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June 2026

FROM PROMISE TO PRACTICE

Addressing the systemic challenges of underinvestment in prevention

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OHE | Change Initiative

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Key messages

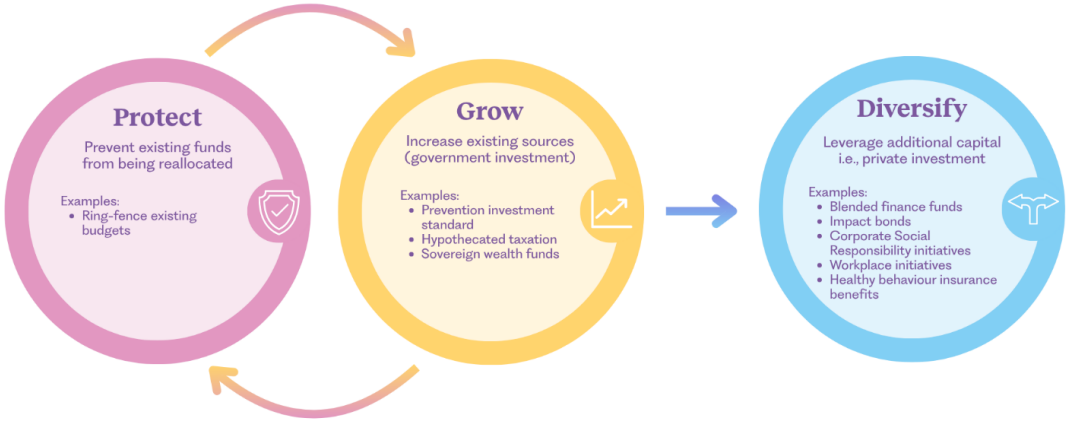
- Systemic barriers drive persistent underinvestment in prevention, including prioritisation of treatment over prevention, political and budgetary short-termism, misaligned incentives, and challenges of invisibility and attribution.
- Protecting, growing and diversifying funding sources can address key challenges; more innovative approaches can overcome multiple barriers simultaneously, although bring higher complexity and capacity requirements.
- Funding mechanisms must be combined and tailored to local and clinical contexts, underpinned by a long-term shift to a core approach to funding prevention.
- Addressing the systemic barriers to underinvestment in prevention is necessary to support in implementing effective funding mechanisms.

Executive summary

Prevention of ill-health is an underexploited tool for protecting health systems and societies. It offers the potential to curb increasing demand for healthcare services, increase participation in education and the workforce, and reduce inequality. However, despite extensive evidence of the potential benefits, spending on prevention is routinely deprioritised.

Underinvestment in prevention is driven by a fundamental misalignment between the characteristics of prevention and the way health systems are governed and financed. Prevention delivers benefits over long time horizons, often outside political and budgetary cycles; benefits tend to accrue across multiple sectors, while funding decisions are made within siloed budgets, and based on narrowly-scoped investment frameworks; and success is defined by the absence of illness which makes outcomes difficult to measure, attribute and communicate compared to that of acute care. Under fiscal pressures, decision makers are therefore incentivised to prioritise visible, short-term treatment over long-term prevention, reinforcing a cycle of reactive spending on the treatment of disease which could have been mitigated with earlier intervention.

We set out a framework via which potential funding mechanisms for prevention can be grouped into three categories: Protect, Grow and Diversify. Protect includes funding mechanisms that prevent crowding out during budgetary pressures, when prevention competes directly with acute care priorities. Grow includes funding mechanisms that generate additional government funds that can be directed to preventative healthcare. Diversify includes funding mechanisms that mobilise new funding streams beyond government sources such as philanthropic or private capital.



Analysis of each funding model confirms that the different models have the potential to overcome the challenges to funding prevention to varying extents. Approaches that protect prevention budgets can mitigate further erosion of prevention funding but cannot close the existing funding gap, while approaches that grow public investment can increase resources but remain vulnerable to reallocation without protection during periods of fiscal stress. Some approaches that diversify funding, such as blended finance funds (BFFs) and social impact bonds (SIBs), have the potential to overcome multiple barriers to funding prevention, by aligning incentives across sectors and tying funding to clear goals and outcomes respectively. However, such models are not universally applicable due to their complexity and cannot substitute broader structural reform. Our 'checklists for success' set out the conditions under which BFFs and SIBs can effectively mobilise private capital while delivering meaningful social impact.

A sustainable approach to prevention financing requires selecting a combination of mechanisms that are most appropriate for local contexts. Selecting appropriate funding mechanisms will entail considering the barriers overcome by each funding mechanism, as well as the practical implementation benefits and challenges of each approach. This should include considering the factors that will drive successful implementation. For example, for BFFs and SIBs we have determined this will entail considering factors related to the characteristics of the preventative intervention(s) being funded, the governance and data systems needed, the expertise needed to support a successful funding mechanism, and the funding mechanism's agreement structure.

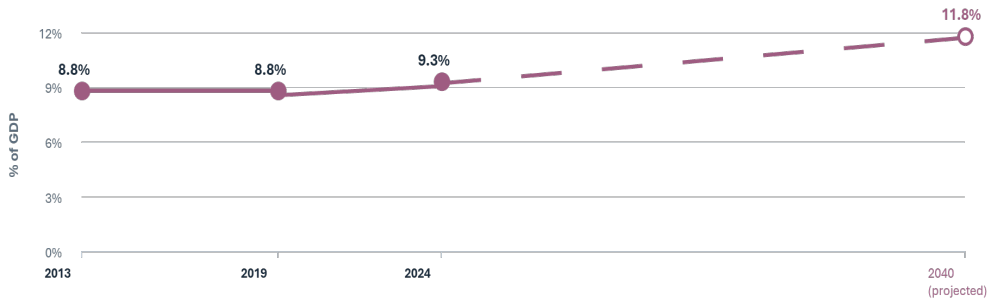
A key limitation to current approaches to funding prevention is that the funding mechanisms are typically utilised for individual or (small) groups of preventive interventions. They have not been used to date to support more general shifts towards systematic, multifaceted, comprehensive approaches to prevention. A core approach to funding prevention in each clinical or geographic context is still required. To achieve this, further work to address underlying structural barriers to sustained and comprehensive investment in prevention, such as the misalignment of incentives, is needed.

1 Introduction

Globally, the number of years spent in ill health is growing. The gap between life expectancy and healthy life expectancy globally grew from 8.7 years in 2000 to 9.5 years in 2021 (WHO, 2024a; b). Non-communicable diseases, such as cardiovascular disease, diabetes, musculoskeletal disorders and mental health conditions, account for nearly two thirds of the leading causes of disability worldwide (Hay et al., 2025), and multimorbidity is increasingly common in younger ages, driven by rising prevalence of risk factors including smoking, high blood pressure and obesity (Hay et al., 2025; IHME, 2025a; Chowdhury et al., 2023). At the same time, infectious diseases still present a significant challenge, with global vaccine coverage rates plateauing, and in some cases declining, which has led to the re-emergence of outbreaks in countries where diseases had previously been eliminated (WHO, 2020a).

Beyond the impact on patients, these factors are driving high and increasing health expenditure. Organisation for Economic Co-operation and Development (OECD) governments already spend more on healthcare than any other function except social protection (pensions and sickness, disability and unemployment benefits) (OECD, 2025a). In 2024, total health spending in 33 OECD member countries reached US$10.5trillion, equivalent to 9.3% of gross domestic product (GDP), a number which is expected to continue to rise (Figure 1) (OECD, 2025b; c).

Figure 1 Healthcare spending trajectory



Source: OECD, 2025b

Post-pandemic debt and rising healthcare costs exacerbate the financial challenge, and in low- and middle-income countries (LMICs), cuts in development assistance add additional strain to already stretched resources (IHME, 2025b; OECD, 2025a). Current health spending trajectories are unsustainable, with long term projections of health and age-related spending growing faster than both GDP and public revenues, putting increasing pressure on governments to raise additional financing, reallocate spending from other functions or find efficiency gains within the system (OBR, 2024; OECD, 2024).

Prevention is uniquely positioned to address the problem at its source by reducing both the incidence and progression of disease. Beyond easing pressure on health systems, healthier populations stay in work longer, are more productive and rely less on welfare services, generating material fiscal headroom for governments (OBR, 2024; OECD, 2024). Despite this, prevention consistently receives only a small proportion of health spending compared to curative and rehabilitative care. In the last decade, only 3% of annual healthcare spending in OECD countries has been directed towards prevention activities, compared to over 60% for treatment activities[1] (OECD, 2025b). During the pandemic, this proportion increased temporarily, but by 2023 it had returned to pre-

[1] *Defined as curative and rehabilitative care services primarily delivered through inpatient and outpatient services (OECD, 2025b).*

