INNOVATIVE FINANCING FOR PREVENTION

FROM HEALTHCARE COSTS TO HEALTH GAINS

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PREFACE

Every year, Social Finance NL publishes a report on our own initiative about a topic it considers important. This year is the first time we choose a specific domain: health care. Few areas show as much energy and ambition to organise and finance differently. Every day, organisations approach Social Finance NL with ideas or a desire to contribute in a positive way. The urgency is clear. If we want to keep good care accessible and affordable for everyone, we need to collaborate and finance more effectively.

In the Netherlands, long standing structures and vested interests make it difficult to place a stronger emphasis on prevention. In that sense it is almost reassuring that we did not find a single country where the financing system is fully aligned with prevention and health promotion. Even so, we did encounter innovative and effective examples abroad that put prevention at the very heart of the health care system.

This report highlights pioneers who dare to work and finance differently and who achieve remarkable results. At the same time, many initiatives, both in this report and in Social Finance NL's day-to-day practice, struggle to grow beyond the pilot stage. That is not because their initiators lack creativity or entrepreneurship. It is because of the current system itself: a financing approach that rewards treatment, rather than encouraging health or preventing illness.

So how do we make sure prevention initiatives can thrive *because* of the financing system, rather than *despite* it? This is the central question of this report.

We did not write this report on our own. We are grateful to all interviewees for generously sharing their knowledge, insights, and experiences. The advisory panel of field experts was equally essential. We also want to thank Rabobank and Invest NL for their network, expertise, and financial support. Without them, this report would not have been possible.

This report is not a ready-made blueprint for the perfect way to organise healthcare financing. What it does show is that by organising and financing more intelligently, prevention can gain more room and resources to make society healthier. By putting these cases in the spotlight, we hope to inspire health care professionals, financiers, and policymakers to help shape new ways of financing prevention, in service of a healthy, vital, and future proof society.

Social Finance NL is happy to play its part in this.

Bernard ter Haar

Chair, Social Finance NL

MANAGEMENT SUMMARY

PREVENTION IS ESSENTIAL

Ageing, staff shortages, and lifestyle-related diseases are driving health care costs up to as much as €200 billion by 2050. The shortage of health care workers could grow to well over 250,000. Quality and accessibility are increasingly coming under pressure.

Prevention can reverse this trend. By preventing health problems or postponing them, the demand for care decreases and well-being improves. Yet prevention remains structurally underfunded. Only 5% of health care spending goes to prevention.

Even though there is no debate about the necessity of prevention, large-scale investment in prevention is not getting off the ground. A key reason is the financing system. Current financing mainly rewards health care production rather than health gains, and the benefits of prevention often accrue to other parties or only in the long term. As a result, it does not pay off for individual organisations to invest in prevention over the long term.

PREVENTION MUST BE FINANCED STRUCTURALLY

This report explores how innovative financing models in the Netherlands and abroad can help ensure that prevention is no longer dependent on temporary subsidies but is secured as a structural investment in health.

Each case study highlights a key question:

HOW DO WE MAKE PREVENTION PROFITABLE?
Germany, the Netherlands, Finland

HOW DO WE WORK AS ONE SYSTEM?
Alaska, the Netherlands, United States

HOW DO WE EMBED PREVENTION SUSTAINABLY?
Iceland, United Kingdom, Australia

The examples show that structural change becomes possible once three conditions come together:

1. Stimulating health is made financially attractive.
2. Collaboration across domains is organised structurally.
3. There is a fixed infrastructure to measure, learn, and reinvest.

EXAMPLES SHOW THAT FINANCING CAN BE MORE EFFECTIVE

REWARDING HEALTH

Germany
The Netherlands
Finland

In **GERMANY** we see how care providers and health insurers together are financially responsible for the health of 70,000 residents. Through a single regional budget and a shared-savings model, savings are reinvested in prevention. The number of hospital admissions fell by 20%, while health care costs decreased structurally. Health literally became profitable.

The **DUTCH** Health Impact Bond *Stevig Staan* shows that private up-front financing can accelerate public investment. Investors paid in advance for a fall-prevention programme for elderly; municipalities and health insurers only repaid once results were proven. Falls incidents had dropped by 67% halfway through the programme and more than €1 million in health care costs was saved.

The **FINNISH** Lapset-SIB shows that outcomes-based financing can also work at scale. Five municipalities jointly finance preventive youth care via one fund. Private investors bear the risk, while municipalities only pay once demonstrable results are achieved. In this way, prevention becomes a shared investment rather than a cost item.

JOINT STEWARDSHIP

Alaska
The Netherlands
United States

In **ALASKA**, Alaska Native communities quite literally took health care into their own hands. Through the Nuka System of Care, they manage the health care budget themselves, with fixed teams around families and long-term relationships between residents and care providers. The result: 44% fewer emergency visits, 43% fewer hospital admissions, and 98% satisfaction.

In **THE NETHERLANDS**, *Gelijk-Gezond* shows that health gains also start with social factors such as income, housing, and debt. They see the health gap widening. Municipalities, insurers, and investors work together to support residents in an integrated way, using *"doorbijters"* (persistent support navigators) who navigate across domains and rules to secure the right support for residents. By working across domains, the barriers between health care and social care disappear.

The **AMERICAN** Kaiser Permanente combines insurance, hospital care, and medical teams within one organisation. Because care delivery and financing sit with the same party, it pays to prevent illness. The results are impressive: 33% fewer premature deaths from heart disease and 20% fewer from cancer.

STRUCTURAL EMBEDDING

Iceland
United Kingdom
Australia

ICELAND shows that prevention works when it is structurally embedded in policy and budgeting. Through a national programme, municipalities collect annual data on young people, use it to adjust policy, and invest in meaningful leisure activities. Alcohol use among 15- and 16-year-olds, for example, fell from 42% to 5%.

In the **UNITED KINGDOM**, the Life Chances Fund provides national co-financing for local prevention projects based on results. Municipalities receive an additional government contribution once they achieve demonstrable social outcomes. In this way, risks are shared, knowledge is standardised, and successful projects are scaled up.

The **AUSTRALIAN** state of Victoria goes a step further. There, prevention is embedded in the budgeting system itself. Through the Early Intervention Investment Framework, a portion of achieved savings is credited back to the department that invested. This creates a structural incentive to act early and finance proven interventions over multiple years. ▶

RECOMMENDATIONS

The transition from care to health does not require more projects, but new rules of the game.

REGIONAL PREVENTION FUNDS

Pool resources from municipalities, health insurers, and employers into a regional fund.

This enables parties to invest jointly in what works locally and to reinvest realised benefits into new prevention.

Breaks fragmentation and strengthens local ownership.

NATIONAL PREVENTION OUTCOMES FUND

Create a national fund that co-finances successful initiatives once impact has been proven.

The fund acts as a catalyst between municipalities, health insurers, and investors, and ensures national standards for measurement and evaluation.

Makes prevention structurally financeable and scalable.

A HEALTH ACT AS A STATUTORY COMPASS

Legally anchor national health goals, multi-year prevention budgets and shared responsibility

Provides continuity, direction, and shared accountability for health.

CONCLUSION

The Netherlands already has the knowledge, data, and initiatives to strengthen prevention. What is missing are rules of the game that reward health, make collaboration possible, and guarantee continuity.

Once health is seen as the outcome we pay for, the boundary between prevention and outcomes-based financing disappears. Prevention then becomes not a cost item, but an investment that leads to longer healthy life years, lower health care expenditure, and a stronger society.

The pioneers in this report show that it can be done. The next step is to implement the recommendations above so that the Netherlands moves towards a prevention system that invests structurally in health.

1. INTRODUCTION

This report focuses on several pioneers who are using new forms of financing to strengthen prevention. We describe these initiatives, the lessons they offer, and how their approach can inspire policy and practice in the Netherlands. Based on these insights, we conclude with three concrete recommendations.

The report opens with the importance of prevention, followed by an analysis of the main bottlenecks that hinder investment in prevention in the Netherlands (Chapter 2). These bottlenecks are then explored in more depth: lack of investment incentives (H3), fragmentation across domains (Chapter 4), and lack of prevention infrastructure (Chapter 5).

Each chapter includes practical examples showing how these barriers can be overcome. For instance, we see how in Germany care providers and health insurers are jointly financially responsible for a regional budget, how in Alaska residents are co-owners of their care system, and how in Australia prevention has secured a fixed place in the government budget. Each chapter ends with a lesson for the Netherlands. The final chapter translates these lessons into three concrete recommendations for financing sustainable prevention in the Netherlands.

While writing this report, we noticed that almost all parties within the health care system share the same ambition: making a healthy society possible. Yet it proves difficult to make the structural shift from treating illness to investing in health. With this report we show that structural prevention is possible when financing, organisation, and accountability are designed differently. In doing so, we aim to help public and private parties make the transition from treating illness to investing in health.

Photo: Evelien Hogers

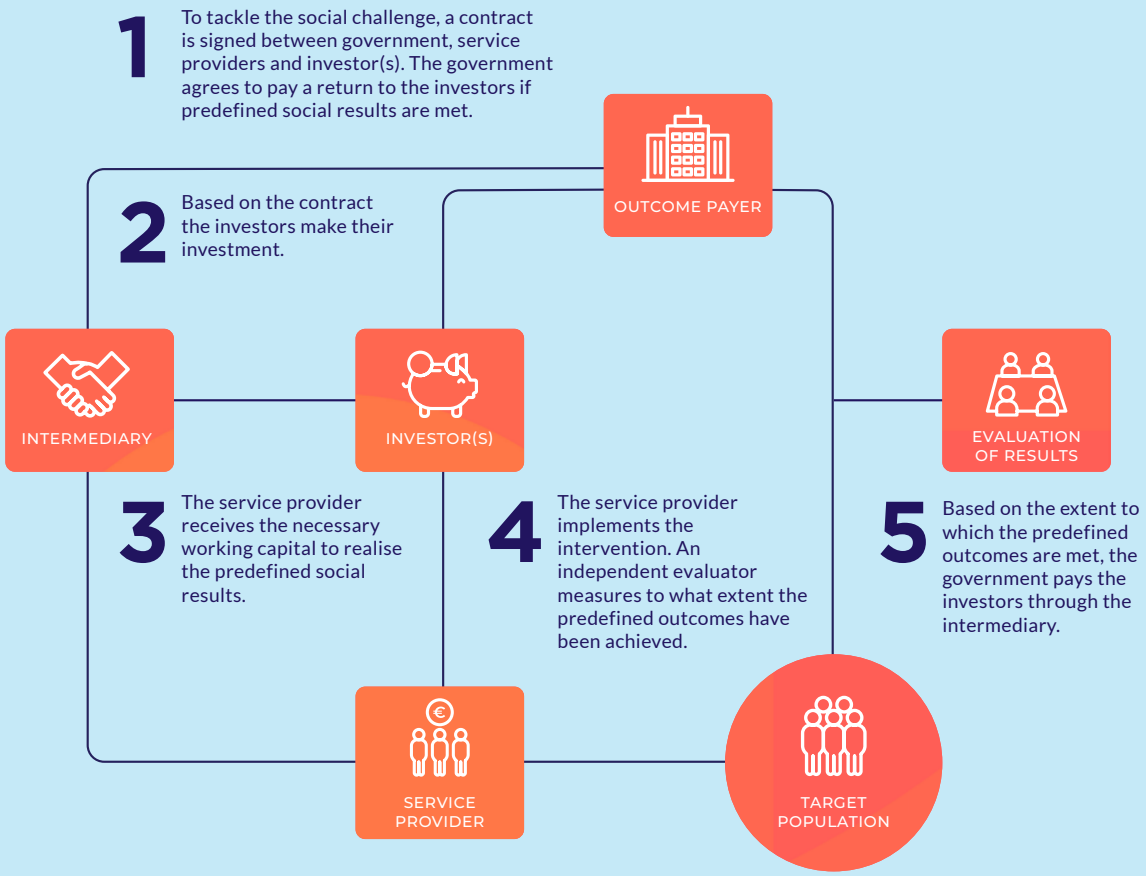
OUTCOMES-BASED FINANCING, HEALTH IMPACT BONDS AND SOCIAL IMPACT BONDS

This report discusses different forms of outcomes-based financing. We use the following terms:

OUTCOME BASED FINANCING refers to funding that is explicitly tied to the results achieved by an activity. The central focus is the change delivered for the target group, rather than the mere implementation of programmes. This approach incentivises not only efficiency but, above all, effectiveness. The party that pays for the outcome (the outcome payer, such as a government body or insurer) makes payments only after pre-agreed targets have been demonstrably met. These results are assessed by an independent evaluator. If the targets are achieved, investors are repaid, potentially with a return. If the intended effects do not materialise, investors bear part or all of the loss. In this way, financial risk is temporarily shifted to investors, creating space for preventive or innovative initiatives.

