The Royal Society of Medicine

Community for Health Equity

Session 4 report
‘The Business Case for Health Equity’

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Session 4 Report 'The Business Case for Health Equity'

Executive summary

This report captures learning from the fourth session of the Community for Health Equity programme, which focused on the business case for health equity and the role of return on investment in shaping decisions about prevention, innovation, partnership and resource allocation. The session brought together senior NHS finance and policy insight from Nicci Briggs, Deputy Chief Financial Officer, Operational Finance at NHS England and Emily Hopkinson, Senior Policy Manager at the Healthcare Financial Management Association, alongside operational insight from Kathleen Sadler, Director of Operations at Brook, health communications and behavioural science expertise from Dr Freddie Lewis and Dr John Brinsley at Havas Lynx and community-led health equity leadership from Professor Faye Ruddock, Founder and Chair of the Caribbean and African Health Network.

The session examined how organisations can move from recognising health inequalities to making a practical case for investment. Across the presentations and discussion it emerged that health equity is often presented as a moral and policy priority, but delivery depends on whether it can be translated into the language of finance, commissioning, operational pressure and measurable impact. This means ensuring that the full value of equity-focused work, including improved outcomes, reduced demand, better quality of life, workforce participation and wider social value is visible to decision-makers.

A key challenge is that the costs and benefits of prevention often sit in different budgets, sectors and timeframes. This makes equity-focused investment harder to sustain unless the value of earlier intervention, reduced demand and wider social benefit is recognised across the organisations that share responsibility for outcomes.

Presentations highlighted five complementary routes to making this case:

1. Return on investment can help finance and delivery teams understand whether interventions are reducing demand, improving outcomes and supporting service sustainability.
2. Data and modelling can identify where current payment models, access routes or service designs are reinforcing inequity and where targeted investment could shift outcomes.
3. Long-term partnerships can support innovation in service design, workforce capability, digital tools and stigma reduction, creating business value by improving reach, increasing uptake, reducing avoidable demand and building assets that continue to support delivery beyond the initial investment.
4. Storytelling and campaign design can support behaviour change, which is often necessary before financial, clinical or social returns can be realised.
5. Community-led approaches can create trusted routes into care, particularly for communities that experience poorer outcomes, later diagnosis and lower trust in statutory services.

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The session also highlighted that members of the Community for Health Equity experience challenges around ROI differently. Many stakeholders hold useful evidence, insight and practical tools, but they are not always able to translate these into a case that commissioners, finance leaders and partners can act on. Community organisations may struggle to evidence return in the format expected by funders. Industry partners may have strong experience of demonstrating ROI but need to ensure their contribution is rooted in trust, transparency and patient benefit. NHS leaders may understand the problem but still face short-term financial and operational pressures that favour activity over prevention.

The report concludes by identifying areas for further consideration, including how participants could share ROI and equity resources, strengthen the case for equity-focused innovation, capture practical examples, build campaign design capability and improve links between community-led organisations, finance leaders and innovators.

Programme overview

The Royal Society of Medicine (RSM) and the NHS have a shared commitment to reducing health inequalities, as outlined in the NHS Core20PLUS5 initiative and the NHS 10 Year Plan. The Community for Health Equity (CHE) Programme builds on this partnership, recognising that healthcare industry professionals (pharmaceutical, biotechnology and medical technology companies) possess unique resources and expertise that can support NHS goals. This includes supporting the adoption and spread of innovation and improving how equity considerations are built into value propositions, evidence generation and implementation.

By engaging industry, patients, clinicians and other stakeholders, this programme aims to bridge gaps between commercial innovation and public health NHS needs. The RSM, as an independent professional body, provides a neutral convener platform where industry, NHS leaders and other stakeholders can dialogue and co-create solutions. This alignment ensures that NHS leader's priorities – such as equitable access to medicines and advancing national strategic goals – are informed by industry insights, while industry is guided toward addressing unmet needs in underserved communities.