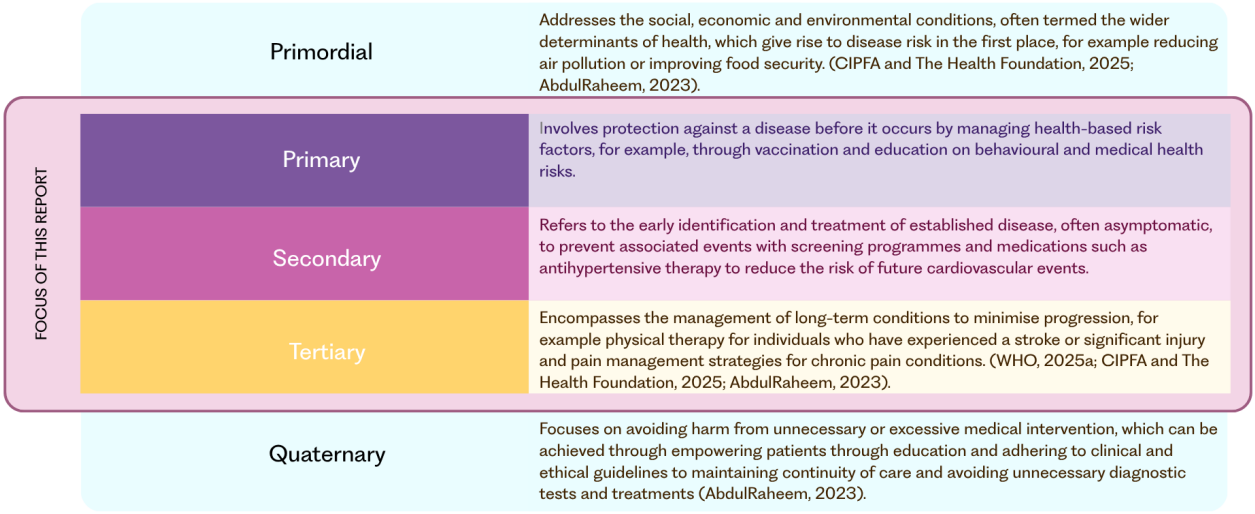
pandemic levels and has since remained stable (OECD, 2025b). In LMICs, a greater proportion of healthcare budgets is dedicated to prevention at roughly 8%-10%, but absolute spend remains low (Penn et al., 2025).

Traditional funding mechanisms, designed primarily for acute and chronic care, have, to date, failed to direct resources toward the longer-term gains provided by prevention. There is growing interest in alternative and innovative funding models for prevention, but actionable evidence and practical guidance on their implementation remains limited (Radford, Fu and Williams, 2025; Holdroyd et al., 2024). Addressing this gap requires further analysis of how alternative models could operate in real-world settings.

1.1 What do we mean by prevention?

Various different types of prevention are set out in the literature (WHO, 2025a) (CIPFA and The Health Foundation, 2025; AbdulRaheem, 2023). We summarise these in Figure 2.

Figure 2 Types of prevention



In practice, boundaries between different types of prevention, and between prevention and treatment are often difficult to define, which can make prevention difficult to classify, measure and fund as a distinct group of activities (CIPFA and The Health Foundation, 2025). For example, statins are used to treat high cholesterol — a risk factor for heart disease; in individuals without heart disease, they are primary prevention while in patients with heart disease, they are secondary prevention, to reduce the risk of a heart attack or stroke.

In this report prevention refers to primary, secondary and tertiary preventative interventions delivered through or funded by health systems. While acknowledging the importance of wider determinants of health, these are not the primary focus of the financing analysis.

1.2 Why invest in prevention?

There is a significant evidence base which demonstrates that preventive strategies deliver substantial returns on investment across multiple levels: at the **individual level** through improved health and quality of life, **health-system level** through cost savings, and at the **societal level** through increased productivity and reduced inequality (Ntais and Talias, 2024).

At the individual level, health benefits from prevention increase both the quality and length of life by eliminating or reducing the development and transmission of illness. Vaccination alone is estimated to save 4 million lives annually (CDC, 2025), with modelled scenarios suggesting this could increase to 5.6 million if coverage targets are met (IA2030, 2025). Furthermore, screening programmes detect disease at an early stage allowing for prompt treatment, while also empowering individuals to make informed decisions about their health and lifestyle choices, ultimately leading to better health outcomes (Mukherjee, 2024). These individual health improvements form the foundation for wider system-level and societal benefits.

From a health-system perspective, prevention activities reduce demand for healthcare services by decreasing the incidence and severity of disease. Fewer cases of advanced illness lead to fewer hospital admissions, reduced use of high-cost acute and emergency care, and less pressure on system capacity (Arnold and Holden, 2025). Individual preventative interventions often offer good value for money from a health-system perspective (WHO, 2020b). For example, a systematic review of 45 studies on interventions to reduce modifiable risk factors for dementia across a range of income levels, found that 14 of the 18 interventions assessed from the healthcare system perspective were cost-effective (Walsh et al., 2022).

At a societal level, the benefits of prevention extend well beyond the health system. People who remain healthy stay in education and employment for longer, gain better qualifications, take less time off for illness and are more productive when they are at work (Wouterse, Santos and Hiligsmann, 2025a). These wider effects translate into higher tax receipts and lower welfare spend which, combined with the compounding effect of lower borrowing reducing debt interest costs, dominate the headline fiscal case for prevention (OBR, 2024; OECD, 2024). When these benefits are accounted for, prevention activities deliver even greater rates of return on investment. Immunisation alone has been estimated to generate returns of 19x - 44x across low, middle and high income countries when broader social and economic benefits are included (see Box 1) (WHO, 2025b; Chowdhury et al., 2025a). Preventable illness also falls disproportionately on lower-income groups and communities with least access to services, so effective interventions may also help to reduce these inequalities (WHO, 2020a, 2023; Wouterse, Vasco Santos and Hiligsmann, 2025).

Despite these wider returns, investment in prevention is typically judged on a narrow basis. The Office of Budget Responsibility (OBR) finds that only a quarter of the fiscal benefit from improved population health in the UK comes directly from lower health spending, the rest accrues beyond the health system (OBR, 2024). Yet health-sector business cases and investment frameworks are typically scoped to costs and outcomes within the health system and lack evidence to credibly capture or claim wider fiscal and social returns (Grimm, van Mastrigt and Hiligsmann, 2025). As a result, prevention is routinely assessed against a small proportion of the value it generates, making the impact look modest even where the full societal return may be substantial. We consider this and other barriers in more detail in Chapter 2.

Box 1 The socioeconomic value of vaccination and persistent underinvestment

WHO, (2025) estimate the return on investment from 10 childhood immunisations in 94 LMICs, targeting haemophilus influenzae type b, hepatitis B, human papillomavirus, Japanese encephalitis, measles, meningitis A, rotavirus, rubella, pneumococcal disease, and yellow fever. When broader social and economic benefits were included, net returns amounted to 44 times the costs.

Chowdhury et al., (2025) estimate the socioeconomic value of adult immunisation programmes for influenza, pneumococcal disease, herpes zoster, and respiratory syncytial virus across ten countries representing diverse health systems and demographics. Across Australia, Brazil, France, Germany, Italy, Japan, Poland, South Africa, Thailand, and the United States, the lifetime returns reached 19 times the initial investment when the full range of benefits are considered.

Together, these findings highlight the potential to ease pressures on health systems by investing in prevention, with immunisation providing long-term benefits that may help to mitigate emerging global healthcare demand challenges.

However, evidence also shows that spending on immunisation may be too low to meet international vaccine targets, despite the potential for significant returns (Gmeinder, Morgan and Mueller, 2017; Spayne and Hesketh, 2021; Idris et al., 2024; El-Banhawi et al., 2023). This persistent underinvestment is driven by several interconnected political, structural and individual barriers (Hampson et al., 2023; Radford, Fu and Williams, 2025; Wouterse, Vasco Santos and Hiligsmann, 2025). We explore these further in Chapter 2.

1.3 About this report

In this report we briefly set out the root causes of underinvestment in prevention and then provide a detailed examination of potential solutions for overcoming these challenges.

Chapters 2 and 3 present the results of targeted literature reviews to identify the key barriers (Chapter 2) and possible solutions (Chapter 3) to prevention funding. As part of the solutions, we present potential funding options and an overview of the challenges solved by each model. We also present a framework to categorise the funding mechanisms into three groups of approaches — i) protecting existing funds, ii) expanding funding from existing sources and iii) diversifying income streams by mobilising private capital.

In Chapter 4, we explore two innovative financing mechanisms in greater depth: blended finance funds and social impact bonds. For each analysis we conducted additional targeted literature reviews to explore their real-world applications and identify the drivers of success. We analysed how these can be designed to best overcome the challenges to funding prevention and provide practical, evidence-based recommendations to support policymakers via a 'checklist for success'.

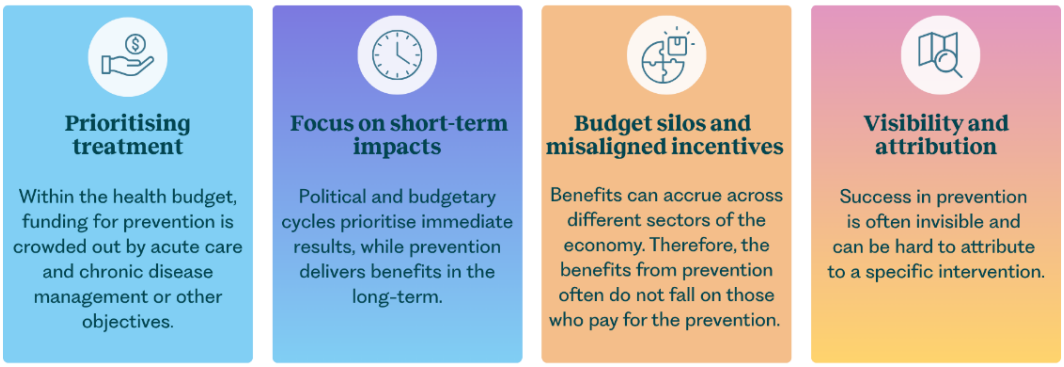
In Chapter 5, we provide a discussion of the results of this research and the necessary next steps for unlocking the benefits of effective prevention.