One of the best known forms of outcome based financing is the **SOCIAL IMPACT BOND** (SIB). In a SIB, private capital is used to address social challenges. Governments or other outcome payers repay investors only when the agreed social outcomes have been achieved, as verified by an independent party. As with outcome based financing more broadly, investors are repaid with possible returns if the goals are met, while they absorb losses if outcomes fall short. This structure transfers upfront risk away from the public sector and enables experimentation with preventive or innovative solutions.

A **HEALTH IMPACT BOND** (HIB) applies this principle to health goals. External investors fund preventive health measures, such as preventing illness or fall incidents. If the intervention is successful, the investor receives a payment, typically from the government or a health insurer, based on demonstrably achieved health outcomes, such as fewer falls, improved health or reduced demand for care, and the resulting savings in healthcare costs.



2. PREVENTION IS ESSENTIAL

2.1 WHAT IS THE PROBLEM?

The Dutch health care system is facing enormous challenges. Demographic developments, an unhealthy lifestyle and living environment, staff shortages, and rising health care costs are making the current model increasingly unsustainable.

Sickness absence in the health care sector is structurally high; prolonged absence in particular is increasing. In addition, one in five health care professionals is considering leaving the sector within a year.[1] According to the most recent labour-market forecasts for the health care sector, the shortage of care workers will rise to around 265,600 by 2034. That is a fourfold increase compared with 2025.[2] Health care costs will also continue to rise sharply. The RIVM expects that care spending in 2050 will exceed €200 billion[3], an increase of more than 76% compared with health care expenditure in 2024, when €113,5 billion was spent.[4]

Waiting lists are growing, and both the quality and accessibility of care are coming under increasing pressure.[5] In addition, the health gap is widening: differences in health between population groups based on factors such as education, income, occupational status, and migration background.[6]

Without far-reaching changes, the system threatens to stall. In short: something needs to change now to prevent our health care system from becoming unmanageable. Prevention should therefore not be a side issue, but a necessary pillar of a sustainable health care system. The following paragraph explores why. ▶

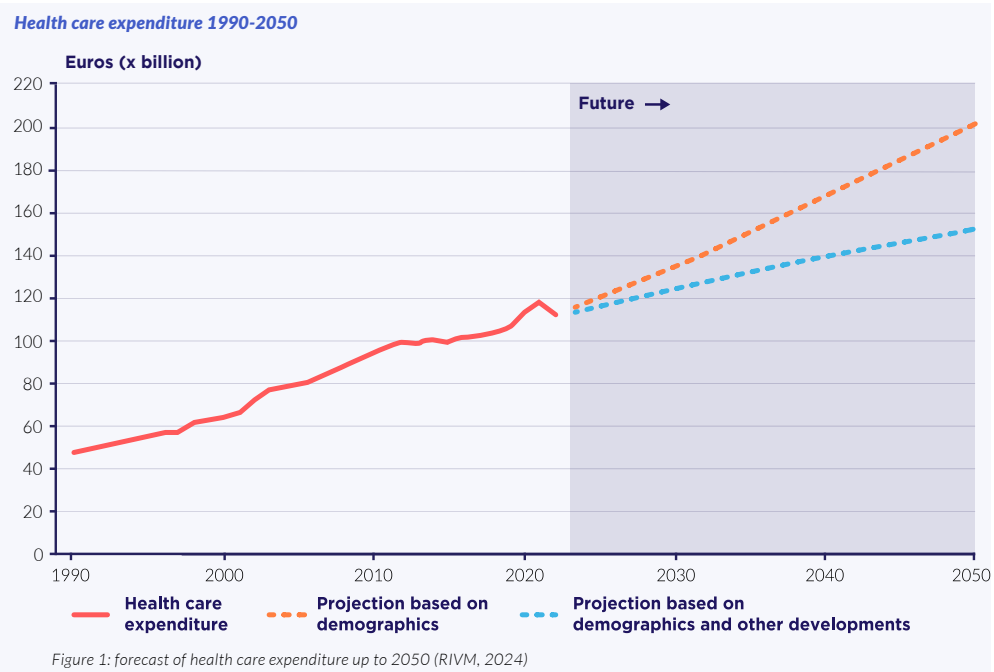


Figure 1: forecast of health care expenditure up to 2050 (RIVM, 2024)

2.2 WHY INVESTING IN PREVENTION PAYS OFF

Prevention includes all measures aimed at preventing diseases and health problems, detecting them early, or preventing them from worsening. The goal of prevention is for people to stay healthy for as long as possible, by promoting and protecting their health. Prevention comes in many forms: from individual lifestyle interventions to broad societal measures that make living environments healthier.

In this report, we define prevention as part of the health care domain, with an emphasis on interventions that help prevent, postpone, or reduce disease and the use of care. At the same time, we explicitly view prevention in relation to the social domain, because factors such as living environment, income, and youth policy are decisive for both health and the effectiveness of preventive care. Interventions outside health care that directly affect health are also considered part of prevention.

This broad approach makes it clear that prevention cannot be separated from the way care and social support are organised. It is an indispensable link in the shift from illness and care towards health and resilience. Prevention can create social value.

WHAT IS PREVENTION?

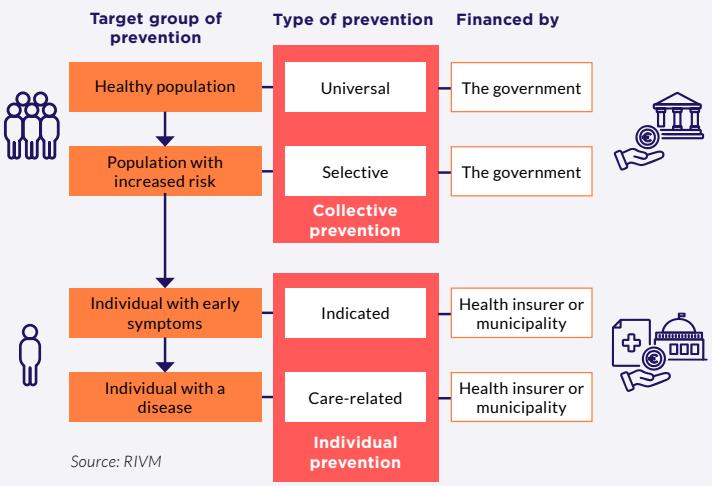
Prevention includes all measures that help prevent health problems, detect them early, or limit deterioration. The RIVM distinguishes four levels of prevention:

Universal prevention: Targets the entire population and aims to promote health and prevent disease, for example through vaccination programmes or campaigns about a healthy lifestyle.

Selective prevention: Targets risk groups who have an increased chance of health problems, such as people with overweight or a low income.

Indicated prevention: Targets individuals who show early symptoms or risk factors, to prevent these from developing into disease.

Care-related prevention (also called disease prevention): Aims to prevent complications, relapse, or further deterioration in people who already have an existing condition.



Source: RIVM

PREVENTION CAN STRUCTURALLY REDUCE DEMAND FOR CARE

By preventing disease, postponing it, or easing it, prevention can reduce demand for care, narrow health inequalities, and increase well-being. Prevention is therefore essential for easing pressure on the health care system. The causes of that pressure are broader than just ageing and staff shortages. Prevention forms a crucial part of the solution, especially for chronic diseases that are linked to lifestyle and health inequalities. An important share of the health gains that prevention can deliver leads to fewer chronic conditions, a better quality of life, and, in the long run, lower health care costs.[7]

Health is the outcome of an interplay of factors: not only medical care and lifestyle, but also social circumstances and the living environment affect health. Prevention can strengthen this interplay by supporting and maintaining health, instead of intervening only once someone becomes ill. In the Netherlands, 20% of the total disease burden attributable to lifestyle and the living environment. Together this concerns a combination of smoking, unhealthy diet, excessive alcohol consumption, and too little physical activity.[8] Precisely in these lifestyle-related risks lies the greatest potential for health gains.

PREVENTION REDUCES CHRONIC DISEASES AND LIFESTYLE-RELATED PREMATURE MORTALITY

Various studies show that lifestyle interventions can reduce the risk of diabetes by 2%, heart disease by 2%, and cancer by 2% over ten years. These diseases are among the so-called non-communicable diseases (NCDs), which together are responsible for over 80% of the disease burden in Europe. These include cardiovascular disease, diabetes, cancer, and chronic lung conditions, which are among the main causes of avoidable, premature death. Because these diseases are strongly influenced by lifestyle and the living environment, there is a large prevention potential here. It is estimated that around 60% of annual deaths in Europe are preventable through lifestyle interventions, including quitting smoking, healthier eating, and sufficient physical activity. 40% is preventable through timely and high-quality care. [9]

Effective preventive interventions that target healthy nutrition, adequate exercise, and smoking prevention can reduce the incidence of these conditions and thus lower future care demand. In doing so, it is important not to focus solely on individual responsibility for the problems, but also to look at the design of the living environment and the unhealthy choices it enables.

The broader perspective on health is increasingly finding its way into practice. An inspiring example is found in Zuid-Limburg, where *Het Beweeghuis* ('movement house') shows how health gains can be strengthened through medical interventions and lifestyle support in the same place. Het Beweeghuis offers people with (early) symptoms first an intensive exercise- and lifestyle pathway, tailored to their specific condition. Support from general practitioners is embedded in the process. The participant is discouraged from making a medical choice too quickly in favour of, for example, a new knee. In this regional collaboration between hospitals, orthopaedists, GPs, exercise coaches, sports associations, and municipalities, health has become a structural part of the entire care pathway. The results speak for themselves: after completing the pathway, participants need lower-level care less often; they return sooner to work or daily activities. For everyone invested euro, the programme yields four euros, largely because of fewer operations, lower health care costs, and fewer sickness-absence days.[10]

PREVENTION CAN DELIVER SAVINGS IN HEALTH CARE COSTS

Numerous studies in the areas of nutrition, ageing, and public-health interventions show that preventive measures reduce the number of new cases of chronic conditions and thereby lower future health care costs.[11] ▶

PREVENTION INCREASES WELL-BEING AND REDUCES INEQUALITIES

Prevention is not only about preventing illness, but also about strengthening well-being, self-reliance, and quality of life. People in lower socio-economic groups benefit most from investments in healthy living environments, basic security, and participation. Prevention is therefore also a strategy for equality.

PREVENTION DELIVERS BROAD SOCIAL BENEFITS

The benefits of prevention extend beyond health care alone. Healthier people participate more often in the labour market, experience greater well-being, and make less use of social services. The gains from prevention therefore also accrue to employers and businesses in the form of lower sickness absence, less work disability, and longer sustainable employability of workers.

Together these insights sketch a clear future vision: a society in which investing in health is as self-evident as investing in education or infrastructure. A system that does not wait until people become ill but protects health as a collective good.

Such a system is not only better prepared for tomorrow's challenges but also contributes to a healthier society. This vision is widely shared, yet in practice we see that large-scale change is not easy to realise. The following paragraphs illustrate this.