Ultimately, the initiative seeks to deliver tangible health improvements on the ground through a series of targeted engagements and outputs.

Co-development and status

This report has been co-developed with programme members. It reflects perspectives shared during the session and does not represent formal policy positions of the Royal Society of Medicine or participating organisations.

Financial contributions and independence

We would like to thank Bayer plc, which has financially supported the delivery of this programme through a sponsorship agreement. Bayer plc provided insights to inform the initial scope of the programme, with no further involvement in the content, programme, or organisation of this meeting.

We would like to thank our Industry Members [AstraZeneca, Boehringer Ingelheim, Gilead, Merck Group, Novartis and Pfizer] for their financial support of this event.

Organisations represented across this session

AstraZeneca
Boehringer Ingelheim UK and Ireland
Brook
Caribbean and African Health Network
Coventry & Warwickshire Partnership Trust
East of England NHS Collaborative Hub
Havas Lynx
Health Innovation Network
Healthcare Financial Management Association
Marie Curie
NHS England
North Central London Cancer Alliance
Novartis
Patient Information Forum
Patients Association
Pfizer
The Association of British HealthTech Industries
The Association of the British Pharmaceutical Industry
UCL
UCLH

Context and background

Health inequalities in England include differences in health status, access to care, experience of services and outcomes. They are systematic, avoidable and shaped by socioeconomic factors, geography, protected characteristics, exclusion, discrimination and wider determinants of health.[1] Previous sessions in the Community for Health Equity programme have examined how these inequalities are reproduced through definitions of need, data gaps, access routes, digital design, patient information, partnership models and delivery choices. This session focused on a further delivery question: how can the value of reducing health inequalities be made visible in decisions about funding, commissioning, innovation and service redesign?

The case for this work has become more urgent. Recent analysis by the Health Foundation shows that healthy life expectancy in the UK has fallen over the past decade, with people expected to spend fewer years in good health than before.[2] Office for National Statistics data for 2022 to 2024 shows healthy life expectancy at birth was 60.7 years for males and 60.9 years for females in the UK, the lowest level since the time series began in 2011 to 2013. The gap in healthy life expectancy across local areas also remains substantial, with local variation of 14.7 years for males and 15.8 years for females.[3]

This context gives return on investment a practical role. The NHS 10 Year Health Plan sets a direction towards prevention, neighbourhood delivery and digital transformation. Delivering those shifts will require investment decisions to place greater emphasis on long-term value, prevention and distributional impact. This is difficult in a system facing sustained financial and operational pressure, where immediate demand, productivity and activity requirements can shape what is prioritised. Existing work from Healthcare Financial Management Association (HMFA) as well as NHS Alliance has highlighted the importance of making the value of prevention visible to finance and commissioning teams, including through clearer approaches to return on investment. [4][5] The business case for health equity is therefore about ensuring decision-making captures who benefits, who is excluded and whether investment reduces avoidable demand over time.

This was a central theme in the contributions from Nicci Briggs, Deputy Chief Financial Officer, Operational Finance at NHS England, and Emily Hopkinson, Senior Policy Manager at HFMA. Both speakers brought senior finance and policy perspectives on how health equity is considered within NHS decision-making, including how prevention, value, access and unmet need can be made more visible in business cases, financial planning and service redesign.

The session also built on earlier learning about innovation. Innovation in health equity does not always mean introducing a new technology.

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[1] The King's Fund, *What are health inequalities?*
[2] The Health Foundation, *Healthy life expectancy trends in the UK: a watershed moment*
[3] Office for National Statistics, *Healthy life expectancy, UK: between 2011 to 2013 and 2022 to 2024*
[4] Healthcare Financial Management Association, *Return on investment A guide for NHS finance teams*
[5] The NHS Alliance, *Unlocking prevention in integrated care systems*

Context and background

It can involve new payment mechanisms, different commissioning incentives, better use of population health data, trusted community screening models, digital front doors, culturally relevant information, behaviour change campaigns and partnership models that combine clinical, community, industry and patient expertise. In each case, the test is whether innovation changes access, experience and outcomes for people who are currently least well served.