Throughout the analysis we validated emerging findings through four interviews and a subsequent roundtable. Interviews were used to test and refine insights from the literature reviews, and the roundtable enabled collective discussion of our conclusions. Experts brought experience in global health, practical implementation of innovative public sector

contracting, evaluation of innovative funding for healthcare (including social impact bonds) and clinical commissioning, with perspectives from both high-income and lower-middle income settings.

2 Saving Money, Saving Lives—But Still Not a Priority?

Figure 3 The root causes of underinvestment in prevention



Prioritising treatment

Health systems are under extreme financial pressure with rising demand, capacity constraints and escalating costs. There is little fiscal headroom for upfront investment, so it is extremely difficult to shift spending towards prevention; instead, available resources are directed to activities which relieve immediate pressures. This creates a self-perpetuating cycle in which reactive treatments receive most of the available funding, even though prevention would reduce future demand and relieve pressure in the long-term. While some preventative measures deliver relatively short-term benefits such as the flu vaccine which protects against illness that year, many others generate benefits which materialise much later. The human papillomavirus (HPV) vaccine for example, has a 35 year delay between administration in adolescents and onset of cervical cancer which typically occurs at 50 years of age (Borda et al., 2024). Under system-wide pressures, decision makers are therefore compelled to allocate resources to treatment programmes, which crowd out available funds for prevention, even when there is strong evidence of its positive health impact and cost-effectiveness (Borda et al., 2024).

Focus on short-term impacts

Political and budgetary cycles reinforce short-termism. Policymakers within government must demonstrate impact within electoral cycles, while health ministers and budget holders operate within annual budget frameworks. These both favour initiatives with near-term, measurable impacts, and hence these decision makers are incentivised to prioritise spending which yields visible results within short fiscal horizons. As a result, the substantial long-term health gains and cost-savings that prevention can offer are often overlooked (Hampson et al., 2023; Radford, Fu and Williams, 2025).

Budget silos and misaligned incentives

Around the world, preventative care is funded by a number of actors, each with distinct budgets and responsibilities. The precise set-up varies by context but can include public health agencies and local authorities funding population wide programmes like healthy behaviour campaigns (Buck and Jefferies, 2026; Rechel, Jakubowski and McKee, 2018), national health systems or insurance schemes funding clinical prevention such as

vaccinations, screening and chronic disease management, and employers investing in workplace health initiatives (Jun et al., 2026; Wipfli et al., 2018). In LMICs, external donors also have a significant role to complement national health funding, including in infectious disease control (Adamu et al., 2024).

However, the benefits of prevention often extend far beyond the system which paid for it, thereby skewing incentives. For example, in England, local authorities fund many preventative interventions, such as smoking cessation services (DHSC, 2024), yet the positive outcomes such as reduced hospital admissions and improved productivity accrue elsewhere (Wouterse, Vasco Santos and Hiligsmann, 2025; Radford, Fu and Williams, 2025). Vaccines (often paid for by the health system) can show returns of up to 19 times the initial investment, when benefits beyond the health system are monetised, including mortality and productivity benefits for patients and carers (Chowdhury et al., 2025b). These cross-sector spillovers mean that each stakeholder only captures a fraction of the total value generated by prevention which impacts their motivation to invest, particularly when budgetary pressures are high.

This problem is compounded by structural barriers that prevent effective coordination and resource sharing across sectors. Public services operate with siloed budgets where different departments and levels of government manage separate budgets with limited flexibility to transfer resources or share costs (Radford, Fu and Williams, 2025; Hampson et al., 2023). Without formal structures to enable cross-sector cost and benefit sharing, even when stakeholders recognise the broader value of prevention, they lack the means to pool resources or fairly distribute financial responsibility (Radford, Fu and Williams, 2025; Hampson et al., 2023).

Furthermore, there is misalignment in the timing of benefits which has generational implications. For many preventative activities there is a considerable lag between intervention and the full realisation of benefits; outside of the individual gains, the broader returns such as increased health system capacity and associated productivity are captured by future generations of patients and payers, rather than those currently driving demand on the system. This further weakens the incentive for today's decision makers to commit resources.

Visibility and attribution

Another key barrier to realising the value of prevention, and hence funding it, is that success is invisible because it is defined by the absence of disease onset or progression. Outcomes such as a surgery averted, a hospital bed not filled, or a life extended by a decade are profoundly impactful but do not attract public attention like new, high-tech treatments. Invisible, intangible benefits are less compelling to both the public and policy makers which makes it harder to justify investment compared to acute care, which delivers immediate, measurable results that align closely with short-term political and budgetary priorities.

When researchers try to measure the impact of prevention, they face significant challenges, both in quantifying outcomes and capturing their full value. Benefits can be difficult to quantify and attribute to a specific intervention due to complex and interdependent causal pathways (Wouterse, Vasco Santos and Hiligsmann, 2025). Multiple factors can influence health outcomes simultaneously, from individuals' behaviour and genetic predisposition to environmental conditions and access to healthcare, which makes it hard to isolate the precise contribution of a single intervention (Wouterse, Vasco Santos and Hiligsmann, 2025). This means that it is often difficult to demonstrate the value of preventative interventions and so decision makers face uncertainty about whether investments in prevention will deliver the expected returns.

Furthermore, evaluation frameworks often adopt relatively narrow perspectives, focusing primarily on impacts within the healthcare system rather than capturing broader societal

benefits such as productivity gains, informal care, and wider economic effects (Grimm, van Mastrigt and Hiligsmann, 2025). As a result, even where outcomes can be measured, the full value of prevention may still be underestimated, reinforcing the perception that preventative interventions offer limited returns and weakening the case for investment.

When prevention programmes are funded and available, uptake is often suboptimal. Many of the socio-economic and behavioural factors that influence broader healthcare utilisation are amplified in the prevention context (Wang and Lo, 2022; Kelleher, Doherty and O'Neill, 2021; Eberhardt et al., 2025). In addition, the invisibility of the benefits of prevention means individuals struggle to prioritise interventions in the absence of symptoms, particularly when they require sustained lifestyle changes that compete with short-term enjoyment. This also makes prevention particularly vulnerable to misinformation and mistrust, because people find it easier to dismiss or delay action when there is no tangible problem to address (Wang and Lo, 2022; Kelleher, Doherty and O'Neill, 2021). These demand-side barriers can reduce uptake and mean that implemented preventative interventions would not achieve the full potential that would be possible with higher uptake. This, therefore, reinforces reluctance to invest as it is difficult to reassure investors that the potential value would be possible to measure and achieve in practice.

These four barriers to investment in prevention are not independent: short political horizons amplify the treatment imperative, siloed budgets compound invisibility and weak attribution reinforces short-termism. Because of this, solutions must target multiple barriers at once. In Chapter 3 we evaluate several funding mechanisms against these barriers.

3 How can we fund prevention?

Traditional funding mechanisms for healthcare, designed primarily for acute care, are poorly suited to prevention due to the barriers outlined in Chapter 2. We present nine examples of potential means of funding prevention outside typical public health and healthcare budgets and categorise these into three buckets: protect, grow and diversify (Figure 4).

Protecting prevention budgets is essential to ensure resources are not reallocated and to establish the foundation for long-term investment. At the same time, prevention budgets must be **grown**, either by expanding existing public allocations or by identifying new streams of capital through **diversification**. These approaches are not sequential but are complementary, and a comprehensive funding strategy could employ elements of each simultaneously.

Figure 4 Approaches to funding prevention

In the following sections we: i) explain each funding mechanism and provide examples of where they have been used before (denoted by) ii) reflect on which of the four key barriers (Figure 1) they do overcome ( ), and iii) state which of the barriers they do not overcome ( ).

Protect existing funding sources

Protection of existing funds is critical to ensuring that allocated resources remain dedicated to preventative interventions. Without safeguards against crowding out, any new or expanded funding is at risk of replacing rather than supplementing existing sources.

Ring-fenced funds

Ring-fenced funds create dedicated funding pools legally protected for a designated purpose (Hampson et al., 2023; Radford, Fu and Williams, 2025; Atun et al., 2016). Although ringfencing can be applied to any pool of funds to protect them from reallocation, it is often used to maintain investment in high cost, innovative treatments to protect patient access by shielding funds from competing demands. Examples include the Cancer Drugs Fund (CDF) in the UK, which is ring-fenced with a fixed annual budget of £340 million and has provided treatments to over 104,000 patients since 2016 (NHS England, 2025b), and ring-fenced funds for rare diseases in Romania, Thailand and Malaysia to address underfunding and ensure continuity of care (Brown and Burr, 2021).

Ring fencing is attractive as it protects against crowding out which occurs when prevention competes directly with acute care priorities, and it leverages existing budget processes so no new and complex financial structures are required. Real world examples demonstrate the feasibility of this approach, and how it can be used to support innovation and accountability. Furthermore, by securing funding through ring fencing, this could serve to signal policy priorities and raise the profile of prevention (Hampson et al., 2023; Holdroyd et al., 2024).

However, ring-fencing only protects funds for a broad purpose, it does not determine whether those resources are used optimally, nor whether the amount allocated is

sufficient to meet population needs. It requires clear specification of the boundaries of the fund, and capacity for compliance monitoring and reporting to ensure funds are being spent as intended (Radford, Fu, and Williams, Mark, 2025; Hampson et al., 2023). Moreover, ringfencing does not inherently solve other prevention barriers, such as short-termism, misaligned incentives and invisibility of success, though it could be applied to a fund that was designed with these in mind.