2.3 PREVENTION INVESTMENT IN PRACTICE

The importance and urgency of prevention are now widely recognised in policy. Both the Integrated Care Agreement[i] (IZA, 2022) and the Healthy and Active Living Agreement[ii] (GALA, 2023) emphasise that prevention plays a crucial role in keeping care affordable and accessible. The IZA explicitly calls for strengthening preventive health policy through collaboration between the medical and social domains. GALA builds on this and translates this ambition to the local level: municipalities, insurers, and the Ministry of Health, Welfare and Sport (VWS) have agreed to work together on a broad, integrated prevention approach, to reduce health inequalities and make healthy choices easier.

The content of GALA aligns well with the municipal vision on prevention. Yet the current financing structure hampers sustainable implementation. The GALA and IZA funds, totalling around €2,8 billion, are primarily intended as transformation resources to set a shift in motion towards a more prevention-oriented health care system. Through transformation plans, regions are mapping what is needed to make the transition to a sustainable system. In practice, however, the follow-up step has often remained underexposed. Many plans focus on implementing initiatives within the scope of these funds, and less on structurally embedding outcomes-based financing after 2026.

Because the GALA and IZA funds are temporary (2023–2026), municipalities may struggle to secure results. The Association of Dutch Municipalities (VNG) expects that only a limited share of the funds, about €195 million, will remain structurally available after 2026.[12] Municipalities indicate that this project-based financing structurally undermines prevention efforts.

The Council for Public Health & Society (RVS) states that structural embedding of prevention is necessary to ensure the transformation is sustainable after the subsidy period. This could be achieved, for example, by embedding prevention in regular financing systems or through joint governance by, for instance, municipalities and health insurers.

Investments in preventive health measures lag behind those in curative care.[13] In 2024, a total of €113,5 billion was spent on health care; only €6,165 billion of this went to prevention.[14] That means just one in twenty euros in Dutch health care in 2024 was spent on prevention.

To understand why despite broad support prevention has not yet become a self-evident part of our health care system, we need to look at the main bottlenecks that stand in the way.

i *A healthcare agreement between governments and healthcare stakeholders that focuses on transforming the healthcare chain.*

ii *An agreement between various governments and healthcare stakeholders that focuses on supporting municipalities to promote prevention and health for all residents..*

2.4 WHY PREVENTION IS NOT YET SELF-EVIDENT

Despite broad societal consensus on the importance of prevention, structural investment in preventive solutions remains difficult. There are three key bottlenecks that hinder effective, integrated, and sustainable investment in prevention: 1) a lack of investment incentives, 2) fragmentation and siloing, and 3) limited infrastructure for scaling up and embedding prevention.

LACK OF INVESTMENT INCENTIVES

A persistent bottleneck in prevention policy is the lack of effective incentives to invest in it. Preventive measures require investments now, while the benefits often only become visible years later and frequently accrue outside the financial domain. [15] Think, for example, of a municipality that invests in health promotion, while health insurers ultimately benefit from lower health care costs.

Not every social effect necessarily needs to be compensated through a financial incentive. Different layers of government and societal actors each have their own responsibility for public health. The problem, however, is that these responsibilities do not align well, making joint investments in health gains difficult to realise. This so-called wrong pocket mechanism discourages collaboration, hampers innovation, and explains part of the underinvestment in prevention, especially when budgets are under pressure.[16]

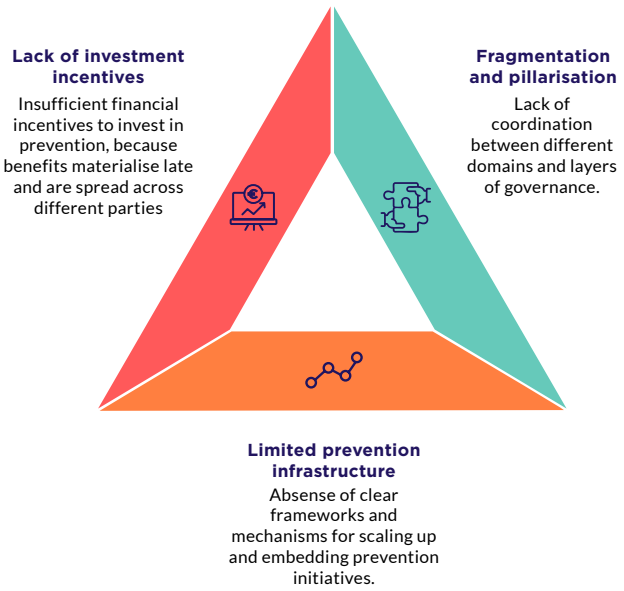
At the same time, it is important to recognise that this principle occurs more broadly in health care. In curative care, too, others may benefit from societal returns, such as employers who profit financially when an employee recovers and can return to work. The difference is that preventive care involves a different set of trade-offs than curative care. Curative interventions are accepted as long as they are medically necessary, whereas prevention requires a much more complex decision-making framework, with financial interests of multiple parties, political preferences, and various laws and budgets that must be taken into account.

FRAGMENTATION AND PILLARISATION

Prevention touches on a wide range of domains such as health care, social welfare, education, and employment, and also falls under the responsibility of multiple layers of government. As a result, there is no single clear party that holds final responsibility for the coherence and implementation of prevention policy. Each domain works with its own funding structures, data sources, and policy frameworks, which hampers integrated approaches.[17]

LIMITED PREVENTION INFRASTRUCTURE

Existing laws and regulations in health care are primarily aimed at curing and caring for people with an existing care need. Structural embedding of prevention is largely missing. Even where preventive approaches demonstrably work, a clear framework for wider implementation is often lacking. There are no consistent agreements on what exactly we measure, how we assess results, and how we subsequently finance them. Governance arrangements are also often temporary, and there is no clear way to reinvest achieved savings into prevention. Without such fixed ground rules, scaling up becomes complicated and costly. This leads to separate projects that end after a certain period, whereas a sustainable approach requires clear measurements, stable agreements, and broad support. ▶



These barriers are not impossible to overcome. Under the leadership of State Secretary Tielen, the Ministry of Health, Welfare and Sport (VWS) is currently developing an investment model for prevention. It is doing so by establishing guidelines for appropriate evidence for prevention, creating an assessment framework, streamlining financial decision making, and improving access to relevant data. [18]

At the same time, more and more initiatives from practice show that things can be done differently, with new ways of organising, measuring, and financing. In the following chapters, we present examples from the Netherlands and abroad that illustrate how financial and organisational incentives can be designed to promote health gains, how collaboration across domain boundaries can be strengthened, and how decision making and funding can be organised at a larger scale. In this way, multiple pathways emerge to structurally embed prevention in the health care system.

The cases are intended as inspiring examples of what is possible. Success depends strongly on the local context. Not all elements can be transferred one to one to the Netherlands, but they do show that alternatives are possible.

“The number of good initiatives that, on paper, show a positive business case turns out to be harder to realise in practice. In addition, it is difficult to link financing to aspects that are classified as ‘social added value,’ because the returns do not end up with the one who invests.”

– MAARTEN FISCHER, PROGRAMME MANAGER, NOABER FOUNDATION (CO-FINANCIER OF HET BEWEEGHUIS)

3

LACK OF INVESTMENT INCENTIVES:
HOW DO WE MAKE PREVENTION PROFITABLE?

FINANCING BASED ON IMPACT

Stakeholders often find investing in prevention unattractive. The costs are immediate, while the benefits come later and do not always accrue to the party that pays. At the same time, many providers experience a tension: they want to invest in health and well-being but are also steered by funding systems in which care providers are rewarded based on volume. As a result, important preventive approaches are difficult to scale up and remain temporary and vulnerable.

HOW DOES THIS BOTTLENECK WORK?

- **Benefits fall elsewhere or later.** The party investing does not see the financial gain, or only much later. Without agreements on sharing the benefits, investing remains unattractive.
- **Short time horizons and no room for upfront investment.** Year to year budgeting makes it difficult to invest now and allow later returns to flow back, or to prevent those returns from being lost.
- **We pay for activities, not for results.** Funding systems reward deliverables: health gains and societal effects are barely rewarded. Measuring preventive results is also an obstacle. The effects of prevention are often only visible over the long term and are hard to attribute to a single intervention or actor. This limited evidence makes financing based on results complex. Without reliable data on health effects and cost savings, it remains difficult to conclude outcome-based contracts.

The examples in this chapter show how innovative financing forms can reverse these incentives. Whether through a regional budget, an impact bond, or results-based payments, the underlying idea is the same: financial gains are shared and health gains are financially rewarded. This creates a different playing field in which investing in prevention becomes worthwhile for all parties involved.

GESUNDES KINZIGTAL
GERMANY

Like the Netherlands, Germany struggles with rising health care costs and a fragmented system in which financial incentives are tied to the production of care. Prevention and collaboration are barely rewarded. There is little incentive to invest jointly in health. The German example of Kinzigtal shows how a single shared regional budget and collective responsibility can shift financial incentives and reward collaboration.

LOCATION:
Kinzigtal, Southwest Germany

TARGET GROUP:
Around 70,000 residents, of whom 34,000 are insured with AOK Baden Württemberg and LKK/V-SLfG Baden Württemberg.

INITIATORS/ PARTNERS:
- Gesundes Kinzigtal GmbH (partly owned by physicians' network MQNK, 66.3%)
- OptiMedis AG (33.7%)

FINANCIERINGSVORM:
Financing model: Long term contract (minimum 10 years) based on population-based payments and shared savings. €4 million in start-up capital invested by the insurer.

WHY IT WORKS:
- Regional budget with long running contracts and a shared savings system;
- Joint accountability of providers and insurers;
- Transparent and independent data management and predefined outcome measurement.

CASE DESCRIPTION

In 2005, the *Gesundes Kinzigtal* ('Healthy Kinzigtal') model was launched in the southern German Kinzigtal region. It is a regional integrated care model in which health care providers and health insurers are jointly financially responsible for improving population health, optimising patient experience, and lowering health care costs.

Implementation and management of the regional budget lie with Gesundes Kinzigtal GmbH, a partnership between the regional physicians' network and the organisation OptiMedis AG, which has multi-year contracts with two regional insurers. The programme connects health care providers, insurers, municipalities, businesses, and schools. Together, they work on health, prevention, and participation. The approach focuses on integrated care: all involved parties work toward one goal, improving health in the region and organising care more intelligently. They do this through shared digital patient dossiers and joint management structures. All insurers, for example, have access to programmes aimed at prevention and quality improvement, such as stop smoking support, physiotherapy programmes, sports and nutrition initiatives for risk groups. Initially, the general practitioner played a central role as a trusted point of contact and supported patients in formulating their health goals. Later, Gesundes Kinzigtal introduced nurses and social workers as case managers, primarily for complex patients with multiple conditions.

"Health insurers should be rewarded for improving the health of their population, not for having a sicker population."

– DR HELMUT HILDEBRANDT
CEO OPTIMEDIS DE

A REGIONAL BUDGET THAT REWARDS COLLABORATION

At the heart of the model is a shared savings contract: the annual health care expenditures in the region are compared with a risk-adjusted, national benchmark. If costs are lower, the savings are shared between the providers and Gesundes Kinzigtal GmbH. Participating providers benefit from the network's positive results. Part of the savings is reinvested by Gesundes Kinzigtal GmbH into new preventive and innovative projects.

This incentive structure makes health economically attractive. Doing fewer treatments becomes valuable, because better health, not production, determines returns.

With the start-up capital, a regional management and data platform was built to support collaboration and quality improvement. The model has proven to be continuously scalable and sustainable. At its core is shared savings, underpinned by trust, transparency, and multi-year contracts.

RESULTS AND IMPACT[19]

- Fewer hospital admissions: 20% fewer hospital admissions compared to the control group.
- Cost reduction: €6.8 million lower spending for insurers in 2020. Over 2007 to 2020 this cumulated to €66.7 million.
- Delayed need for long term care: Participants reached the point of needing long term nursing care on average three years later than the control group.
- More autonomy and trust: Participants report greater control over their health and more trust in the GP as care coordinator. 92.1% would recommend the programme.