This is particularly important where the financial and clinical burden of inequity is concentrated. Participants discussed examples where small groups of people accounted for disproportionate demand across urgent care, ambulance, mental health and community services. They also discussed pathways where late diagnosis, low screening uptake, stigma or lack of culturally appropriate support creates higher downstream costs. These patterns show why equity work cannot sit outside mainstream financial planning. The same decisions that determine affordability, procurement and service sustainability also determine whether the system continues to absorb preventable demand.

For industry, the session raised a parallel challenge. Industry partners can bring data capability, implementation support, evidence generation, communications expertise, global insight and innovation capacity. However, that contribution must be grounded in trust, transparency, clear governance and patient benefit. Equity-focused partnerships need to be able to show both social impact and operational value, while avoiding approaches that treat underserved communities as an afterthought or a communications audience rather than partners in design and delivery.

The central question for the session was therefore how the Community for Health Equity can help stakeholders make a stronger, more practical case for investment. This includes supporting NHS teams to use ROI to improve decisions, helping community organisations evidence value in ways commissioners can use, enabling industry to align value propositions with equity outcomes and supporting all partners to design interventions that are specific enough to reach the people most affected.

Presentations

This section summarises the presentations given during the session and the key insights gained. These informed the later discussion and provided framing for the recommendations and actions to be taken.

1. Exposing the mountain: the economic case for tackling health inequalities

Organisation overview

Emily Hopkinson, Senior Policy Manager at the Healthcare Financial Management Association, brought a national NHS finance policy perspective to the session. HFMA supports and represents NHS finance professionals, and its work on health inequalities has been developed with NHS England's healthcare inequalities team. Her presentation focused on how NHS finance teams can understand the impact of investment, resource allocation and value-based decision-making on health inequalities, and how return on investment can help make the case for prevention and earlier intervention.

Presentation summary

The presentation positioned health inequalities as a financial and operational challenge for the NHS, as well as a moral and health outcomes issue. Using the analogy of "exposing the mountain", Emily Hopkinson described how short-term savings can help systems manage immediate pressure but are insufficient against rising demand driven by population ageing and increasing levels of poor health. Return on investment was presented as a practical tool to help decision-makers understand which interventions reduce demand, improve outcomes and support wider social and economic value.

Key insights

- ROI should be understood broadly, including financial returns, reduced demand on services, health outcomes and wider environmental, social and economic value.
- NHS business case decisions often prioritise financial savings and demand reduction, which means equity-focused interventions need to be framed in terms that finance and operational leaders can use.
- Prevention and earlier intervention create a practical bridge between health improvement and system sustainability.
- showed how ROI analysis can support improvement, not just justify investment, by identifying variation between trusts and points where patients dropped out before completing treatment. Further detail on this example is included in the discussion section.
- Decisions to decommission, reduce or withdraw services need explicit equity assessment, as blanket changes can disproportionately affect people facing poverty, disability, language barriers, low literacy or digital exclusion.

If you only read one resource: Return on investment: a guide for NHS finance teams

2. Case study ROI in ICBs: senior NHS finance leadership perspective

Organisation overview

Nicci Briggs, Deputy Chief Financial Officer, Operational Finance at NHS England, brought senior NHS finance leadership and practical system experience to the session. She was previously Chief Finance Officer at NHS Cambridgeshire and Peterborough Integrated Care Board, and has held senior finance and transformation roles across NHS organisations. Her presentation drew on practical examples of how NHS systems can use data, financial modelling, payment reform and local delivery to identify unmet need, target investment and redesign services around equity.

Presentation summary

The presentation used two examples, NHS dentistry and high-intensity users, to show how systems can use data to define a problem, establish a baseline and make the case for targeted investment. The central argument was that innovation in commissioning, payment models and neighbourhood delivery depends on understanding where demand, cost and unmet need sit across a population.