Grow government sources

Growing prevention funding involves increasing the overall volume of resources available to support preventative interventions. In this section, we consider growth via expansion of government funding for prevention.

Prevention investment standard

Investment standards establish minimum spending thresholds, often expressed as a percentage of total health budgets, to signal prioritisation and guide resource allocation. In the UK, the Mental Health Investments Standard (MHIS) requires annual mental health spending - as a minimum - to increase in line with overall healthcare budget growth (Hampson et al., 2023; Holdroyd et al., 2024). More specifically in the prevention space, Italy mandates that regional health authorities allocate at least 5% of their budgets to prevention (Poscia, Silenzi and Ricciardi, 2018).

Employing a prevention investment standard would ensure that increases in health budgets are proportionally reflected in prevention spending. This reduces the risk of reallocation to acute care and could also signal policy priorities and increase the visibility of prevention.

However, a prevention investment standard does not specify the source of funding and so it would not resolve the underlying trade-off between treatment and prevention spending. Furthermore, these types of commitments require administrative capacity to monitor compliance — in the UK, subnational health boards must publicly declare whether they have met the obligations regarding the MHIS and independent reviews are required to validate each one each year (NHS England, 2025a). Without strong enforcement they can struggle to drive meaningful change - Italy's prevention spending has consistently fallen below the 5% target, averaging around 4.5% (Poscia, Silenzi and Ricciardi, 2018; Hampson et al., 2023; Holdroyd et al., 2024).

Moreover, these standards do not alter incentive structures or fully address the problem of short-termism. While they secure spending in the immediate term, they do not shift perspectives toward valuing long-term outcomes and remain vulnerable to changing political priorities across electoral cycles, meaning they cannot guarantee sustained investment. Finally, they do not resolve the challenge of the invisibility of success.

Hypothecated taxation

Governments primarily raise funds for public healthcare through general taxation, with revenue contributing to a central pool that is allocated to different sector budgets. Hypothecation earmarks a specific revenue stream for a specific purpose, in this case prevention. There are numerous different types of taxation that could be leveraged in this way; however, this full breadth of potential taxation is beyond the scope of this report. Here, we focus on taxation mechanisms that have a direct link to prevention — 'sin taxes.'

Sin taxes are a type of excise tax applied to harmful products such as tobacco, alcohol and sugar-sweetened drinks. They offer a pragmatic opportunity to generate resources to fund prevention because they serve a dual function in public health policy. They act as a

prevention strategy themselves, by increasing the cost of consumption, thereby discouraging use and contributing to a reduction in the incidence of related diseases, while also providing a source of funds (Miracolo et al., 2021). As an example, the Thai Health Promotion Foundation, which supports cross-sector initiatives to improve public health, is fully financed by hypothecated taxes on tobacco and alcohol (Sopitarchasak, Adulyanon and Lorthong, 2014).

This type of taxation creates a logical connection between revenue generation and prevention funding, because the tax burden falls on products that directly contribute to healthcare costs (Elendu et al., 2025; Wouterse, Vasco Santos and Hiligsmann, 2025). As a result, they help to overcome the challenge of misaligned incentives by linking the cost of harmful consumption directly to investment in health improvement.

However, if effective as a disincentive, these taxes will not raise significant revenue in the long-term. Furthermore, they can be regressive because the financial burden falls disproportionately in lower-income areas since the tax represents a larger fraction of their income (Miracolo et al., 2021). They also depend on the price elasticity of demand which determines how strongly consumption falls in response to the tax (Miracolo et al., 2021)

While these types of taxes are widespread, few countries dedicate the funds to health interventions and instead they are absorbed into broader fiscal allocations. Repurposing or increasing existing sin tax revenue for prevention would require ring-fencing, otherwise it risks being reallocated to other priorities (Miracolo et al., 2021). Furthermore, it does not mitigate short-termism, but it does have the potential to survive across political cycles, depending on the stability of the tax policy and the commitment of successive governments. Innovation taxation does not make the success of prevention more tangible, because funds are generated regardless of outcomes.

Sovereign wealth funds

Sovereign wealth funds (SWFs) are large, state-owned investment funds which use surplus revenue to generate long-term results (TheCityUK, 2024). These surpluses can come from trade profits, budget savings, currency operations and proceeds of privatisation and are typically invested into foreign assets. SWFs are created to stabilise state budgets by saving surplus revenues to offset future declines from volatile revenue sources, save for future generations and support long term wealth preservation (TheCityUK, 2024; Schepp, 2025).

Prevention focused SWFs remain an emerging policy idea rather than an established financing tool, however, advocates in the UK and Canada are calling for this to change (Clarke and Abdool, 2020; Common Wealth Canada, 2025; Allcock, 2025; Price, 2023). There are examples which engage with the health sector which illustrate their potential to fund prevention. Australia's Medical Research Future Fund supports long-term medical innovation through ten-year investment cycles, and Abu Dhabi's ADQ includes the health and life sciences sector as a strategic priority in their portfolio (ADQ, 2025; Department of Health, Disability and Ageing, 2025).

A prevention focused SWF could address key barriers related to the stability of prevention funding. These funds are designed with long-term returns in mind and are resilient to short-term political cycles to preserve intergenerational wealth. SWFs also realign incentives because they are national vehicles and so sit above all sectors, aligning incentives across society. They could also signal policy priorities and increase the profile of prevention.

However, they do not inherently protect from reallocation, they would require ring fencing for prevention funding, and they do not increase the visibility and attribution of outcomes. Perhaps most importantly, they also require substantial initial investment, which necessitates available resources and sufficient political will to prioritise prevention over

other competing demands. In the current economic climate, such initial investment may be difficult to secure.

Diversify through private capital and innovation

Diversification introduces new streams of capital beyond traditional public sources, e.g. private and philanthropic capital, helping to grow available funds. By widening the range of actors who invest in prevention, diversification expands the overall pool of resources available and reduces pressure on existing health budgets.

Blended finance

Blended finance is an umbrella term for all mechanisms which combine public, philanthropic and private capital into a single investment. The public and philanthropic capital is concessional, meaning it assumes the first-loss position, absorbing initial losses if an investment underperforms. This mobilises private capital by acting as a buffer and making the investment more attractive to private investors who would otherwise consider the risk-reward profile too high (Radford, Fu and Williams, 2025). These models (also referred to as blended investment vehicles) include guarantees, co-investments, technical assistance (TA) facilities, impact bonds, credit enhancements and blended finance funds (BFFs). In this report we focus on blended finance funds and impact bonds as the two that have the greatest potential to overcome the four barriers set out in Chapter 2.

Blended finance funds

Blended finance funds, also known as blended private funds, are a type of blended finance, in this case a structured fund with different options (known as capital tranches) for each investor that align the investor risk/return profiles with the aim of the investor (Amundi, 2025). Funders such as development finance institutions (DFIs), philanthropic foundations and governments (via aid or finance), who provide concessional capital, will typically accept higher risks and/or lower returns for investments than private investors and are willing to engage in the fund to both support the aim of the fund and to attract private capital (Convergence, 2026; Oso et al., 2025).

BFFs can take multiple structures, including different structures for how returns are delivered to investors in the fund and different approaches to distributing funds to investees such as through private equity, loans, bonds or a combination of these. A key characteristic of the fund as opposed to other types of blended finance is that the money is pooled to achieve a set goal and so delivers both financial returns and broader impact. However, due to the undefined structure of BFFs the term blended finance is often used as a synonym and research on BFFs is often hidden in broader discussions of blended finance.

A BFF with the goal of funding prevention has the potential to overcome all of the key barriers to investment in prevention. By creating new capital specifically for funding preventive interventions, independent of health budgets, this means that the funds are protected from reassignment to other health system priorities. The funding must be directed towards activities that support the defined objectives of the fund and in this way the fund acts as form of ring-fencing to achieve the goals of the fund.

In order to ascertain if the objectives have been achieved, so that private investors can achieve a return, the success of the prevention initiatives financed by the fund must be visible and measurable . While investors will want a reasonable timeline for the return on their investment, the fund should be established on the understanding that outcomes will be realised in the long term, overcoming the short-termism challenge. In addition, the financial structure of the fund aligns incentives for each stakeholder**:** concessional capital

is incentivised by the promise of achieving their goal, with private investors being incentivised through returns on their investment.

Despite their potential to overcome all the key barriers to prevention funding, there are limitations to the BFF model due to their complexity and resultant capacity demands (Thomas, 2026). They also require an upfront contribution of public or philanthropic capital to absorb risk, and the cost of private capital within the structure may exceed typical government borrowing rates (Oso et al., 2025).

The case study in Chapter 3.2 explores examples of how BFFs operate, their limitations and an example of successful implementation. The chapter also provides a checklist for success for BFFs to facilitate in understanding whether a BFF may be an appropriate solution to funding prevention in different contexts.

Impact bonds

Impact bonds, outcome bonds, impact contracts, benefit bonds and pay-for-success contracts are all referring to the same model which we will refer to as impact bonds. These are another type of blended finance, specifically with outcomes-based contracts which directly link investor returns to measurable health outcomes (GOV.UK, 2012). In principle the impact bond model is straightforward - private investors fund interventions, and are repaid (with a financial return) by an outcome payer if predefined outcomes are achieved (Radford, Fu and Williams, 2025; Social Finance, 2011). In practice the design and implementation are typically more complex, with structures varying depending on the context. Two main variations exist, distinguished primarily by the outcome payer and scope of the interventions they fund. They are called social impact bonds (SIBs) and development impact bonds (DIBs)

SIBs use public-sector bodies as outcome payers, and are more common in high-income countries (HICs) where governments have the fiscal space and institutional capacity to pay for outcomes (Social Finance, 2011; Holdroyd et al., 2024). They typically fund specific interventions with a narrow scope, piloting interventions, generating evidence to inform decisions about the integration of an intervention into routine commissioning. In healthcare, they have been effective in chronic disease prevention and treatment, for example diabetes and human immunodeficiency virus (HIV) prevention (Aarhus, 2021; EIT, 2020; Stanworth, 2024) and treatment of long term physical and mental health conditions (Ronicle and Stanworth, 2025; Social Ventures Australia, 2025). They have also been used to improve the wider determinants of health including education, housing and social care (Carter et al., 2024).