LESSON FOR THE NETHERLANDS

The Kinzigtal model shows that prevention pays off when insurers and providers share responsibility for health and manage one regional budget with a shared savings mechanism. When investing in health improvement leads to lower care costs, the savings are distributed among the parties involved. This creates a direct incentive to invest in better health.

INTERVIEW WITH HELMUT HILDEBRANDT – CEO Optimedis DE

What is the biggest advantage and risk of the shared-savings model?

"The core of the shared-savings model is that you invest in health promotion and prevention. If that results in lower health care costs, you receive a share of the savings. The biggest advantage is that health care providers are encouraged to invest in better health. The biggest risk is the time delay: you invest now, but only years later do you see whether there is actual financial and health gain. There is also the risk that investments may not yield returns for every patient group."

Which conditions are essential for the success of this model?

"Success requires rapid and transparent outcome measurement, simplified regulation, participation of all insurers in a region, a focus on collaboration, and a transition from 'paying for services' to 'rewarding health gains'. Patients must be actively involved, and data-driven decision-making is essential. Without these conditions, sustainable population-based payment and shared savings remain vulnerable and difficult to implement."

STEVIG STAAN
THE NETHERLANDS

Falling accidents are the largest cause of injury and rising care dependency among older adults. The direct health care costs amounted to €1.5 billion in 2024 and are expected to rise to €5 billion by 2050[20]. Although research shows that training and exercise programmes can reduce these costs, there was still no structural financing in place in 2022. Municipalities were often responsible for implementation, while insurers benefited from lower care costs. As a result, no single party had a clear financial incentive to invest.

The Health Impact Bond *Stevig Staan* ('Standing Strong') shows how temporary coordination by private investors can accelerate public investment in prevention and reduce risk.

LOCATION:
North-Limburg (7 municipalities)

TARGET GROUP:
Community dwelling older adults (70+) with increased fall risk

INITIATORS/ PARTNERS:
- Municipalities
- Health insurers (VGZ, CZ)
- VGZ-care office
- The care providers
- Investors (BNP Paribas, Rabobank, Bridges, Invesdor)
- Social Finance NL
- Vilans
- VeiligheidNL

FINANCING MODEL:
Health Impact Bond, €2.8 million pre-financed by private investors, repaid by municipalities and health insurers based on demonstrated savings.

WHY IT WORKS:
- Private investors provide upfront financing; repayment follows only after proven health gains.
- Transparent measurement and shared accountability between care providers, municipalities, and insurers.

CASE DESCRIPTION

At the end of 2022, municipalities and health insurers launched Stevig Staan, the first Dutch Health Impact Bond (HIB) aimed at fall prevention. The principle is simple but innovative: private investors finance a prevention programme in advance, in this case a fall prevention course.

Municipalities, insurers, and the care office repay the investors only when pre-defined health goals are demonstrably achieved, in this case a measurable reduction in the number of falls among older adults. By temporarily placing financial risk with the investors, space is created to organise fall prevention on a scale. At the same time, this construction requires sharper outcome measurement, more transparency, and deeper collaboration between parties that normally operate within their own financing frameworks.

The HIB therefore makes a transition possible: it is the first results-based financing arrangement through which municipalities, insurers, and care offices jointly invest in a prevention programme. This means that costs and benefits are shared across domains from the outset, creating a direct breakthrough of the wrong pocket mechanism
.

"Everyone sees the value of prevention, but no one feels automatically responsible for paying the bill. That is why you need new financing models."

– MARLEEN JANSEN, RABOBANK

RESULTS AND IMPACT[21]

The results from Stevig Staan come from the first two years of participation. A review of interim figures (2023 to 2025) shows:

- 1,825 older adults participated in the fall prevention course.
- Among participants, 617 falls were prevented, a reduction of 66.6%.
- Lifestyle changes: 61% became more physically active or did exercises more often.
- Health care savings: €1.1 million.
- Average rapport score: 8.3.

The HIB also served as a catalyst. It is a temporary instrument to structurally embed a proven intervention in the prevention landscape. The programme is now being expanded: Step In is running in 2023 and is continuing with additional funding for fall prevention. Within the Healthy and Active Living Agreement (GALA), the HIB also opened the door to structural prevention funding for municipalities and insurers. The HIB essentially bridges what was missing: it helps overcome the investment gap, demonstrates the added value of prevention, and clears a path toward regular financing.

LESSON FOR THE NETHERLANDS

Stevig Staan shows that a Health Impact Bond can remove investment barriers in prevention. By pre-financing through private investors and repaying based on results, prevention becomes scalable and cooperation between parties with separate budgets is strengthened. The HIB functions as a temporary lever toward structural funding: a tool that moves the system from one off private pre-financing to a durable public framework for prevention.

INTERVIEW MET MARLEEN JANSEN

– Sectormanager Health Care Rabobank

What does the Health Impact Bond for fall prevention show about financing prevention?
"Everyone finds prevention important, but ultimately no single party feels structurally responsible for paying for it, often because they do not benefit from the returns. In prevention of fall accidents, you see this very clearly: municipalities invest, while insurers benefit. With the HIB we have broken that pattern and parties were inspired to invest together."

What, in your view, determines the success of a HIB such as Stevig Staan?
"A HIB is complex; it certainly takes one to two years to set up. Success depends not only on the contract, but also on the people who dare to take the step and are willing to commit. You need to go through a whole dynamic process together, build mutual trust, work with data, and make societal outcomes central and therefore accountable."

What lessons does the HIB for fall prevention teach us about how parties should collaborate?
"You need to be prepared to step out of your own silo and work together. Municipalities, insurers, and investors all have different interests and tempos. The biggest gain of an HIB is that the transition is realised with insight into the data, so you can evaluate it well. More prevention brings us closer to a healthier society, even if the ideal outcome is not fully achieved."

CHILDREN'S WELFARE SOCIAL IMPACT BOND
FINLAND

In Finland, child welfare services used to respond only once situations had already escalated. This led to high costs due to intensive forms of youth protection and foster care. Preventive support was fragmented and dependent on temporary subsidies.

Municipalities wanted to invest in early escalation prevention and family support but lacked financial room and certainty. The Finnish Lapset SIB shows how results-based payments and shared responsibility can make early support structurally available.

LOCATION:
Five Finnish municipalities: Helsinki, Hämeenlinna, Kemönsaari, Lohja, Vantaa

TARGET GROUP:
Children, young people, and families at increased risk of out of home placement or psychosocial problems.

INITIATORS/PARTNERS:
- Sitra (innovation fund)
- FIM (fund manager)
- Central Union for Child Welfare
- SOS Children's Village
- Iceheart

FINANCING MODEL:
Social Impact Bond with a 12-year term. Risk is shared across five municipalities; payment is made based on realised outcomes and cost reductions.

WHY IT WORKS:
- Economies of scale through one contract for multiple municipalities, with shared responsibility.
- Independent monitoring and national coordination.

CASE DESCRIPTION

In 2019, the public innovation fund Sitra launched the Children's Welfare Social Impact Bond (Lapset SIB).

Within a national framework, municipalities could participate in a joint fund. Private investors pre-financed preventive services, municipalities repaid only when measurable results were achieved, such as fewer out of home placements, less school drop-out, or reduced need for specialised care.

Sitra brought together parties such as asset manager FIM, the Central Union for Child Welfare (LSKL), and the participating municipalities to develop a standardised legal framework. Shared responsibility is reflected in how risks, decision making, and evaluation are organised:

- Municipalities pay only when results are proven and remain responsible for local implementation.
- Private investors provide upfront financing and carry the financial risk and return.
- Sitra acts as a system player, co invests, and ensures knowledge sharing, transparency, and central coordination.
- The Finnish Institute for Health and Welfare (THL) provides independent monitoring using uniform indicators.

This setup created a shared learning and financing model. Municipalities could share risks, learn from each other through data on progress and effects, and benefit from proven preventive gains.

The Lapset SIB not only brought funding together, but also administrative continuity and shared ownership of outcomes. Sitra introduced the instrument in Finland to make public money more effective and results-oriented, not as a temporary funding fix but as a lever for systemic change. By linking payments to societal effects, a culture shift emerged from production driven to impact driven work.

"We worked under one shared umbrella and one fund; within that framework each municipality could choose its own approach."

– MIKA PYYKKÖ,
FORMER PROJECT DIRECTOR IMPACT INVESTING, SITRA

RESULTS AND IMPACT[22]

600 children and young people received intensive, tailored preventive support.

Well-being and family resilience improved, and families experienced less psychosocial distress.

€8.5 million invested, of which about €4 million has been paid out as rewards for proven effects. Municipalities finance this from realised savings.

Quantitative data (care use, well-being) is still only partly public. Qualitative feedback shows that families feel better supported and that help is deployed earlier.

LESSON FOR THE NETHERLANDS

The Lapset SIB shows that paying for results instead of activities can work, and that a national framework for results-based financing makes collaboration structural.

By combining central coordination with room for local tailoring, and by tying financing to proven effects and shared accountability between public and private parties, prevention becomes a viable joint investment rather than a cost item. This creates a direct incentive to intervene early and to invest together in durable improvements in health and well-being.

INTERVIEW WITH MIKA PYYKKÖ – Former Project Director Impact Investing, Sitra

Why did you choose a Social Impact Bond?
"We wanted to show that private capital can be used within a strong public system if public payment is tied to proven results. Municipalities then face less risk and are incentivised to invest earlier in support for families."

How did you design the SIB model to work for both national coordination and local delivery?
"At Sitra, my team laid the foundation for the SIB model. We created the core design with clear goals, a measurement approach, and a shared understanding of what the outcomes mean in euros. That allowed us to make agreements with investors and municipalities on a common basis.

After that, municipalities procured one independent SIB fund with programme management to organise implementation. It involved one central fund that multiple municipalities could join. Each municipality works with its own approach and target group that fits local circumstances. The Central Union for Child Welfare led the programme management, including selection and coordination of service providers."

How do you effectively steer on outcomes?
"We pay for concrete and verifiable outcomes. In Hämeenlinna, for example, we look at whether boys are in school or working at age eighteen. We can also pay earlier if costs decline or school performance improves.

My advice is simple: start by thoroughly understanding the problem, then set clear and measurable goals, and only afterwards choose the activities you are going to deliver."

CONCLUSION: FROM COST ITEM TO SHARED INVESTMENT IN HEALTH

This chapter shows that the structural undervaluation of prevention in health systems is partly rooted in misguided financial incentives and an unequal distribution of benefits and burdens. These mechanisms reinforce one another and make investment in prevention structurally unattractive. Despite evidence that prevention delivers health gains and cost reductions for society, it does not always pay for individual organisations to contribute. As a result, effective interventions remain fragmented and vulnerable.

The case studies show that things can be done differently.

Germany's Kinzigtal addressed the problem that benefits materialise elsewhere or only later by making care providers and health insurers jointly financially responsible for the health of the regional population. Thanks to a multi-year regional budget and a shared-savings mechanism, savings are shared and reinvested in prevention. This shifts funding away from paying for activities towards rewarding health outcomes

The Dutch Health Impact Bond *Stevig Staan* broke through, among other things, the problem that up-front investments in prevention are difficult to organise and that benefits often accrue to others. By allowing private investors to carry the risk temporarily, space was created to invest in falls prevention at scale without municipalities or insurers needing certainty about outcomes in advance. Payment followed only when results were proven – that is, fewer falls and lower care costs. In this way, a shift is achieved from paying for actions to rewarding impact.

The Finnish Lapset-SIB brings together all three bottlenecks described in this chapter. Municipalities wanted to invest in early detection and family support, but the benefits would arise elsewhere or only in the long term, and there was no room for up-front investment within municipal budgets. By having private investors cover the start-up costs and only paying once measurable results were demonstrated, the structure of financial incentives changed fundamentally. The system no longer rewards activities, but societal outcomes.