Key insights

- Defining the problem and establishing a baseline are essential. Without this, systems cannot know whether a new model is delivering benefit.
- The dentistry example showed how existing payment models can reinforce inequity where providers lose money on lower-band NHS treatments, particularly in more deprived areas.
- Modelling different options enabled the system to identify a tiered reimbursement approach that incentivised delivery against NHS contracts and increased access.
- Early results from the dentistry test phase showed increased activity, including growth in lower-band treatments, which are important for preventing escalation into more complex and costly care.
- The high-intensity user analysis showed how a small number of people can account for a disproportionate share of contacts and cost across A&E, ambulance, mental health, community and outpatient services.
- Population-level data needs to be paired with local action, including neighbourhood teams, voluntary sector partners and patient-centred solutions.

If you only read one resource: How finance teams are helping to reduce health inequalities: further case studies

3. Brook: working together to improve young people's sexual health

Organisation overview

Brook is a national charity delivering sexual health, mental health and wellbeing services, alongside education, training and advocacy. Its work focuses on accessible, inclusive and non-judgemental support for young people.

Presentation summary

The presentation described a long-term partnership between Brook and Bayer from 2017 to 2024. The partnership supported a series of projects focused on contraception access, intimate health, body literacy, digital access and heavy menstrual bleeding. Across these projects, innovation was framed less as a single product and more as sustained capacity building, service redesign, digital tools, clinician training and youth-led engagement.

Key insights

- The partnership addressed areas of unmet need where stigma, misinformation and lack of accessible information can delay help-seeking.
- Investment supported both infrastructure and workforce capability, including clinic refurbishment, clinical training and education resources.
- Co-design with young people was central to making resources relevant, accessible and usable.
- Digital tools and campaigns, including the Love Your Vulva programme and Heavy Talk campaign, helped reach young people beyond traditional service settings.
- The partnership shows how industry support can contribute to long-term capacity where governance, independence and content boundaries are clear.
- Innovation was strongest where it combined evidence-based information, trusted delivery routes, youth engagement and service capacity.

If you only read one resource: Love Your Vulva digital resource

4. The Impact of Resonance: storytelling as a catalyst for health equity and organisational change

Organisation overview

Havas Lynx brings specialist expertise across healthcare strategy, medical communications, behavioural science, patient engagement, disease awareness and health equity. Dr Freddie Lewis, Medical Director at Havas Lynx, and Dr John Brinsley, Senior Medical Advisor at Havas Lynx, brought substantial clinical, strategic and communications expertise to the session. Their experience spans frontline NHS care, mental health, emergency medicine, primary care, AI transformation, behavioural change, patient and professional engagement, and work with underserved populations. The presentation showed how high-quality health communications can move beyond awareness raising to address stigma, improve access, support behaviour change and contribute to measurable health equity outcomes.

Presentation summary

The presentation argued that data, financial evidence and measurement are necessary but insufficient on their own. To generate ROI, health equity work often needs behaviour change, and behaviour change depends on insight, emotion, relevance, trust and cultural fit. Drawing on Havas Lynx's wider health communications work, the presentation showed how campaign design can support measurable change by addressing stigma, improving engagement, increasing uptake and making services more accessible to people who are underserved or less likely to seek care. Storytelling was presented as a tool for changing how people think, feel and act, particularly where stigma, taboo or distrust block access to care.

Key insights

- Awareness alone rarely changes behaviour. Campaigns need to identify the behaviour they are trying to shift and the barrier that sustains it.
- Stories can make data feel immediate, personal and actionable, helping people move from understanding a problem to doing something differently.
- Effective campaigns do not always confront a cultural barrier directly. They can sometimes work by subverting or using existing cultural practices and language.
- Examples included HIV stigma, breast cancer screening, learning disability and prostate cancer among farmers.
- Havas Lynx's examples showed the breadth of its health work across different conditions, audiences and access barriers, including HIV stigma, breast cancer screening, learning disability and prostate cancer among farmers.