DIBs using philanthropic foundations or development agencies like USAID or the World Bank as the outcome payer are more common in LMICs, where governments capacity is more restricted (Centre for Global Development, 2025). These models typically fund activities aligned to long-term aid and development objectives such as improving sanitation and reducing poverty. Examples in health include the Utkrisht Impact Bond in India funding interventions for improving maternal and newborn health outcomes, and the Humanitarian Impact bond in Mali, Nigeria and the Democratic Republic of Congo which delivers rehabilitation services for people with disabilities in conflict zones (Centre for Global Development, 2025; Clarke, Chalkidou and Nemzoff, 2018).

Both SIBs and DIBs overcome the four key barriers in prevention financing. Structured outcome payments help to address misaligned incentives since commissioners only pay when results are achieved, and multi-commissioner contracts allow different outcomes payers (e.g. from health, housing and education) to each contribute funding tied to savings within their own budgets, collectively funding an intervention which individually they could not justify paying for. These models require outcomes monitoring which quantifies the impact of prevention and translates it into tangible financial returns, addressing the invisibility problem. Furthermore, the funding provided is inherently

dedicated to the intervention of interest and hence protected from reallocation to competing acute care pressures. Finally, they are designed to support long-term outcomes - DIBs are typically aligned to broader development goals while SIBs, although acting as shorter-term pilots themselves, aim to generate evidence for integrating successful interventions into routine commissioning for sustained delivery (Centre for Global Development, 2025; Clarke, Chalkidou and Nemzoff, 2018).

However, their implementation involves significant practical considerations. They have high transaction costs associated with complex contracting, data collection and outcome evaluation, and also require an upfront contribution of public capital to absorb risk (Social Finance, 2011; Holdroyd et al., 2024). As a result, they are more feasible in countries with strong political backing and institutional capacity for blended finance approaches. Furthermore, the need for investor returns creates tension between short-term measurable proxies and long-term outcomes. The case study in Chapter 3.3 examines how SIBs operate in practice, the conditions required for successful implementation, and the limitations commissioners must consider when deciding if this financing model is appropriate for their context.

Corporate social responsibility initiatives

Corporate social responsibility (CSR) initiatives are voluntary actions taken by companies to contribute to the wellbeing of their community and beyond. In the context of prevention these could include directly funding programmes, donating medicines, staff time or infrastructure (Give, 2025). CSR efforts are often global and led by multinational corporations providing aid to LMICs. For example, several pharmaceutical companies have partnered with GAVI the Vaccine Alliance, to donate millions of vaccines to low-income countries (Elendu et al., 2025).

CSR initiatives partially overcome the challenges of funding prevention by providing a new revenue stream dedicated to prevention protecting against crowding out. Investments are also made with the knowledge that outcomes will be long-term, and initiatives are not directly impacted by health system budgets or political cycles.

However, these initiatives are typically small scale and possibly not reliable long-term, fluctuating with corporate policies. Regarding misaligned incentives the companies do not directly benefit from the health outcomes of the prevention. Finally, they can raise the profile of prevention but cannot quantify the value or make success tangible so do not directly increase the visibility of success, although initiatives are more likely to be made in areas where there is a clear theory of change.

Workplace initiatives

Workplace initiatives are an example of a small-scale investment in prevention where employers pay for health and wellbeing activities because they expect returns in reduced absenteeism, high productivity and lower insurance costs. Initiatives could be in-house services for example health screenings and vaccinations in the workplace, or external such as subsidised or paid for gym memberships or well-being programmes (Javanmardi et al., 2025).

These initiatives overcome multiple barriers to funding prevention interventions. They prevent the deprioritisation of prevention to treatment because employers pay directly for prevention initiatives, so the funds are protected for this purpose. Also, short-termism because some initiatives will be focused on the near-term prevention (e.g. flu vaccination) whereas others (e.g. increased physical activity) will be realised over a longer period. Finally, invisibility of success is overcome because prevention gains visibility in the workplace culture, and if the company tracks outcomes to justify their investment it could help quantify the effects of prevention making it more tangible.

However, the incentives for employers to invest in these activities is limited by high employee turnover which means employers may not benefit from long-term savings of the prevention they provide. When employees move between employers there is a delay in outcomes vs payment which weakens the alignment of incentives considerably. In addition, in countries like the US where private healthcare is typically funded by employers, the employers are already investing in healthcare which reduces the incentives to further invest in preventative healthcare.

Healthy behaviour insurance

Healthy behaviour insurance (or behaviour-based insurance) is an insurance model which adjusts individuals' private health insurance premiums or offers rewards based on individual lifestyle choices to encourage engagement in preventative behaviour (Vlaev et al., 2019). In the US for example, employers can offer wellness incentives worth up to 50% of the health insurance premium as an incentive to quit smoking, and up to 30% for activities such as exercise, having a healthy diet and health screening attendance (Kaul et al., 2024). In Germany, statutory health insurance providers have set up bonus schemes to incentivise members to partake in preventative measures using data from wearable digital activity tracking devices which earn users points against specific healthy behaviours (Bredthauer, Kuhn and Buyx, 2025). There is scope for insurers to incentivise more healthy behaviours. In doing so, insurers would take on increasing financial responsibility for prevention with the aim of reducing future claim costs.

This model helps overcome several key barriers to prevention funding. First, it provides dedicated funds to prevention because insurers are paying for them directly. It addresses the invisibility problem by making the benefits of healthy behaviour more immediate and tangible. Private insurers are well placed to track the benefits of any privately funded programme over the longer term. Furthermore, while the health outcomes of prevention may take years to materialise, the financial reward of lower insurance premiums is short-term. This helps to align incentives by linking insurance costs to individual behaviour — those who engage in preventative behaviour are rewarded, while those who do not face higher premiums. The implication is that those who are more likely to require healthcare resources have paid a greater share. The insurance company effectively pays the individual to engage in the prevention activity and recoups the benefits of reduced claims. It also partially mitigates the challenge of short-termism, because insurance companies provide the schemes with the awareness that benefits may be long term. Furthermore, these schemes are implemented through private firms/employers and are less directly affected by the timelines of governing bodies, although they may still be influenced by changes in political leadership.

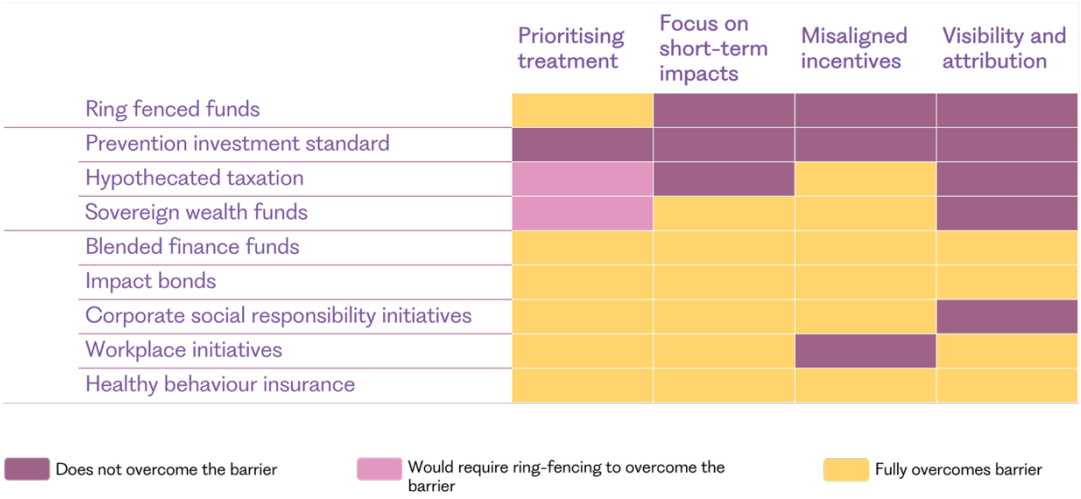
However, the barrier of misaligned incentives is not overcome in the long-term as insurance plan members can switch between providers. This means that the insurer who pays for the prevention may not see the long-term savings of the prevention that they paid for. This disincentivises insurers from including preventative interventions in their benefit packages.

Summary

Figure 5 summarises the funding models we have identified and whether they have the potential to overcome the key barriers to prevention financing. Whether that potential is realised in practice depends on the design of the funding mechanism, and on implementation barriers which are likely to vary across different contexts. Simpler tools such as ring-fencing and investment standards are already commonly used across many geographies, involve fewer stakeholders to implement and can be integrated into existing budgetary and regulatory process. This makes them easier to implement, however, they address only a narrow set of barriers to prevention funding. More complex options like BFFs and SIBs can address multiple barriers simultaneously but face a wider range of

implementation challenges because they require significant resources and political backing. This trade-off between feasibility and structural impact underscores the need to combine protect, grow and diversify models, and to assess more demanding methods carefully to determine when their use is justified. The next chapter examines BFFs and SIBs in depth to support this assessment.