These examples show that prevention will only take root sustainably when investing in health also pays financially. That requires not only new incentives through innovative financing models, but also clear frameworks for collaboration, transparency, and the reinvestment of achieved gains.

Outcomes-based financing and preventive financing are closely related. Where outcomes-based financing rewards health outcomes after the fact, preventive financing makes those outcomes possible by creating room up front for collaboration, measurement, and investment in the foundations. The case studies show that forms of outcomes-based financing are only viable if results can also be measured reliably and unambiguously. In many prevention programmes, the evidence base is still limited or fragmented, making it difficult to attribute effects to a single intervention or party. Structural data collection, jointly agreed success indicators, and independent evaluation are therefore crucial conditions for applying this approach on a larger scale. Preventive financing is needed to strengthen the measurement base that outcomes-based financing requires and to accelerate the transition. Once health itself becomes the outcome on which payment is based, the two converge.

4 FRAGMENTATION AND PILLARISATION: HOW DO WE WORK AS ONE SYSTEM?

FINANCING COLLABORATION

In many healthcare systems, centralised remote governance, parallel funding streams, and separate service desks create fragmentation. Healthcare providers operate alongside each other with their own contracts and indicators, causing coherence and joint governance to be lost. Budgets and contracts are spread across different laws, such as the Health Insurance Act (Zvw), the Long-term Care Act (Wlz), the Social Support Act (Wmo), the Youth Act and the Public Health Act (Wpg), and are accounted for separately. As a result, it is difficult to invest in initiatives that connect domains, even though precisely those investments are needed to strengthen both health *and* trust.

Prevention requires collaboration across domains, but in practice there is a lack of shared rules, performance agreements, and a decision-making structure.

HOW DOES THIS BOTTLENECK WORK?

- **Separated responsibilities and governance.** Policy domains and administrative levels each have their own goals, legislation, and budgets. There is no central governance over health, because no single party is ultimately responsible for the whole.
- **Closed financing structures.** The Zvw, Wlz, Wmo, Youth Act and Wpg each have separate funding titles and accountability frameworks. Joint investments in health rarely fit within these structures, making it difficult to pool resources and causing collaboration to stall.
- **Lack of shared governance and joint reinvestment.** In many regions, care providers, municipalities and health insurers still work with separate budgets and decision-making processes. As a result, there is no shared financial structure to pool resources, reinvest benefits, and guide prevention at the regional level. Without shared governance, integrated plans remain dependent on temporary programmes and incidental funding.

The examples in this chapter show that it is possible to break down the silos between domains. By placing ownership and decision-making closer to residents, connecting healthcare and the social domain through joint pathways, and developing regional funds in which parties co-invest in health.

NUKA SYSTEM OF CARE
ALASKA

Originally, the federal government organised healthcare in Alaska in a bureaucratic, fragmented, top-down manner, resulting in high costs, poor health outcomes, and little connection to the local community. Residents felt unseen, prevention was nearly absent, and care aligned poorly with their needs and culture. This led to low trust and low satisfaction.

The Nuka System of Care demonstrates that local ownership, pooled resources, and long-term relationships lead to better health outcomes and greater trust in the system.

LOCATION:
Alaska, US

TARGET GROUP:
Alaska Native community

INITIATORS:
Southcentral Foundation (entirely community-owned)

FINANCING MODEL:
Structural contracts with public and private health insurers; local redistribution within a single budget.

WHY IT WORKS:
- Ownership and co-design by the local Alaska Native community.
- Integrated regional budget for health and well-being.
- Fixed multidisciplinary teams with long-term relationships with residents.

CASE DESCRIPTION

In Alaska, Southcentral Foundation (SCF), fully governed by the Alaska Native communities, chose a radical transformation. Under the Indian Self-Determination Act, the federal government awards multi-year contracts to SCF, giving residents true ownership over their care system. These contracts give SCF authority over a single locally managed, pooled budget covering both traditional and Western care. With one unified budget, fixed family-centred care teams gained the freedom to do what works locally, without navigating fragmented funds and protocols.

CARE IN THE HANDS OF THE COMMUNITY

This created the Nuka System of Care, an integrated model that prevents fragmentation: local teams jointly decide on resources and care. Traditional and Western care are funded from one shared budget. Every family has one dedicated care team using shared information and goals, eliminating unnecessary handovers and separate service desks.

Residents are no longer “patients” but *customer-owners*: active co-owners of their health. Stable relationships foster shared decision-making and cultural safety, enabling providers to respond to residents’ context, values, and preferences. Continuous feedback through community councils keeps priorities rooted in the community. Accessibility is essential, with same-day appointments whenever possible.

According to SCF, long-term, trust-based relationships are the key to behavioural change and improved health outcomes.

Nuka is funded by a mix of public and private sources, largely through fixed budgets. About half from the Indian Health Service; the rest from Medicaid, Medicare, and private insurers.

It is not a fully public system, but rather a societal model in which public and private resources converge.

RESULTS AND IMPACT[23]

- Emergency department visits down 44% in the four years after implementation (2000–2004).
- Hospital admissions down 43% and outpatient visits down 33% since 2000.
- Average annual healthcare costs per resident reduced to $3,500–$4,500, about half the U.S. average.
- 90% of employees and 98% of customer-owners report being satisfied with the Nuka system.

LESSON FOR THE NETHERLANDS

The Nuka System of Care shows that relationship-based care, local ownership, and an integrated regional budget can lead to better health outcomes and lower costs because care aligns with the community's values and needs.

Real transformation occurs when both ownership and financial resources are placed in the hands of the region itself. This requires shifting from central governance to regional budgets or health funds, in which municipalities, insurers, and residents jointly decide and invest in what works locally.

"We measure success by the strength of relationships, not by the number of clinical tasks performed"

– APRIL KYLE,
CEO OF SOUTHCENTRAL FOUNDATION

INTERVIEW WITH APRIL KYLE – CEO Southcentral Foundation

What prompted the transformation toward the Nuka model?
"We had a system that did not work for our community. It was bureaucratic, poorly organised, and people did not feel safe in it. When we were given the opportunity to take responsibility ourselves, we redesigned the system. Everything started with listening to the community. What do you need? What is missing? And from there we started building."

The Nuka model was created by and with the Alaska Native community. Is it conceivable that a healthcare system elsewhere, with a very different culture, could also adopt these principles?
"Absolutely. Although our approach is rooted in values like family, community, and reciprocity, the underlying principles are universal: relationship-based care, trust, and autonomy. Wherever we go, London, Singapore, or New Zealand, we see the same need: people want to be seen and heard as a whole person, not just as a patient. The key is not to copy the model literally, but to translate it to the local context. Start with the values of your own community; that is where sustainable change begins."

GELIJKGEZOND
THE NETHERLANDS

Many residents with health problems also face debt, stress or poor housing conditions. Because healthcare and the social domain operate separately, these interconnected issues often remain unnoticed and underfunded. *GelijkGezond* ('Equally Healthy') demonstrates how integrated support and joint outcome-based financing can break through this system barrier.

With over €5 million in transformation funds from the National Integrated Care Agreement (IZA), GelijkGezond can set up and scale this cross-domain approach, including in Tilburg and Dordrecht.

LOCATION:
Netherlands (initially launched in Amersfoort)

TARGET GROUP:
People with a minimum income or in vulnerable circumstances.

INITIATORS/PARTNERS:
- Impact investors and foundations (AHTI, Noaber Foundation, Invest-NL, Rabo Foundation, Buurtzorg Nederland, Instituut GAK, VSB Fonds, Philips Foundation, Parsifal BV, Council of Europe Development Bank – CEB)
- Municipalities
- Health insurers (VGZ, DSW and other Dutch health insurers)
- Independent evaluation by Ecorys.

FINANCING MODEL:
Outcome-based financing with upfront funding from impact investors and IZA transformation funds. Impact investors carry the initial financial risk; municipalities and health insurers only pay when results are proven.

WHY IT WORKS:
- Integrated support across domains (healthcare, social support, housing, income)
- Small teams with decision-making authority and low thresholds
- A local, person-centred approach

CASE DESCRIPTION

GelijkGezond was launched in 2023 to reduce the gap in healthy life expectancy between wealthier and poorer populations through an integrated approach linking healthcare and the social domain. People on minimum incomes often face an accumulation of challenges: poor health, debt, housing issues and chronic stress.

At the heart of the approach are the *doorbijters* (persistent support navigators), personal guides who help residents disentangle complex problems and regain control over their lives. They look across all life domains, healthcare, social support, finances and housing, and remain involved for as long as needed. Their work helps prevent crises that would otherwise lead to expensive care or emergency shelter. Examples include arranging a house move for a woman with multiple sclerosis, or securing a culturally appropriate interpreter for an Eritrean family.

JOINT INVESTMENT IN BROAD HEALTH GAINS

GelijkGezond's financing consists of a mix of private and public resources. Around €4 million in impact capital is raised in the form of loans from impact investors to enable implementation and scaling. Additionally, €5.5 million in IZA transformation funds is available: an initial portion has been released to set up operations, while the majority will be awarded in phases based on preagreed KPIs.

The funding covers the costs of the "*doorbijters*" and the required supporting infrastructure. Municipalities and health insurers ultimately only pay when lower societal costs are achieved. These outcome payments are then used to repay the investors' loans, including interest.

Results are measured using quality-of-life questionnaires, cost scenario analyses and CBS (Statistics Netherlands) data. Independent evaluator Ecorys monitors whether the agreed indicators are achieved and whether repayment is justified.

RESULTS AND IMPACT[24]

The programme is in its initial phase. In four municipalities, the goal is to support 500 residents per municipality in phase one, scaling up to 1,250 per municipality in phase two.

First participants report increased control, reduced stress and better alignment with support services.

LESSON FOR THE NETHERLANDS

The GelijkGezond case shows that health outcomes are strongly linked to social determinants such as debt, housing and income. When these factors are integrated into the approach and fragmentation between healthcare and the social domain disappears, health can significantly improve.

The initiators recommend integrating social living conditions into preventive financing. Explicitly include income, debt and housing in funding structures. Adjust the Health Insurance Act (Zvw) and the Social Support Act (Wmo) to allow shared funding streams for integrated programmes with joint outcomes. This would enable municipalities and health insurers to jointly pay for results that generate both health and social benefits.

"Ideally, we will eventually create a persistent-support arrangement that allows us to help residents who truly need it, independent of regulations, domains or laws."

– JORIS VAN EIJCK,
INITIATOR OF GELIJKGEZOND

INTERVIEW WITH STANLEYSON HATO (left) – Team Lead Life Sciences & Health InvestNL AND JORIS VAN EIJCK (right) – Initiator GelijkGezond

What enables GelijkGezond to succeed where other initiatives get stuck?
Joris van Eijck: "We keep thresholds low and the system transparent: simple agreements for municipalities, clear outcome payments for insurers, and a structure where philanthropic funds also participate so institutional parties can join more easily. Everyone contributes their part, and because all parties see that the target group truly benefits, willingness to participate grows."

Why does Invest-NL invest in these types of social innovations?
Stanleyson Hato: "Healthcare is good, but inequality is increasing: people with higher education find their way more easily, while others fall through the cracks. We want to keep care accessible and affordable. That requires not only technological innovation, but also social innovation. GelijkGezond shows how prevention and well-being can be combined. Our goal is to make these types of propositions more attractive to large-scale capital by embedding risk and measurement methods more effectively."

What role do "doorbijters" play in breaking down silos between healthcare and the social domain?
Joris van Eijck: "The "doorbijter" doesn't just look at medical issues, they examine all life domains at once: debt, housing, work and health. That improves quality of life and prevents crises that would otherwise lead to expensive care or shelter."