If you only read one resource: Health for All: What if no one was left behind?

5. The return on investment for investing in Black and other underrepresented communities often left behind

Organisation overview

The Caribbean and African Health Network (CAHN) is a community-led organisation focused on ending health inequalities and wider disparities for Caribbean and African people. Its work combines advocacy, prevention, health literacy, community engagement and culturally competent support.

Presentation summary

The presentation made the case that investment in Black and other underrepresented communities is economically rational as well as ethically necessary. Professor Faye Ruddock highlighted disparities across maternity, hypertension, mental health, stroke and cancer and argued that avoidable late diagnosis and crisis intervention generate human and financial costs. CAHN's model shows how community-led initiatives and innovation can create trusted access routes, identify risk earlier and reduce downstream demand.

Key insights

- Language matters. Communities are often described as "hard to reach" when the real issue is how systems try to reach them.
- Black communities face avoidable illness, later diagnosis, poorer outcomes and higher-cost intervention across several pathways.
- Trust is a delivery mechanism. Community organisations can create access points that statutory services may struggle to establish.
- CAHN's community screening programme reached over 1,500 Black residents through trusted venues, identifying hypertension, diabetes risk, obesity and kidney disease earlier.
- Culturally adapted prevention pathways can generate ROI by avoiding admissions, complications, litigation, workforce loss and crisis-care costs.
- Innovation in this context means shifting investment upstream, working through trusted community infrastructure and designing interventions with the people they are intended to reach.

If you only read one resource: Knowledge. Access. Screening. Opportunities

Discussion

The discussion explored how health equity can be translated into decisions that affect funding, commissioning, procurement, professional practice, public engagement and service redesign. Across the session, participants returned to a central tension. Most organisations understand that health inequalities exist and that prevention is important, but this knowledge does not automatically change decisions. The practical challenge is how to make health equity visible in the systems that decide what is funded, what is sustained, what is scaled and what is stopped.

ROI as a tool for changing decisions

Building on the NHS finance perspectives provided by Nicci Briggs and Emily Hopkinson, participants discussed return on investment as a tool for bringing health equity into financial and operational decision-making. Their contributions reinforced that equity-focused work needs to be visible in the language and processes that shape NHS decisions, including business cases, commissioning, financial planning, payment models and service redesign. ROI was seen as useful because it gives organisations a method for connecting investment to value. However, participants also cautioned against treating ROI as purely financial.

The South Yorkshire QUIT example was seen as important because it showed ROI being used dynamically. The analysis did more than estimate a return. It helped identify where the pathway was underperforming, where variation existed and what would need to improve for the programme to reach its intended value. ROI can be used as a one-off calculation to secure approval, or it can be used as an improvement tool to test assumptions and adapt delivery.

Participants also discussed the difficulty of making ROI arguments across organisational boundaries. The costs and benefits of prevention often sit in different budgets, different sectors and different timeframes. An intervention may reduce demand on urgent care but require investment from primary care, local authorities, voluntary sector partners or community organisations. This creates an integration problem as much as a financial one. The discussion reflected interest in models where budgets, priorities and accountability are brought together around shared outcomes, with Greater Manchester referenced as one place where more integrated arrangements can make testing innovative initiatives easier.

A further issue was the type of outcome that is valued. Participants noted that many economic models focus on returning people to work or reducing acute hospital use. These are important, but they do not capture all forms of value. Palliative care was discussed as an example where quality of life, family experience, carer burden and avoidance of inappropriate acute care may be more relevant than traditional productivity measures. This highlighted the need for a broader understanding of return that reflects the purpose of the intervention and the population it serves.

Innovation as a practical route to prevention and earlier intervention

The session broadened the discussion of innovation beyond products or technologies. Across the examples, innovation was most relevant where it helped systems act earlier, target resources more precisely or redesign the conditions that shape access. This included new payment models in dentistry, population health analytics for high-intensity users, digital and youth-centred information through Brook, community-based screening through CAHN and behaviour change campaigns that addressed stigma and trust.