Figure 5 Overcoming barriers to prevention funding



4 Making it work: Case Studies in BFFs and SIBs

Despite increasing interest in alternative and innovative funding models for prevention, there is limited analysis of how these alternative models might operate in practice. In this chapter of the report, we explore BFFs and SIBs in more detail.

For each case study we describe what the model is and provide examples of how it has worked in practice, the conditions that make it successful (or limit its success) and what this tells us about when and where they would be most appropriate to consider. Finally, we provide checklists for successful implementation of each of these funding models, identify the conditions under which they can effectively mobilise private capital while delivering meaningful social impact.

4.1 Blended finance funds

Overview

BFFs are financing structures that combine concessional capital from public or philanthropic sources with commercial capital from private investors to support projects that generate societal benefits (e.g. health or environmental benefits) alongside financial returns. The core objective of BFFs is to address market failures that prevent private investment in socially valuable sectors by using concessional capital to de-risk projects, improving the risk—return profile and crowding in private finance that would not otherwise participate (OECD, 2018; Convergence, 2023). In this way, blended finance aims to mobilise private capital to support public policy objectives, particularly in contexts where public resources alone are insufficient to meet development or social investment needs.

By bringing together DFIs, governments, philanthropists and commercial investors within shared investment vehicles, BFFs can foster coordination across stakeholders who would otherwise operate independently (OECD, 2018; Tonkonogy et al., 2021). The presence of public or philanthropic capital can also provide credibility and signalling effects, reducing perceived risk and helping to build investor confidence in preventative healthcare markets (Convergence, 2023). Moreover, BFFs are typically used to pool funds for multiple investments to meet a common goal. This structure allows for portfolio diversification, supporting innovation while spreading risk across multiple investments.

However, there are also limitations to BFFs. BFFs are operationally demanding, involving complex structures and lengthy negotiations, particularly where multiple classes of capital and differing return expectations coexist. Transaction costs can therefore be high, limiting feasibility in settings with weak institutional capacity or limited private capital (Oso et al., 2025).

The additional complexities of establishing a BFF also mean that they are more burdensome to establish compared to typical public sector and private borrowing. Therefore, BFFs are likely to be most attractive for investments that would have not proceeded on purely commercial terms. In practice, this means investments that have a clear aim to deliver a societal benefit, but where governments do not have the capital or willingness to fund in its entirety, or the markets are not yet established enough to generate sufficient private sector interest without concessional capital in place to reduce the risk.

BFF structure

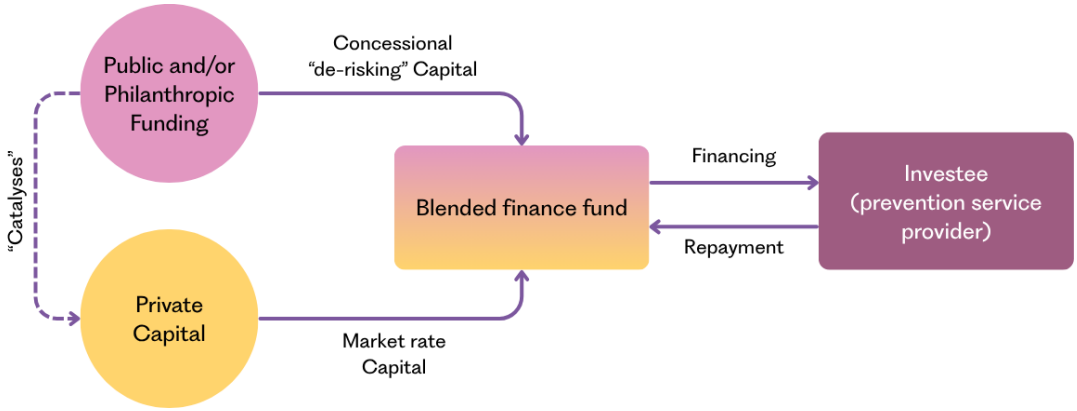
Figure 6 illustrates a generalised BFF structure used to support social or development outcomes. Concessional 'de-risking' capital — typically provided by governments, DFIs or philanthropic foundations — is provided to the blended finance fund (1), which would be managed by a specialist fund manager. This capital may be structured as first-loss equity or guarantees, explicitly absorbing a greater share of risk or accepting below-market returns (OECD, 2018; Convergence, 2023). As part of their involvement, concessional investors can ensure alignment of funding with national priorities and public health goals (Oso et al., 2025). Commercial investors provide additional capital (2), benefiting from the improved risk—return profile created by the concessional investors.

The pooled capital is invested by the fund manager into a portfolio of investees (3), such as service providers, social enterprises or infrastructure projects delivering services aligned with agreed impact objectives. How the funds are distributed, and as result, how the returns are made can take many different forms. For example, the funds could be distributed through making investments in companies (blended private equity) with returns made through a share of profits generated by the company (the investee) or through sale of the business. In the case of prevention, the company could be a private firm delivering preventative interventions that require payment from individuals or governments for their services (e.g., the Africa Healthcare Network that is a for-profit company providing dialysis services that are paid for by the patients) or into businesses that sell preventative interventions (e.g., Insta Products that prepares ready-to-use therapeutic food for malnourished children under 5 in East Africa and sells these to humanitarian aid organisations). Alternatively, funds could be structured as debt funds, distributing funds as loans to providers of preventative interventions, with returns made through interest paid on the loans. The financial returns flow back to the fund (4) and are distributed to investors according to the pre-agreed capital structure (5), with concessional investors typically bearing losses first or receiving capped returns.

In practice, BFF structures vary significantly in design. Some employ layered capital structures with multiple tranches of equity and debt, while others rely on partial guarantees (guarantees to pay for a defined percentage of any potential losses) or TA facilities to reduce risk at the investee level (non-financial support provided directly to investees — e.g., training — to reduce the risk of the investee) (Tonkonogy et al., 2021). Governance arrangements also differ, with some funds retaining strong public-sector influence over investment strategy, while others delegate decision-making authority to independent fund managers.

Unlike SIBs or DIBs, these funds typically do not rely on government outcome payments, which can be advantageous in fiscally constrained settings, but also means that accountability for impact depends heavily on fund-level governance and reporting practices. Investee performance is often monitored through a combination of financial reporting and impact measurement frameworks, often aligned with established standards such as Impact Reporting and Investment Standards (IRIS+) that support the measurement of social, environmental and financial performance of an investment) or the UN Sustainable Development Goals (Global Impact Investing Network, 2020).

Figure 6 Structure of an BFF in healthcare



Global applications

BFFs have been utilised in a wide range of sectors and geographies, with particularly strong uptake in LMICs, where financing gaps for social infrastructure and essential services are most acute. Between 2012 and 2022, more than US$200 billion in private capital was mobilised through blended finance mechanisms globally, with health, energy, financial inclusion and agriculture among the largest recipient sectors (OECD, 2023; Convergence, 2023).

Health-related BFFs have been used to support pharmaceutical innovation, primary care networks, diagnostics and supply chains in LMICs, where traditional public funding and purely commercial investment have struggled to meet population needs. For example, the Transform Health Fund is a BFF that is structured as blended private equity (FSD Africa, 2025; Health Finance Coalition, 2024). The fund is pan-African and targets supply chain transformation, innovative care delivery and advancing digital innovation. The fund has raised US$111 million, of which US$20 million has been committed to funding dialysis and preventative treatment (Africa Healthcare Network), optical care (Lapaire Glasses) and ready-to use therapeutic food for malnourished children and mothers (Insta Products) (Health Finance Coalition, 2024).

Examples of different structures are also used in practice in healthcare in LMICs. For example, the Medical Credit Fund (MCF) is a BFF structured as a debt fund offering loans and TA to sub-Saharan African private healthcare providers. The fund has provided more than €165 million in loans to over 2,100 healthcare businesses. This includes support for preventative activities such as malaria prevention.

In high-income countries, blended finance has been used more selectively, often to support local regeneration, affordable housing and climate-related investments, rather than core health services or prevention activities (OECD, 2018).

In Box 2 we discuss an example of the use of a blended finance fund in practice in greater depth.

Box 2 The Global Fund to Fight AIDS, Tuberculosis and Malaria

Context

The Global Fund is a worldwide partnership to defeat AIDS, tuberculosis (TB) and malaria (The Global Fund, 2025a). The fund is a partnership between civil society, governments, the private sector, philanthropists, technical partners and communities who work together to fight the diseases in more than 100 countries (The Global Fund, 2025a). The fund is the world's largest multilateral funder of global health grants in LMICs, disbursing over US$69 billion since 2002 (The Global Fund, 2025a).

AIDS, TB and malaria disproportionately affect LMICs, yet these settings have historically faced chronic underinvestment due to fiscal constraints, high delivery risk and weak health systems, which have compounded the challenges we outlined in Chapter 2. Prior to the establishment of the Global Fund, financing for these conditions was fragmented, unpredictable and insufficient to support large-scale prevention, treatment and health system strengthening, particularly in settings with weak fiscal capacity (Schocken, 2008). Traditional aid modalities struggled to mobilise resources at the scale required and often failed to align external funding with country-led priorities.

The Global Fund represents one of the earliest and most prominent examples of large-scale blended and pooled financing for health. Its purpose was to mobilise substantial volumes of international concessional capital, use this to reduce risk and financing constraints at country level, and thereby enable large-scale investment in disease control and health systems that domestic budgets and commercial capital alone could not support (OECD, 2018; The Global Fund, 2025a).