KAISER PERMANENTE
UNITED STATES

In many health care systems, insurers and care providers are at odds: insurers focus on cost control, while providers are often paid per procedure. This creates conflicting incentives that hinder early intervention and prevention. Kaiser Permanente removes that tension by integrating insurance, hospitals, clinics, and physician teams within one organisation, under one mission and a single set of incentives: keeping people as healthy as possible.

LOCATION:
United States (8 regions; including California, Washington State, and Colorado)

TARGET GROUP:
Approximately 12,6 million members

INITIATORS/PARTNERS:
Non-profit insurance and hospital organisation working exclusively with regional physician groups (the Permanente Medical Groups).

FINANCING MODEL:
Members pay a fixed prepaid premium; the same organisation provides the care.

WHY IT WORKS:
- Insurers and care providers operate as a single organisation and share the same goals.
- Easy access to support.
- Health care and living environment are interconnected.

"You need people who believe in the mission of the organisation: to care for people and keep them healthy."

– DR DAVID CUTLER,
HARVARD UNIVERSITY

CASE DESCRIPTION

Kaiser Permanente organises the entire care chain as one integrated whole. It originated in the 1930s as a health care system for labourers building the Colorado River Aqueduct (and later in Henry J. Kaiser's shipyards, from whom the organisation takes its name). Because construction sites were remote and fee-for-service care was unpredictable and expensive, workers paid a fixed amount per person for comprehensive health care. This gave doctors and hospitals stable financing, provided workers with certainty, and created incentives to prevent illnesses and accidents. In 1945, the integrated model was opened to the general public and has since expanded across multiple U.S. regions.

Because premium collection and care delivery sit within the same organisation, goals are aligned and early action and prevention become the norm. Care teams work with a single shared digital record, where risk groups are visible and reminders for check-ups are automated. As a result, people don't get lost between service desks, and teams can distribute tasks and follow up without delays.

A COHESIVE WORKING METHOD

Kaiser Permanente's approach is intentionally simple and replicable. For members with high blood pressure for example, care teams follow standardised treatment steps with frequent, short contact moments, making early intervention easy. For fracture prevention, high-risk individuals are proactively identified, receive timely bone density scans and appropriate treatment, and the team systematically checks whether the steps were taken. This removes fragmentation between primary care, hospitals, and aftercare.

The organisation also links clinical care to the social environment. Through a national network (Thrive Local), professionals can directly refer members to support with housing, nutrition, and transportation integrated into the medical record. In addition, a dedicated housing fund invests in affordable homes, recognising that housing stability improves health and prevents downstream care needs. In this way, organisational and financial barriers between health care and the social domain are actively removed.

RESULTS AND IMPACT[25]

- Through annual at-home tests with active outreach, colon cancer mortality dropped by approximately 50% in Northern California.
- Members have 33% lower premature mortality from heart disease and 20% lower premature mortality from cancer compared with non-members in the same regions.
- Shifting hip and knee injury recovery to at-home rehabilitation reduced hospital stays and saved an estimated $72 million since the start of the programme.
- $400 million invested through the Thriving Communities Fund, aiming to create or preserve 30,000 affordable homes by 2030.

LESSON FOR THE NETHERLANDS

Aim for a single regional care-and-insurance budget. Make this concrete with multi-year contracts in which health insurers, hospitals, primary care and the social domain jointly steer on predetermined outcomes, with mandatory reinvestment of realised savings.

INTERVIEW WITH DR DAVID CUTLER – The Otto Eckstein Professor of Applied Economics aan Harvard University

What role should health care organisations ideally play outside traditional medical care?

"For many complex patients, the biggest problem is not just their medical condition, but the difficulties they face navigating society. That's why health care organisations must also help with things like nutrition, medication management in daily life, and work even if those are not strictly medical issues. This doesn't mean they have to deliver all such services themselves: many organisations partner with others who, for example, can teach healthy cooking or offer appropriate support. The health care organisation provides medical knowledge; the partner provides healthy meals or guidance. Together you help someone manage their condition better than with medical advice alone."

What are the key prerequisites for an effective integrated care model?

"The prerequisites are closely related to what we see at Kaiser. You need financial flows that don't work against you, otherwise it feels like you're constantly swimming upstream. Technology is also essential to track patients, make preventive decisions, and intervene in time. And you need a shared mission: the organisation must be fundamentally oriented toward caring for people and keeping the population healthy."

CONCLUSION: FROM FRAGMENTED DOMAINS TO SHARED STEWARDSHIP OF HEALTH

This chapter shows that it is possible to break down the barriers between domains. In various contexts, parties succeed in sharing responsibility, decision-making and resources, enabling them to jointly steer toward better health. The examples demonstrate that fragmentation is not an inevitable fact of life and can therefore be changed.

The cases in this chapter illustrate what this can look like.

In Alaska, healthcare had long been shaped by separated responsibilities and a centrally governed system in which the community's voice was barely heard. The Nuka System of Care reversed this by placing ownership of healthcare back into the hands of residents themselves. By pooling health and social care within one integrated budget, the closed financing structures disappeared, creating space to set local priorities. Family-centred teams with long-term relationships and shared goals restored trust and coherence in the system. This also addressed the bottleneck of lacking shared governance: decision-making and responsibility were reunited within the community itself. Nuka shows that regional authority and pooled resources are key to coherent, sustainable care.

In the Netherlands, GelijkGezond illustrates that shared governance is also achievable even when statutory domains remain formally separated. By enabling municipalities, health insurers, philanthropies and impact investors to jointly fund integrated support for residents, the initiative demonstrates that health gains occur when social determinants are included as part of an integrated approach for people facing multiple challenges. Joint outcome-based financing can ultimately serve as a practical pathway for opening up closed financing structures and steering toward broader health outcomes.

In the United States, Kaiser Permanente shows what happens when insurance and healthcare delivery are brought together in a single organisation. Because premium collection and care provision fall within the same chain, the tension between cost control and production disappears, creating a single shared objective: promoting health rather than maximising volume. Care teams work with one shared record, a simple and standardised workflow, and direct links to support in the living environment. The result is predictable follow-up, fewer handovers between service desks, and room to invest where health benefits are greatest, from early treatment of high blood pressure and fracture prevention, to home recovery after surgery and investments in housing security. This case illustrates that sustainable prevention becomes achievable when responsibilities are shared across domains.

Together, these cases make clear that fragmentation is not merely a technical or governance issue, but a matter of shared direction and trust. It is possible for different domains to pursue a unified goal, provided there is a place where decision-making, resources and responsibility come together. Collectively, they show that prevention can only become sustainable when financial silos disappear and a shared (regional) budget enables health insurers, municipalities and other partners to jointly steer toward health rather than care volume. (Regional) collaboration then becomes a permanent feature of the healthcare system, rather than a temporary programme.

5

LIMITED PREVENTION INFRASTRUCTURE:

HOW DO WE EMBED PREVENTION SUSTAINABLY?

FINANCING FOR SCALING AND EMBEDDING PREVENTION

Many pilots show that prevention is effective but scaling it up is far from self-evident. In 2025, the responsible State Secretary stated that it remains difficult to link upfront investments in prevention to later savings.[26] For that reason, a prevention structure is needed with clear agreements on measuring and funding, a standardised method that enables multiple parties to co-invest, and long-term governance authority. Without a solid system with clear standards, reliable measurements, appropriate funding mechanisms and public support, prevention cannot be easily scaled or structurally embedded.

In the Netherlands, the Ministry of Health, Welfare and Sport (VWS), together with the RIVM, is developing an investment model and assessment framework for prevention. This model aims to make both the societal and financial value of preventive measures visible in advance, and to support decision-making.[27] This contributes, just like the examples in this chapter, to embedding preventive logic in the national budget.

HOW DOES THIS BOTTLENECK WORK?

- **No shared measure of outcomes.** There is a lack of indicators and measurement protocols for prevention, making it difficult to compare effects and slowing down decision-making.
- **No fixed route for co-financing and reinvestment.** Multiple parties benefit from prevention, yet there is no straightforward mechanism to pay jointly or to channel realised savings back into preventive efforts.
- **Insufficient institutional embedding of prevention funding.** Prevention often remains temporary and project-based because funding, decision-making and budgeting are not structurally embedded in the system. As a result, scaling and long-term anchoring fail to materialise.

Different countries break through these structural barriers in various ways; their examples in this chapter illustrate how this can be done. Some systems opt for a national infrastructure for measurement and continuous learning, others focus on shared co-financing, or on budgeting mechanisms that recognise prevention as an investment. Together they show that sustainable prevention requires structural funding, robust governance, and a legal framework that anchors health as a shared societal responsibility.

HET ICELANDIC PREVENTION MODEL
ICELAND

Promotion of a healthy lifestyle often remains limited to stand-alone campaigns that mainly reach groups with higher health literacy. The very people who would benefit most are left out of sight, and many initiatives disappear once the funding ends. Without a national framework, lifestyle promotion does not grow into a sustainable system.

Iceland demonstrates, through the Icelandic Prevention Model, how structural public financing and a national data cycle can make this possible. Planet Youth is an external organisation that supports this approach and helps disseminate it to other countries.

LOCATION:
Iceland

TARGET GROUP:
Young people aged 12–16

INITIATORS/PARTNERS:
- Icelandic municipalities
- University of Iceland (data & monitoring)
- Planet Youth, exporting organisation of the Icelandic Prevention Model

FINANCING MODEL:
Structural public funding via municipalities and government

WHY IT WORKS:
- Structural public financing and an annual data cycle with a strong evidence-based, collective prevention approach.
- Active involvement of parents and schools.
- Local policy freedom within national frameworks.
- Focus on alternatives to unhealthy behaviour.

"We don't tell children that they're not allowed to drink; we simply make it easier to choose something else."

– PÁLL RÍKHARÐSSON, CEO PLANET YOUTH

CASE DESCRIPTION

In Iceland, prevention is considered a public responsibility. The national prevention programme, known since the late 1990s as the Icelandic Prevention Model, is jointly financed by the national government and municipalities. The model is not a central organisation but a way of working embedded within municipal and national prevention units. It focuses on reducing substance use among young people by providing them with structural access to leisure activities such as sports and culture. Such leisure participation has been proven to be protective: young people who actively take part use significantly less alcohol and drugs. Parents make joint agreements through local platforms, for example on curfews and alcohol use, which helps establish shared social norms that make healthy behaviour the default.

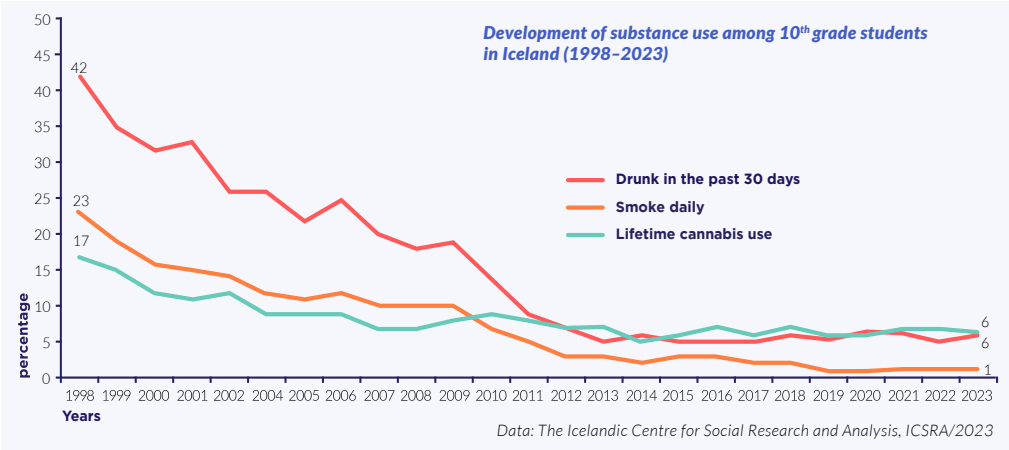
At the heart of the model lies an annual, nationally funded data cycle. Municipalities collect the same data on lifestyle and well-being, use these insights to adjust their policies, and anchor measures in their budgets. This creates a learning system in which prevention is not dependent on temporary grants or political shifts but is a stable component of local policy.