This matters because the business case for health equity depends on whether innovation changes what happens in practice. The examples shared by Nicci Briggs showed how NHS finance and commissioning decisions can either reinforce or reduce inequity. The dentistry example showed how a different reimbursement model could shift provider behaviour and improve access to lower-band NHS treatment, reducing the risk that unmet oral health need escalates into more complex and costly care. The high-intensity user example showed how data can make concentrated demand visible across urgent care, ambulance, mental health, community and outpatient services, creating a basis for neighbourhood teams and partners to develop more targeted responses.

The discussion also pointed to the value of learning from community-led and international approaches. Participants reflected that some systems and communities have developed models closer to people's everyday lives, using trusted relationships, lower-cost routes, mobile-first approaches or community infrastructure to reach people earlier. This challenged a narrow view of innovation as something introduced into communities from the outside. In equity work, innovation may come from the way communities already navigate barriers, build trust and create access where formal services struggle.

Industry can add value to this agenda when its insight, evidence and global perspective are translated into local delivery with clear governance and patient benefit. Its contribution is strongest where it supports implementation, learning and scale around defined equity challenges, rather than where innovation is treated as a standalone offer.

Behaviour change as a condition of return

A strong theme across the session was that awareness does not equal behaviour change. Participants compared health equity with issues such as climate change, where many people understand the problem but continue with existing behaviours. This has direct implications for ROI. An intervention may have a strong evidence base, but if patients, clinicians, commissioners or providers do not change behaviour, the expected return will not be realised.

The Havas Lynx presentation, delivered by Dr Freddie Lewis and Dr John Brinsley, brought this issue into focus. Drawing on Havas Lynx's wider work across healthcare strategy, behavioural science, medical communications and health equity, storytelling and campaign design were presented as methods for creating resonance, reducing stigma and shifting behaviour. Participants discussed examples where cultural taboos, shame, fear or mistrust prevent people from accessing care, even when services exist. In these situations, more information may be insufficient. The challenge is to understand the audience, the behaviour that needs to change and the emotional or cultural barrier that sustains the current pattern.

This was also reflected in discussion of community champions and trusted voices. Participants noted that campaigns are more effective when the message comes from someone the audience recognises and trusts. Examples included healthcare champions, community leaders, families, charities and people with lived experience. Generic campaigns risk missing the people they are intended to reach, while more specific, co-created campaigns can make smaller budgets more effective.

The design-your-own-campaign exercise reinforced this point. Participants were asked to identify the challenge, the audience, the insight, the narrative, the distribution route and how change would be measured. This structure helped move the discussion from general awareness raising to practical behaviour change. It also highlighted the value of being specific. The more clearly a campaign defines its audience and behaviour, the easier it becomes to identify trusted routes, relevant language and measurable outcomes

Targeting as a route to scale

The session challenged the assumption that equity-focused work is too bespoke to scale. Participants noted that targeted interventions can be more scalable when they are precise about the problem, the population and the mechanism of change. Targeting does not mean creating isolated projects with limited reach. It means designing interventions around the people most likely to be missed or harmed, then learning how that approach can be adapted elsewhere.

CAHN's work provided a strong example. Community-based, culturally competent screening reached people through trusted venues and identified risk earlier. The model is specific to the needs, trust dynamics and access routes of Caribbean and African communities, but it also illustrates wider principles that can inform other equity-focused work: use trusted infrastructure, design with communities, address health literacy and measure early detection and referral outcomes.

The Brook–Bayer partnership also showed how targeted work can create lasting capacity. The projects focused on young people and sensitive sexual, intimate and menstrual health topics. The partnership combined service redesign, clinician training, digital resources and stigma reduction. The result was not a single time-limited campaign, but a set of resources, capabilities and access routes that could continue beyond the initial investment.