Blended finance structure

BFFs only form a part of the funding for The Global Fund. 94% of the funding comes from donor governments with the remaining funding coming from private sector foundations and from innovative financing initiatives, including blended finance (The Global Fund, 2025c).

The fund operates on a 3-year funding cycle from donor governments, philanthropic foundations and private sector partners, providing long-term, predictable funding at scale (The Global Fund, 2025c). To allocate funding, eligible countries make requests for funding to provide services that meet the aims of the fund. If they are approved, they are provided with a grant and are responsible for the delivery of the initiative (The Global Fund, 2025c). Though payments are not contractually tied to specific outcome thresholds, the grant recipients must report back to the Global Fund about the success that they've achieved.

In addition to the grant process, The Global Fund distributes funds raised through blended financing investments which combine their funding with funding from multilateral banks and other financial institutions to invest in projects that support the aims of The Global Fund (The Global Fund, 2025b) with the structure and how returns are generated differing for each agreement.

Successes

Since 2017, the Global Fund has invested in 14 blended finance agreements, providing concessional funding of US$215 million across these investments, alongside approximately US$3.5 billion in partner (e.g., World Bank) and domestic government investments (The Global Fund, 2025c). These agreements have led to improvements in healthcare, such as improving access to malaria case management and preventive treatment for malaria in pregnancy in South Sudan, reaching migrant populations with lifesaving HIV services in Venezuela, providing additional funding to incentivise health reforms and national TB response in Indonesia and integrating HIV and TB care into the Primary health care system in the Lao People's Democratic Republic (The Global Fund, 2025c).

Challenges

- Funding for the global fund is dependent on sustained donor government and philanthropic commitments leaving the funding available vulnerable to geopolitical and fiscal shifts (Kiai, 2024).
- Complex governance structures defined by multi-layered decision-making across global and country levels generates significant transaction costs and can slow funding flows (Schocken, 2008; IHME, 2024).
- The effectiveness of blended financing depends on local systems; in weaker health systems, grant absorption and impact are constrained despite high levels of available funding (IHME, 2024).
- While co-financing requirements encourage domestic spending, transitioning countries off concessional finance to solely domestic funding to minimise long-term reliance on the fund without risking service disruption remains challenging (OECD, 2023).

Learnings

- Blended financing can mobilise capital at scale in ways that project-level instruments cannot, particularly for global public goods such as epidemic control (OECD, 2023; Schocken, 2008).
- Many governments have reduced their contributions to The Global Fund (OECD, 2025a). A reliance on government aid funding has left the fund vulnerable to geopolitical motivations and tighter fiscal space in many Global Fund donors and implementing countries, resulting in declining international funding (The Global Fund, 2025b; a) and constraints in the grants that can be funded and delivered.
- Monitoring and evaluation of the programmes invested in is important. The development of the Global Fund's Monitoring and Evaluation Framework has helped to facilitate performance management of programmes funded by the fund (The Global Fund, 2026d).
- Country ownership and inclusive governance enhance legitimacy and alignment with local needs but must be balanced with strong technical oversight to maintain effectiveness (The Global Fund, 2023; IHME, 2024).
- Predictable, long-term financing is essential; without continued donor commitment, even highly effective blended finance mechanisms risk rapid loss of impact.

Checklist for success

We have developed a 'checklist for success' that presents the factors required for implementation which policy makers should consider when deciding whether a blended finance fund is appropriate in their context.

Figure 7 Blended finance funds checklist for success

Intervention

- Fund directly contributes to disease prevention
- Measurable outcomes that are policy aligned and meaningful to (concessional) investors

Systems

- Robust data systems to track and verify outcomes
- Financial management and compliance systems to manage multi-source capital efficiently

Stakeholders

- Experienced fund manager
- Diverse investor base
- Governance from an advisory board or investment committee with clear decision rights
- Understanding of each investor's motivation (not a desire to change them)
- Shared understanding among stakeholders of the problem, intervention logic and success criteria
- Continued engagement between

Agreement Structure

- Finance anchored to a clear goal (investment in preventative health)
- Alignment of incentives among stakeholders
- Clearly defined roles, responsibilities and financial exposure of each stakeholder
- Commercial sustainability in the long-term with a clear strategy for the duration of and exit from the fund
- Alignment with domestic and international law
- Impact objectives aligned from the inception of the agreement and verifiable via a common monitoring and evaluation framework.

Intervention

BFFs are most effective where the underlying interventions contribute directly to socially valuable goals, in this case disease prevention, and when the specific prevention landscape faces structural barriers that deter purely commercial investment. There therefore must be a disease prevention goal (or set of goals) which the purpose of the interventions can be defined against.

The interventions financed by the fund must translate into measurable outcomes that are meaningful to concessional investors, even when these outcomes are not tied to explicit payment triggers, such as with The Global Fund. While blended finance funds do not, by definition, have to operate on pay-for-success contracts, they still require credible impact pathways and indicators to demonstrate social value and justify the use of public or philanthropic capital (Global Impact Investing Network, 2020).

Systems

Robust systems are critical to managing multi-source capital and maintaining confidence among diverse investors. Blended finance funds require financial management and compliance systems capable of handling layered capital structures, differentiated risk exposure and varying return expectations across investor classes

(OECD, 2018; Convergence, 2023). Weak fund administration can undermine the credibility of the entire structure and deter commercial participation.

Equally important are data systems to monitor and verify performance and impact at the portfolio level. Although returns are not necessarily outcome-contingent, transparent reporting on investee performance and impact is necessary both for accountability and for validating the fund's additionality (Global Impact Investing Network, 2020). Without credible data, it becomes difficult to demonstrate that concessional capital is achieving outcomes beyond what market finance would have delivered alone.

Stakeholders

A fund manager, responsible for structuring investments, managing risk and engaging with both concessional and commercial investors, is important to the success of the BFF. They can support in ensuring a carefully balanced stakeholder ecosystem.

A diverse investor base strengthens fund resilience by spreading risk and signalling confidence in the investments. Clear governance arrangements—typically through an advisory board or investment committee with defined decision rights—are essential to manage potential tensions between investors with different motivations, such as health impact versus financial return (OECD, 2018; Tonkonogy et al., 2021). This is facilitated through an understanding of each investor's motivation: financial return for private capital and societal outcomes for concessional capital.

It is also critical that stakeholders share an understanding of the problem the fund is addressing, the intervention logic and what constitutes success. Misalignment between investors, fund managers and investees can quickly erode trust, particularly where concessional capital is perceived to be subsidising private returns without sufficient public benefit (OECD, 2018; Convergence, 2023). Continuous engagement and transparency help sustain commitment over the life of the fund.

Agreement Structure

The agreement structure must anchor finance to a clear, defensible objective, such as investment in primary prevention, and specify how concessional capital will be deployed to absorb risk or accept lower returns. Explicit articulation of each stakeholder's financial exposure is crucial to avoid ambiguity around risk-sharing (OECD, 2018).

Alignment of incentives across stakeholders is particularly important. Long-term sustainability for investments made from the BFF, such as through a transition to domestic government funding or commercial sustainability, should be a credible long-term objective, supported by a clear exit or transition strategy for the investments from the reliance on financing from the BFF (Tonkonogy et al., 2021).

Agreements should also align with domestic and international law and incorporate shared monitoring and evaluation frameworks from inception, ensuring accountability and consistency throughout the fund's lifecycle (Global Impact Investing Network, 2020; OECD, 2023).

BFF summary

BFFs are best suited to geographic and clinical contexts where there are insufficient government funds or willingness to fund preventative interventions, or there are insufficient markets to supply and deliver preventative interventions. In these contexts, the

BFF will support in implementing preventative interventions that would not have otherwise been implemented in the short to medium term. Therefore, in these circumstances, the additional burden of establishing a BFF can be justified.

To ensure the BFF can achieve a longer-term shift in provision of preventative interventions, the motivations and goals of the BFF must be clear, and funds distributed to investments that support in achieving this goal. In addition, the effectiveness of blended finance depends on robust design, capable (government or independent) fund managers and alignment between public objectives and private incentives.

4.2 Social impact bonds

Overview

Social impact bonds (SIBs) are outcomes-based contracts where private investors pay upfront for an intervention, and are repaid by public-sector commissioners, only if the programme achieves the agreed upon outcomes. By sharing the financial risk with private investors and requiring robust outcomes measurement, they allow commissioners to pilot interventions, generate evidence on cost effectiveness and build confidence before committing to routine public service delivery (Ronicle et al., 2017; Fraser et al., 2023).

Additionally, SIBs bring together stakeholders who would otherwise operate in isolation, encourage integrated solutions in fragmented systems and increase visibility of under-funded issues by linking payments to outcomes, demonstrating potential impact and signalling public commitment (Ronicle et al., 2017; Fraser et al., 2023). Their novelty can also generate momentum, attracting support from investors for projects that, without the SIB structure would otherwise be overlooked. Furthermore, SIBs shift the focus from prescriptive delivery to agreed outcomes, allowing providers flexibility in how those outcomes are achieved (Fraser et al., 2023; Aarhus, 2021; Social Ventures Australia, 2025). This creates space for competition among providers, and naturally incentivises innovation in service delivery (Fraser et al., 2023; Aarhus, 2021; Social Ventures Australia, 2025). These features have made SIBs particularly relevant in areas such as prevention and interventions which target populations with complex, cross-sector needs where standard, rigid commissioning routes often struggle to secure or sustain investment.

