2018 Future cost-effectiveness and equity of the NHS Health Check cardiovascular disease prevention programme: Microsimulation modelling using data from Liverpool, UK	Age eligibility (years): 40-74 Coverage: 13.8%. Uptake (base case): 32.3% Perspectives: Health and social care Time horizon: By 2030, by 2040	Data sources: Liverpool and national data on demographics, risk-factor exposure and CVD epidemiology, health and social care disease costs Comparators: Current implementation, current plus targeted, optimal uptake and prescription rates, current plus structural interventions, current plus targeted plus structural interventions, improve follow-up WTP threshold: 20’000GBP/QALY	The current NHSHC implementation is unlikely to be cost-effective or equitable, whereas targeted delivery to the most deprived areas (especially when combined with structural diet/smoking policies) is likely to improve equity and generate cost savings over time
3	Crossan et al., 2017 Cost-effectiveness of case-finding strategies for primary prevention of cardiovascular disease: a modelling study	Age eligibility (years): 30-74 Coverage: 100%. Uptake (base case): 63% Perspectives: NHS costs Time horizon: Lifetime	Data sources: The Health Improvement Network (THIN) English primary care database (for patient risk factors and drug cessation rates) Comparators: No cases detected WTP threshold: 30’000GBP/QALY WTP threshold: £2,000/QALY	Compared with no case finding, inviting all adults aged 30-74 years in a population of 10’000 yields 30.32 QALYs at a total cost of 705’732GBP. The best-value approach is to invite only the highest-risk 8% (≥12.76% 10-year CVD risk), giving 17.53 QALYs for 162’280GBP

No.	Author, year, title	Design	Methodology	Key findings (non-exhaustive)
4	Collins et al., 2020 Universal or targeted cardiovascular screening? Modelling study using a sector-specific distributional cost effectiveness analysis	Age eligibility (years): 30-84 Coverage: 13.8%. Uptake (base case): 32.3% Perspectives: Healthcare budgets Time horizon: Lifetime	Data sources: Liverpool CVD screening audit data Comparators: Current implementation, increased (coverage and uptake assumptions were based on existing targets), universal plus targeted (based on existing targets to deprived areas) WTP threshold: £2,000/QALY	Compared with the 'current' or 'increased' scenarios, the 'universal plus targeted' option (universal screening with additional delivery to the most deprived fifth) would lower health inequality by −0.65 QALYs per 100,000 person-years
5	Thomas et al., 2020 What are the cost-savings and health benefits of improving detection and management for six high cardiovascular risk conditions in England? An economic evaluation	Age eligibility (years): High CV-risk individuals over 16 Coverage: 100% (assumption). Uptake (base case): 100% (assumption) Perspectives: UK NHS and Personal Social Services Time horizon: 5, 10 and 25 years	Data sources: Health Survey for England (HSE) 2014 Comparators: Current detection levels WTP threshold: n/a	Diagnosing and managing all individuals in England with the six high-risk CVD conditions could save 68GBP billion, gain 4.9 million QALYs and prevent 3.4 million CVD cases over 25 years, with the highest benefits accruing from detecting high cholesterol in the short term and diabetes in the long term
6	Hinde et al., 2016 The cost-effectiveness of population Health Checks: have the NHS Health Checks been unfairly maligned?	Age eligibility (years): 40-74 Coverage: n/a. Uptake (base case): n/a Perspectives: Health and social care Time horizon: Lifetime	Data sources: Effectiveness data from various literature sources, cost data from Department of Health Comparators: No health check WTP threshold: 20,000GBP/QALY	Compared to no check, the NHSHC was associated with a reduction in mean BMI of 0.27, resulting in a gain of 0.05 QALYs per participant, a reduction in disease-related care costs of 170GBP and an ICER of 900GBP per QALY
7	Morton et al., 2025 Lp(a) testing for the primary prevention of CVD in high-income countries: a cost-effectiveness analysis	Age eligibility (years): 40-69 Coverage: n/a. Uptake (base case): n/a Perspectives: Health and social care Time horizon: n/a	Data sources: UK Biobank study Comparators: Standard of care as per European guidelines for CVD prevention WTP threshold: 28,000AUD/QALY (Australia), 20,000-30,000GBP/ QALY (UK)	Lp(a) testing to reclassify CVD risk leads to gains of 217 and 255 QALYs in Australia and the UK respectively, with corresponding ICERs of 12'134AUD (cost-effective) and −3,491GBP (cost-saving)
8	Krstačić et al., 2024 A cost-effectiveness evaluation of a high-sensitivity troponin I guided voluntary cardiovascular risk assessment program for asymptomatic women in Croatia	Age eligibility (years): Women over 45 Coverage: n/a. Uptake (base case): n/a Perspectives: Societal Time horizon: 10 years	Data sources: Observational data from the Women & Heart Project Zagreb Comparators: n/a WTP threshold: 45,000EUR/QALY	hsTnI-based CVD risk assessment of asymptomatic women leads to gain of 15.8 QALYs per 1,000 and lowers CVD-related mortality by 40%

No.	Author, year, title	Design	Methodology	Key findings (non-exhaustive)
9	Søgaard et al., 2022 Cost effectiveness of population screening vs. no screening for cardiovascular disease: the Danish Cardiovascular Screening trial (DANCAVAS)	Age eligibility (years): Men aged 65-74 Coverage: n/a. Uptake (base case): n/a Perspectives: European healthcare systems Time horizon: 5 years	Data sources: Danish National Prescription Registry, DANCAVAS study population samples for Quality of life, and others Comparators: Screening, no screening WTP threshold: EUR 20,000/QALY	The incremental cost of screening for the entire healthcare sector was 207EUR per invitee with gains of 0.023 QALY and ICER of 9'075EUR per QALY
10	Uppsala Region Government report, 2025 Is it cost-effective to offer targeted health consultations to 40-year-olds in Uppsala County?	Age eligibility (years): at 40 (once only) Coverage: 100%. Uptake (base case): 60% Perspectives: Health and welfare Time horizon: 45 years	Data sources: Programme data, Life and Health 2022 population survey, Uppsala County epidemiological data Comparators: Programme, no programme WTP threshold: indicatively 1,000,000SEK/QALY (low)	Cost per QALY gained is 29'757SEK
11	Kievit et al., 2017 Cost-Effectiveness of Cardiovascular Screening in Patients with Rheumatoid Arthritis	Age eligibility (years): adults with rheumatoid arthritis Coverage: n/a. Uptake (base case): n/a Perspectives: Clinical Time horizon: 10 years	Data sources: National health data and others Comparators: Screening, no screening WTP threshold: 20,000EUR/QALY	The mean QALY gain was 0.09 and the mean cost savings were −1'057EUR