Participants also discussed how targeting can strengthen collaboration. When a problem is too broad, partners may struggle to identify what they can contribute. When the audience and challenge are specific, it becomes easier to bring together the right community organisation, clinical team, industry partner, funder or communication route. This has implications for the Community for Health Equity. One of its roles could be to help participants move from broad equity ambition to clearer, investable and measurable propositions.

Culture, confidence and the language of value

The discussion highlighted a capability gap across sectors. Community and voluntary organisations often hold deep insight and trust but may lack confidence in making a financial or ROI case. Industry partners are often experienced in value propositions, business cases, evidence generation and communications strategy, and the Havas Lynx contribution showed how this expertise can be applied to health equity where it is grounded in behavioural insight, clinical credibility, audience specificity and trust. NHS finance and commissioning teams may understand the need for prevention but face immediate affordability pressures and may lack routes to invest in upstream models.

This creates a translation challenge. Participants suggested that the programme could support stakeholders to understand each other's language, incentives and evidence needs. This includes helping community organisations describe value in ways commissioners can act on, helping finance leaders understand the value of trusted community infrastructure and helping industry partners align innovation, evidence and partnership offers with equity outcomes.

Leadership and organisational culture were also seen as important. Participants noted that equity principles need to be embedded into planning, commissioning, professional development and delivery, rather than treated as a separate issue. This includes education and training for professionals, but also practical frameworks that help staff identify what they can change in their own role. Without this, health equity remains an aspiration rather than a routine part of decision-making.

Suggested next steps

The suggested next steps below reflect where participants identified opportunities to strengthen the business case for health equity across the Community for Health Equity programme. They focus on building shared capability, improving practical use of evidence and supporting equity-focused innovation to move from intent to implementation.

1. Create a short guide on how to make the case for equity-focused innovation

The session showed that innovation can take many forms, including payment reform, service redesign, community screening, digital tools and campaign design. However, stakeholders may need support to translate insight and ideas into investable propositions.

Action

- Develop a short practical guide setting out how to make the case for equity-focused innovation.
- Include prompts on defining the problem, identifying the target population, establishing a baseline, describing the intervention, mapping expected returns and setting measures for impact.
- Ensure the guide supports both NHS and non-NHS partners, including community organisations and industry.

2. Support campaign design and health communications capability across the Community for Health Equity

The "design your own campaign" exercise provided a practical framework for turning broad equity challenges into specific behaviour change interventions. This approach could support future projects and partnerships.

Action

- Make the "design your own campaign" template an accessible resource for all participants to access and download.
- Encourage participants to test campaign ideas with patient, community and VCSE partners before implementation.

3. Strengthen links between community-led organisations, finance leaders and innovators

Participants identified a need for better translation between community insight, financial decision-making and innovation development. Stronger links between these groups could help ensure equity-focused projects are designed around real need and supported by credible evidence of value.

Action

- Convene targeted conversations between community-led organisations, finance leaders, commissioners, industry partners and innovators around specific equity challenges.
- Focus these conversations on developing practical propositions.
- Explore how community organisations can be supported to evidence impact and how finance teams can better capture social, community and prevention value.