Where many programmes primarily target individual behaviour change, the Icelandic Prevention Model aims to create healthy environments in which young people naturally make different choices thanks to its structural, collective and data-driven approach.

The model has now been implemented in more than 400 communities across 16 countries, supported and disseminated internationally by the organisation Planet Youth. In the Netherlands, the programme is known as "Growing Up in a Nurturing Environment", launched with six municipalities and now expanded to ten, including Ede, Goeree-Overflakkee, Maastricht and Nijkerk.

RESULTS AND IMPACT[28]

The results among 15-16 year olds are impressive.



Data: The Icelandic Centre for Social Research and Analysis, ICSRA/2023

Behaviour change among 15-/16-year-olds:

Only 9,3% were drunk at least once in the past year; well below the European average (27,4%) and the Dutch figure (32,5%)..

LESSON FOR THE NETHERLANDS

The Icelandic Prevention Model demonstrates that sustainable prevention is achievable when financing, measurement and implementation are structurally connected. By using public funds to support a permanent data cycle and local ownership, dependence on temporary subsidies disappears and continuous learning becomes part of the system itself.

The Netherlands needs structural, long-term financing for regional measurement and learning infrastructures. These are essential for scaling up and embedding prevention. A Health Act could provide a sustainable framework for this: with statutory health goals, multi-year prevention budgets and shared responsibility between the national government and municipalities. By defining health as a collective societal task, a Health Act can also help break down the siloed divide between the health care system and the social domain. In this way, health becomes not just a policy intention but a structural mandate for the entire system.

INTERVIEW WITH PÁLL RÍKHARÐSSON – CEO Planet Youth

In the Netherlands, prevention is often seen as patronizing or moralistic. How do you ensure that prevention is widely embraced in other countries?

"In many countries, people think of prevention as intrusive. People feel their autonomy is being challenged when you talk about lifestyle. What we try to do is flip that perspective. In the Icelandic model, we don't tell people what they shouldn't do. Instead, we invest in structures that make it easier to choose healthy options. That's the whole idea: we build alternatives, we create choices. We don't tell you what you can't do, we make it easier to choose something else."

What does that look like in practice?

"Instead of talking about the negative effects of alcohol or drugs, we prefer to talk about participation in sports, music, theatre, parent-child time, and school safety. Planet Youth works with municipalities to make leisure activities accessible, engage parents, and motivate young people through a positive environment. If children spend more time in safe, meaningful environments, risky behaviour naturally declines. Not because you forbid drinking, but because there are simply better alternatives."

Is the Planet Youth approach scalable beyond small communities like in Iceland?

"Absolutely. We have worked with national governments, such as in Chile, where 18 million people live. There, the model was rolled out at the municipal level, with the school as the core. It can be financed top-down, but the emphasis is on local implementation. Scale is not a problem as long as ownership remains local."

LIFE CHANCES FUND
UNITED KINGDOM

Health Impact Bonds (HIBs) are often short-term and project-based. Each agreement requires customised contracts, indicators, and financing, leading to high transaction costs, strong dependency on local budget cycles, and limited scalability. Without a fixed route for co-financing and reinvestment, outcome-based prevention remains dependent on isolated pilots, with little impact on long-term policy. The UK's Life Chances Fund (LCF) provides a national infrastructure that breaks through this impasse.

LOCATION:
United Kingdom

TARGET GROUP:
People with complex challenges such as long-term unemployment, homelessness, debt, youth care issues, and addiction.

INITIATORS/PARTNERS:
UK national government in collaboration with local authorities.

FINANCING MODEL:
Outcome-based contracts with supplementary public payments.
Total fund size: approx. £70 million

WHY IT WORKS:
- National co-financing reduces financial risk for local governments
- Standardised contracts and independent measurement
- Learning and replication supported by a central knowledge infrastructure

CASE DESCRIPTION

The LCF was established in 2016 by the Department for Digital, Culture, Media & Sport (DCMS) to help local authorities set up outcome-based contracts in areas such as health, employment, housing, and education. Municipalities submit a project and, once pre-defined outcomes are achieved, receive a top-up payment: an additional national government contribution on top of their local budget.

Municipalities typically remain the main payers, with the LCF covering around 20% of outcome payments on average. This co-financing lowers financial risk and reduces the threshold for participation. As a result, there is room for innovative, higher-risk preventive interventions targeting persistent issues such as long-term unemployment, homelessness, debt, and addiction. Projects run over multiple years and can be adapted as circumstances change.

A FIXED ROUTE FOR CO-FINANCING AND SCALE-UP

The LCF provides a standardised approach with template contracts, fixed indicators, independent measurement, and practical support with procurement, data collection, and outcome-based payments. This reduces administrative burden, facilitates scale-up, and ensures consistent accountability. Instead of one-off pilots, the LCF creates a repeatable, scalable infrastructure for outcome-oriented (preventive) projects.

The LCF differs from earlier, short-term impact bonds by creating an overarching budget and infrastructure. This allows multiple outcome contracts to be financed and monitored simultaneously. Through the combination of top-up co-financing and standardisation, a scaling mechanism emerged: local governments use the same templates, indicators, and reporting formats, making knowledge and methodologies transferable.

"Local teams can try out preventive measures that they would otherwise not be able to fund or organise."

– DR. ELEANOR CARTER,
GOVERNMENT OUTCOMES LAB

RESULTS AND IMPACT[29]

29 outcome-based projects supported, including 10 in the category of health and prevention.

More than 60,000 participants facing multiple challenges reached.

5 projects helped people with mental health vulnerabilities into regular employment: – 68% received support – 55% found a job of at least 16 hours per week.

More than 50% of municipalities want long-term contracts and pre-defined outcome indicators to remain in place, indicating lasting adoption of outcome-based working.

In July 2025, the UK Chancellor announced a successor to the LCF: the £500 million Better Futures Fund.

LESSON FOR THE NETHERLANDS

The Life Chances Fund shows that structural preventive financing becomes possible when the national government acts as co-financier and system steward. This creates space to launch innovative and higher-risk interventions. A national outcome fund, in which the government co-finances projects once outcomes are proven, enables risk-sharing, knowledge pooling across national and local levels, and scaling up of successful initiatives.

For the Netherlands, this could mean that the Ministry of Health, Welfare and Sport (VWS), together with municipalities and health insurers, develops a national Prevention Fund that: co-finances projects when outcomes are achieved, provides standard indicators and contracts, organises independent measurement, secures multi-year resources in the national budget This would create a national infrastructure in which successful interventions do not need to be reinvented each time but can be easily applied in other regions using shared frameworks and indicators. A Health Act could provide the legal foundation by embedding goals, indicators, and multi-year prevention budgets, and connecting local implementation with national accountability.

INTERVIEW WITH ELEANOR CARTER – Academic Co-Director, Government Outcomes Lab

Why did local authorities participate in the Life Chances Fund?
"Because the additional contribution to outcomes payments filled exactly the gap in tight local budgets. Without that contribution, many municipalities could not afford to experiment with outcomes-based contracts. With the LCF, they could; and it also allowed teams to start small with a preventive service to see whether it actually worked in practice; something that would never have taken off without that financial support."

How does an outcomes fund support local project delivery?
"Among other things, by equipping project teams to work with data and make evidence-based decisions. It also helps through shared learning; teams openly exchange what does and does not work and solve bottlenecks together. In addition, you can be connected nationally with teams that have tackled similar challenges before, allowing you to adjust course more quickly and confidently during implementation."

EARLY INTERVENTION INVESTMENT FRAMEWORK
AUSTRALIA

Preventive initiatives often generate significant social value but rarely fit the logic of public finance. Departments operate within their own budgets and do not account for savings that occur in other departments. As a result, prevention is difficult to finance structurally.

In the Australian state of Victoria, government expenditure was rising faster than revenue. Prevention initiatives failed to take off because they could not be embedded in the budget. The Early Intervention Investment Framework (EIIF) shows how prevention can secure a permanent place in public budgeting.

LOCATION:
Victoria, Australia

TARGET GROUP:
Among others, people experiencing (or at risk of) homelessness, youth care involvement, school dropout, youth justice involvement, acute mental health issues or chronic health problems.

INITIATOR:
Government of Victoria – Department of Treasury and Finance

FINANCING MODEL:
Structural redistribution of prevention savings between departments.

WHY IT WORKS:
- Prevention is embedded in the budgeting process with clear outcome indicators.
- Structural linkage of expenditures to societal benefits.
- Reinvestment by departments in proven interventions.

CASE DESCRIPTION

Like many governments, Victoria traditionally worked with separate departmental budgets. Preventive measures often produced savings in domains other than where the initial investments occurred. This made cross-departmental collaboration financially unattractive. The EIIF breaks this pattern by allowing savings generated through prevention to (partly) flow back to the department that made the investment.

FROM ISOLATED SPENDING TO AN INVESTMENT SYSTEM

The EIIF was developed by the Department of Treasury and Finance to systematically integrate preventive spending into the national budget. Each ministry can submit proposals for interventions that prevent future costs. For every proposal, outcome indicators and estimates of avoidable costs are established. The Department of Treasury and Finance assesses these based on whether the social return is sufficiently large, even when not all benefits are financial. Non-financial benefits are also considered, as long as the expected effect on health and well-being is convincing. The ministry safeguards the methodology, monitoring and annual reporting.

Once results become visible, they inform future budget decisions and reinvestments. Successful programmes are thus continued and scaled up. The result is a budgeting mechanism that no longer treats prevention as a temporary expense, but as a structural investment with shared benefits. Proven interventions follow a clear pathway toward structural financing. The EIIF makes future savings visible and shareable across policy domains, allowing benefits to flow back to the department that invests.

"For prevention programmes that have been proven effective, the Framework provides a pathway for scaling: with stronger evidence, programmes can be continued or expanded with additional financing."

– MATT DONOGHUE,
DIRECTOR EARLY INTERVENTION AND REFORM VICTORIA

RESULTS AND IMPACT[30]

In 2024 – 2025 Victoria funded 29 initiatives worth AU$1.1 billion via the EIIF – all of which are structurally supported.

Over the next 10 years, an estimated AU$655–770 million in avoided costs due to reduced demand for government services.

For the first time, departments are designing budgets and policies across domains rather than in silos.

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LESSON FOR THE NETHERLANDS

Sustainable anchoring of prevention starts with the budget. By treating preventive expenditures as investments and allowing part of the resulting benefits to flow back, a structural incentive is created to act early and promote health. Such a system makes it possible to finance proven interventions on a multi-year basis and ensures that prevention does not remain dependent on isolated policy programmes.

The Netherlands could explore how to explicitly include prevention as an investment category in the national budget, with fixed calculation rules for avoided costs, agreements on the redistribution of benefits, and a central assessment of results.

INTERVIEW WITH MATT DONOGHUE – Director Early Intervention and Reform in Victoria

What was the main reason for establishing the Early Intervention Investment Framework?
"The Department of Treasury and Finance saw three issues that needed to be addressed simultaneously: spending on acute care was growing faster than revenues; providers had proven programmes with no pathway to scale; and earlier experiences with impact bonds had taught us that fiscal effects must never outweigh primary outcomes for people. The Early Intervention Investment Framework offered an opportunity to connect these three challenges."

What barriers did you encounter in other departments, and how were they addressed?
"The biggest obstacles were changes in working practices and the need to build capacity: open reporting, new forms of collaboration and learning new methods all required time. There will always be tensions between the Department of Treasury and Finance and policy departments regarding savings and scarce resources. We addressed this by collaborating early and opening up the 'black box' of the budget: working from the same information, providing temporary support for modelling and capacity building, and publishing annual outcomes reports. These reports are first reviewed in draft form by all departments. The final version is shared with all stakeholders after government approval as a key feedback mechanism. Growth in transparency and consistency was crucial for building trust and achieving accurate estimates."