Additional resources

Healthcare Financial Management Association

- **Ringrose H**. *How finance teams are helping to reduce health inequalities: further case studies*. HFMA, 18 September 2025. https://www.hfma.org.uk/publications/how-finance-teams-are-helping-reduce-health-inequalities-0
- **Hopkinson E**. *Return on investment: a guide for NHS finance teams*. HFMA, 10 June 2025. https://www.hfma.org.uk/publications/return-investment
- **Hopkinson E**. *Bringing it all together: financial strategies that address health inequalities*. HFMA, 5 August 2024. https://www.hfma.org.uk/publications/bringing-it-all-together-financial-strategies-address-health-inequalities
- **Paskell T, Hopkinson E**. *Commissioning to reduce health inequalities: the role of finance*. HFMA, 20 March 2024. https://www.hfma.org.uk/publications/commissioning-reduce-health-inequalities
- **HFMA**. *A primary care funding model to address health inequalities: a case study from Leicester, Leicestershire and Rutland*. 20 March 2024. https://www.hfma.org.uk/publications/primary-care-funding-model-address-health-inequalities
- **Hopkinson E**. *Case study: Bolton quality contract*. HFMA, 18 January 2024. https://www.hfma.org.uk/publications/bolton-quality-contract
- **Paskell T, Hopkinson E**. *Using financial incentives to tackle health inequalities*. HFMA, 18 January 2024. https://www.hfma.org.uk/publications/using-financial-incentives-tackle-health-inequalities
- **Day S**. *Considering health inequalities in business cases. HFMA*, 1 December 2023. https://www.hfma.org.uk/publications/considering-health-inequalities-business-cases
- **Paskell T**. *How finance teams are helping to reduce health inequalities*. HFMA, 15 September 2023. https://www.hfma.org.uk/publications/how-finance-teams-are-helping-reduce-health-inequalities
- **Paskell T**. *Resources and funding to reduce health inequalities*. HFMA, 12 July 2023. https://www.hfma.org.uk/publications/resources-and-funding-reduce-health-inequalities
- **Khawaja F**. *Health inequalities: establishing the case for change*. HFMA, 11 May 2023. https://www.hfma.org.uk/publications/health-inequalities-establishing-case-change

HFMA e-learning modules

Introduction to health inequalities for finance
Using data to understand health inequalities
- *Allocating resources to address health inequalities*

Reflecting health inequalities in your business case
Investing in prevention: tobacco dependency treatment pathways

Return on investment and prevention

- **Holdroyd I, Ghanchi A, Lunn AD, Diamond P, Harasgama S, Painter H, Pearce H, Torabi P, Vodden A, Wong YL, Ford J**. *Payment mechanisms to improve prevention spending in health care settings: a policy-focused evidence brief*. Public Health in Practice. 2026 February 19;11:100756. *https://www.sciencedirect.com/science/article/pii/S2666535226000352*
- **Holdroyd I, Lunn AD, Diamond P, Harasgama S, Ghanchi A, Painter H, Pearce H, Torabi P, Vodden A, Ling Wong Y-L, Ford J**. *What works: Payment mechanisms to improve prevention spending in health care settings*. Health Equity Evidence Centre, 11 December 2024. https://www.heec.co.uk/resource/what-works-payment-mechanisms-to-improve-prevention-spending-in-health-care-settings
- **Holdroyd I, Lunn AD, Harasgama S, Painter H, Pearce H, Torabi P, Vodden A, Wong YL, Ford J**. *What works: Funding models to address health inequalities*. Health Equity Evidence Centre, 9 December 2024. https://www.heec.co.uk/resource/what-works-funding-models-to-address-health-inequalities
- **Wood M, Patel A, Richardson B**. *Paving a new pathway to prevention: leveraging increased returns on our collective investment*. NHS Confederation, in partnership with Carnall Farrar, 7 October 2024. https://www.nhsconfed.org/publications/paving-new-pathway-prevention

Additional resources

- **Masters R, Anwar E, Collins B, Cookson R, Capewell S**. *Return on investment of public health interventions: a systematic review*. Journal of Epidemiology and Community Health. 2017 August;71(8):827-834. https://jech.bmj.com/content/71/8/827
- **South Yorkshire and Bassetlaw Integrated Care System.** *SYB QUIT*
- **Cairney P, Boswell J, Bliss A, Mahmood H, Raine J**. *Unlocking prevention in integrated care systems. NHS Confederation, 24 October 2024.* *https://thenhsalliance.org/resources/unlocking-prevention-in-integrated-care-systems*

Embedding equity principles

- **Havas Lynx:** *Health for All: What if no one was left behind?*
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Health Innovation Network

Local change, national impact

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