What has concretely changed in investment behaviour and scaling?
"For proposals that work, there is now a clear pathway to scale; funding primarily increases for programmes with strong evidence. Regular reporting provides better insight into what works — and what does not."

CONCLUSION: FROM TEMPORARY PROJECTS TO A SUSTAINABLE PREVENTION SYSTEM

This chapter shows that successful prevention often falters in the transition from pilot to practice. As long as financing remains project-based and budgets are not designed for joint investments, the infrastructure needed to embed proven interventions sustainably is missing. Prevention requires not only good ideas or effective programmes, but a system that enables learning, measurement and financing on a structural basis.

In Iceland, the problem of inconsistent measurement and lack of continuous learning was solved by introducing a national data cycle. Young people complete the same annual questionnaire on lifestyle and well-being, making trends and effects visible at the local level. This also addressed the barrier of insufficient structural financing: the national government and municipalities each contribute to a dedicated prevention budget, ensuring that activities do not disappear once a subsidy period ends. By linking prevention to education, youth policy and local planning, Iceland also tackles the lack of institutional anchoring. Planet Youth demonstrates that prevention can be a system, not a project: structural, data-driven and collective.

In the United Kingdom, prevention had long been hindered by fragmented local initiatives and a lack of pathways for co-financing. The Life Chances Fund addressed this by creating a single national fund through which the government co-finances local projects once they demonstrate societal results. This reduced the financial risk for municipalities and created a clear route for scaling successful interventions. By providing standardised contracts, fixed indicators and independent measurement, it also tackled the absence of shared standards. Moreover, prevention gained a place in the central budget for the first time: the government incorporated co-financing into its multi-year budget cycle. This laid the foundation for an institutional infrastructure in which outcomes-based financing could grow sustainably.

In the Australian state of Victoria, the lack of institutional anchoring for prevention was addressed directly within the budgeting system itself. The Early Intervention Investment Framework makes it possible to register preventive investments as structural expenditures that generate future savings. This creates a clear pathway for reinvestment: departments may reinvest (part of) the benefits they achieve back into prevention. At the same time, the framework addresses the lack of transparent measurement by requiring each proposal to be assessed in advance on societal return and equipped with fixed indicators. By explicitly embedding prevention in the budget, it becomes a fully fledged investment category rather than a temporary policy measure.

The international examples make clear that structural prevention requires more than incidental funding or good intentions. There are different routes, but all aim to organise stability and shared responsibility. For the Netherlands, it seems worthwhile to explore whether a legal framework could support this: a Health Act that provides direction and continuity.

HEALTH ACT

A **HEALTH ACT** is a statutory compass that places health at the centre of policy and maintains direction across government terms. Such an act aligns with international developments in which health is increasingly being embedded in legislation.

For example, Norway's *Public Health Act* (2012) requires municipalities to take health into account across all policy domains—from housing to mobility.[31] Municipalities must periodically (every four years) report on the local health status and their preventive measures and use these as the basis for policy development.

Finland applies the *Health in All Policies* principle as a mandatory, government-wide approach: all ministries and relevant actors must consider health impacts when developing and implementing policy, following a whole-of-government approach.[32]

In Wales, the *Well-being of Future Generations Act* (2015) obliges public bodies, including municipalities and the National Health Service Wales, to act in the interest of current and future generations, with explicit attention to health and well-being. The law requires long-term goal-setting, the creation of well-being plans, annual reporting and collaboration across public institutions. An independent *Future Generations Commissioner* has a statutory mandate to oversee compliance and to issue binding advice and interventions.[33]

A Dutch Health Act would be an adaptation to the national context. Although Article 22 of the Constitution states that the government must take measures to promote public health, it does not specify concrete objectives or contain binding provisions. The Netherlands has existing frameworks, but they are fragmented, lack shared long-term goals and have no enforceable power, resulting in suboptimal alignment of policy and resources.

A Health Act would establish long-term health goals, anchor them legally and link them to a fixed policy cycle: a multi-year plan, annual progress reporting and an independent yearly assessment of whether the country is on track. It could also regulate financing through multi-year prevention budgets, a fixed route for shared contributions and the possibility to reinvest savings where they yield the greatest benefit. For major decisions in housing, education, mobility and work, considering health impacts would become mandatory, ensuring policies are better aligned and mutually reinforcing. In this way, the stable, transparent and learning prevention infrastructure identified in this chapter becomes possible, one that enables proven interventions to be scaled and sustainably embedded.

6 TOWARDS A SUSTAINABLE PREVENTION SYSTEM

The preceding chapters demonstrate that structural innovation in prevention is possible. There are numerous successful examples of sustainable financing, cross-domain collaboration and administrative embedding.

Yet the structural shift in the Netherlands has not materialised. It is not a lack of knowledge or motivation, but the design of the financing system that explains why change remains out of reach. Financing still largely rewards the production of care, responsibilities are often fragmented, and successful initiatives may disappear once temporary funding ends.

Three patterns sustain this situation: the absence of effective investment incentives, fragmented responsibilities, and the lack of structural anchoring of financing. As long as these rules of the game do not change, prevention will remain dependent on isolated projects, good intentions and temporary initiatives.

The task is not to create more initiatives, but to change how we work and finance. This can be done within the existing health system, but it requires adjustments in behaviour and financing mechanisms. Prevention must be viewed as a structural public mandate, with clear goals, stable resources and shared responsibility.

The three recommendations in this chapter are closely interconnected and intervene from different angles in the same systemic problems. Each of them addresses part of the solution to the absence of investment incentives, the fragmentation across domains and the lack of structural anchoring of prevention. Regional funds break through incentive and fragmentation barriers at the local level; a national prevention outcomes fund strengthens incentives, collaboration and scaling; and adapted financing mechanisms ensure that initiatives can be structurally embedded.

Together, they do not form isolated measures but a coherent framework that shifts the financial logic of our health system from volume to health.

1 ESTABLISH REGIONAL HEALTH FUNDS

Regions are where health, housing, work and education come together. It is worthwhile to explore how resources from the health and social domains can be pooled into a single regional budget, with agreements on reinvesting achieved savings. Regional funds break through the barriers of fragmented domains, responsibilities and siloed financing structures. Municipalities, health insurers and providers pool resources from the Health Insurance Act (Zvw), Long-term Care Act (Wlz), Social Support Act (Wmo), Youth Act and Public Health Act (Wpg). The region reinvests realised savings into new preventive programmes. By bundling financial and administrative responsibility, parties can jointly decide, reinvest and maintain strategic direction.

WHAT IS NEEDED?

- **Agreement and collaboration between municipalities, health insurers, public health services (GGDs) and care providers to pool resources.**
- **A governance and accountability model that legitimises joint steering and reinvestment of savings.**
- **Legal exploration of how funds from different laws can be combined within a single regional entity or partnership.**
- **A data infrastructure and monitoring system that provides regional insight into health outcomes, care use and costs.**

Photo: Evelien Hogers

2 DEVELOP A NATIONAL PREVENTION OUTCOMES FUND

Many promising preventive initiatives fail when it comes to scaling. They demonstrate local impact but lack a pathway to structural financing.

A national prevention outcomes fund can bridge this gap. It is worth exploring how the national government could provide co-financing once initiatives demonstrate measurable health outcomes or societal benefits.

Such a fund can serve as a catalyst for collaboration between municipalities, health insurers and investors. By sharing risks and rewarding outcomes instead of activities, investing in prevention becomes more attractive.

National agreements on standards for measurement, monitoring and repayment make it possible to scale local successes sustainably.

A National Prevention Outcomes Fund addresses the lack of investment incentives and fragmentation, and contributes to structurally embedding prevention in the national financing architecture.

Ultimately, prevention financing and outcomes-based financing will converge. A fund that pays for proven results turns prevention from a temporary expense into a structural investment in health. In this way, the financial system itself becomes a driver of better health outcomes.

WHAT IS NEEDED?

Collaboration between the Ministries of Health, Welfare and Sport; Social Affairs and Employment; and Finance to design a co-financing system that rewards outcomes (e.g., avoided health care costs or increased healthy life years).

Clear agreements on definitions, indicators and measurement methods for prevention outcomes (standardisation). VWS is already taking steps here with the National Institute for Public Health and the Environment (RIVM) to develop an investment model and assessment framework for prevention.

Independent validation of results and societal benefits.

Legal design: potentially a public-private implementing body or an agency within VWS.

Guarantees for transparency and continuity of funding (a multi-year fund with results-based allocations).

3 ADAPT FINANCING MECHANISMS AND BUDGETARY SYSTEMS

Without structural adjustments to budgeting logic, prevention remains vulnerable.
It is worthwhile to explore how preventive expenditures can be recognised as investments rather than costs. Ministries, municipalities and implementing agencies must have the ability to reinvest achieved benefits into new preventive activities. By designating prevention as a multi-year investment category, financial continuity and planning capacity increase.
Additionally, a Health Act could legally anchor national health goals, multi-year prevention budgets and joint monitoring, thereby strengthening continuity in prevention policy and stimulating cross-domain collaboration.
Adapting the funding system aligns public incentives more closely with societal value and ensures that prevention is structurally embedded in policy and budgeting.

WHAT IS NEEDED?

- **A macro-level revision of the national budget and the Ministry of Finance's budget rules to recognise prevention as an investment.**
- **Legal anchoring of health in policy (through, for example, a Health Act).**
- **Allowing subnational governments (municipalities, provinces) to reinvest benefits from, for example, reduced care use.**
- **An interministerial coordination mechanism so that domains do not operate from separate silos.**

The three recommendations address the same underlying systemic problems but at different scales. Regional funds strengthen collaboration and incentive structures locally; a national prevention outcomes fund creates a bridge for national scaling; adapted financing mechanisms provide structural anchoring in policy and budgeting. Together, they form an integrated response to the three core bottlenecks in prevention financing.

By placing health outcomes at the centre, we change not only how we finance, but also what we achieve. When resources are structurally tied to demonstrable health outcomes, a direct incentive emerges to act earlier, collaborate better and invest in what truly works. This delivers measurable benefits: lower care utilisation, more healthy life years and greater societal participation. In this way, the impact of prevention becomes visible, and health itself becomes the structural return of our health system.

The pioneers in this report show that it is possible and already happening. From local partnerships to national funds, they demonstrate that sustainable prevention becomes achievable once the rules of the game evolve.

At present, many actors contribute to these initiatives despite existing financing mechanisms. The recommendations above help move towards a system where actors contribute to prevention because of those mechanisms. Only then can we improve and finance our health care system at scale. When we reward prevention and investment in health, many more initiatives will emerge and can be scaled. We hope this report, by highlighting pioneers and drawing lessons for the Netherlands, helps make far more financing of effective prevention possible in the future.

Let's get to work!

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Ruben is the co-founder of Social Finance NL. In 2013, together with the Municipality of Rotterdam, he brought the first Social Impact Bond to the Netherlands. In 2023 he initiated the Health Impact Bond Stevig Staan in North Limburg, a prevention programme for seniors aimed at reducing fall incidents and health care costs. He is also working on a project for the European Commission on sustainable and scalable financing mechanisms for preventive health care. He studied at the University of Amsterdam, where he obtained both his bachelor's and master's degree in Economics (cum laude).

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THE ROLE OF SOCIAL FINANCE NL IN INNOVATIVE FINANCING FOR PREVENTION

Social Finance NL plays a leading role in developing innovative financing models for prevention and social impact. It brings public and private stakeholders together to enable large scale initiatives, such as the Health Impact Bond *Stevig Staan*. In doing so, Social Finance NL acts as a connector between policy, practice, and finance. Where traditional systems often focus on service volume and compliance, Social Finance NL emphasises outcomes, social value, and continuous learning.

Social Finance NL is a social enterprise that captures lessons from each programme and shares them with the wider field. It does so through the *Money Matters* podcast, *Impact Talk*, and an annual thematic report.

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