However, these models also have limitations which must be considered before implementation:

- Attribution is a core challenge in outcomes-based contracts, particularly in complex systems such as healthcare with many interacting actors. This is compounded by the need to demonstrate progress within investor-relevant timeframes, leading SIBs to rely on intermediate or proxy outcomes while the full health benefits emerge over time. Establishing attribution in practice can therefore be difficult and requires sophisticated outcomes monitoring and payment frameworks.

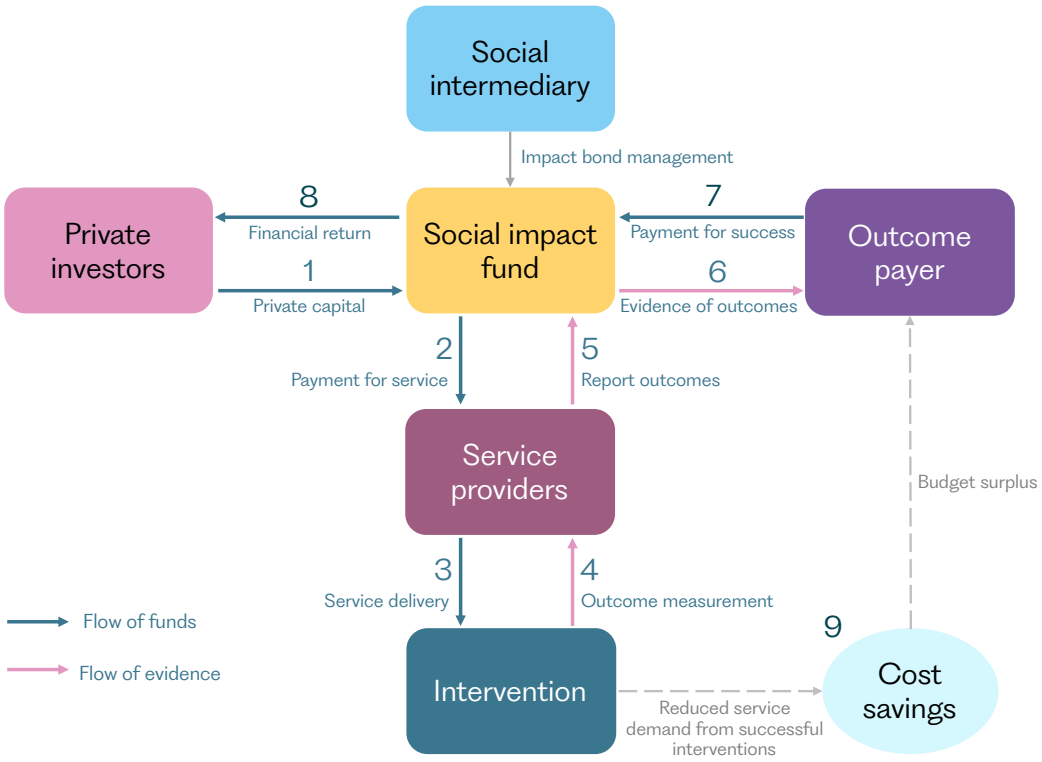
- The structural complexity of SIBs incurs significant transaction costs and can be time consuming to set up. As a result, they are only viable in contexts with sufficient infrastructure, technical capacity and political support.

- SIBs are typically used as pilots, with their value dependent on whether outcomes can be sustained in routine delivery. However, the dedicated project management and close performance monitoring that enable success within an SIB are rarely replicated at scale. It is therefore essential to design SIBs in the context of the wider healthcare system, with a credible pathway into mainstream commissioning from the outset.

SIB structure

Error! Reference source not found. depicts the financial and operational flows of a typical social impact bond contract used to fund a prevention service. A private investor provides capital (1) to a social impact fund managed by a social intermediary, which funds a service provider (2) to deliver the intervention (3). Outcomes are measured by the service provider (4) and reported to the intermediary (5) who verifies the results against pre-defined targets (6). If the targets are met, the outcome payer pays for success (7) and the investor receives returns above their initial investment (8) (Cabinet Office, 2010). These payments are typically made by public-sector commissioning authorities responsible for the outcome using existing budgets, justified by anticipated savings generated through reduced demand for future services, as a result of the intervention (9) (GOLab, 2025a; Fraser et al., 2023).

Figure 8 Structure of an SIB in healthcare



In reality, the design and implementation of individual SIB contracts can vary from the theoretical model, with differing levels of stakeholder complexity, payment triggers and returns structures (Fraser et al., 2023; GOLab, 2025a). There can be multiple of each type of stakeholder — private investors, service providers, outcome payers, and the role of the social intermediary can be distributed across multiple organisations to create a layered governance model rather than a single hub (Logue et al., 2025). Repayment arrangements also vary, for example the Auckland Mental Health SIB used differentiated investor risk classes, offering a 9% return to lower-risk investors and 17% for higher-risk investors (Hulse et al., 2021). Other contracts use tiered returns rather than flat repayments so that incremental performance gains are rewarded, for example the Ways to Wellness (Newcastle) SIB paid investors on a sliding scale — higher patient wellbeing improvements received greater returns (Ronicle and Stanworth, 2025) (**Error! Reference source not found.**). A particularly unique example which sits further outside the standard SIB configuration is the Zero HIV impact bond in London, where the Elton John AIDS

Foundation (EJAF) - a philanthropic organisation - acted as a co-payer alongside local government, providing a rare instance in which outcome payment responsibility extended beyond the government (Stanworth, 2024) (**Error! Reference source not found.**).

Global applications

We found evidence of 47 SIBs which have been launched in the health sector globally, however, uptake remains concentrated in HICs, with the majority of health-related SIB's having been conducted in the UK (Carter et al., 2024). Since pioneering one of the first health SIBs in 2015, 15 SIBs have been launched in the UK, 10 of which have been completed — accounting for 70% of all completed health SIBs worldwide (Carter et al., 2024). Eleven health-related SIBs have been launched in Japan, two of which have been completed, with 12 other countries launching a smaller number of health-related SIBs (Carter et al., 2024). The UK's experience reflects over 15 years of government investment through dedicated outcomes-based funds to support the development and scaling of SIBs. Together, these funds have provided £90million towards outcomes payments, effectively offsetting transaction costs and reducing financial risk for commissioners (DCMS, 2012, 2026). This enabling infrastructure means that the evidence base for SIB implementation remains largely UK based.

In LMICs, adoption of SIBs has been limited, with only one health related project recorded — in South Africa in 2023 (Carter et al., 2024). The extensive negotiation between commissioners, investors, and providers required to launch an SIB result in high transaction costs and complex legal structuring. This is a particular barrier for LMICs where limited fiscal capacity and data infrastructure make these challenges more pronounced (Centre for Global Development and Social Finance, 2013). As a result, alternative methods are needed to test and scale outcomes-based approaches in these settings.

DIBs offer a more viable alternative because they are funded by international donors such as philanthropic foundations, international governments or development agencies who act as the outcome payers rather than domestic governments (Centre for Global Development and Social Finance, 2013). DIBs typically fund interventions which target broader development goals (including interventions to increase access to essential services and health system strengthening) rather than specific health outcomes (Oroxom, Glassman and McDonald, 2018; Clarke, Chalkidou and Nemzoff, 2018; Centre for Global Development and Social Finance, 2013). Funders may choose to pay for a DIB when they want stronger performance incentives and independent verification of results compared to what a traditional grant would provide (Centre for Global Development, 2025). Their structure allows LMICs to pilot outcome-based approaches without bearing financial risk, helping to build local capacity (Centre for Global Development and Social Finance, 2013).

At least eight health related DIBs have been launched to fund interventions such as those tackling period poverty in Ethiopia, sexual and reproductive health services in Kenya, and maternal and newborn health in India (Carter et al., 2024). However, published evaluations of DIBs are uncommon, which makes it difficult to assess their effectiveness. They are likely to face the same barriers as SIBs with an additional challenge of accountability if donor priorities diverge from local needs. If outcome targets align with external development agendas rather than domestic policy goals, resources would be directed towards interventions that do not best serve the local population.

The case studies below illustrate how these models have been used in practice. We present two SIBs which were launched in the same health system but achieved different levels of success integrating the prevention programme into routine clinical commissioning, highlighting key features needed for effective implementation after the termination of the SIB (BOX 3 and BOX 4**Error! Reference source not found.**). BOX 5

describes a DIB and highlights the features of this model for consideration of implementation across different contexts.

Box 3 Ways to Wellness SIB

Context

In Newcastle (UK), high prevalence of long-term conditions such as diabetes and heart disease drives poor quality of life and above average reliance on sickness benefits. Social prescribing provides patients with non-clinical support services to increase wellbeing and self-management. However, it requires integrated care across community, hospitals and mental health teams which routine NHS funding does not support (Ronicle and Stanworth, 2015).

Launched in 2015, the Ways to Wellness SIB funded a social prescribing programme to overcome these barriers. Link workers connected patients to community-based services like exercise classes, volunteering, debt advice, and peer support (Ronicle and Stanworth, 2025).

SIB structure

Investment came from charitable foundations, banks, dedicated social investment funds and public sector pension schemes. Newcastle Clinical Commissioning Group (CCG) was the outcome payer, supported by fixed grants from the National Lottery and the Social Outcomes Fund — a central UK Government fund launched specifically for SIBs. Payments were triggered by a 22% reduction in secondary care costs or wellbeing score improvements (100% payment for 1.4-point increase, tapering to 0% below 0.5-points) compared to a matched cohort who did not receive the intervention (Ronicle and Stanworth, 2015).

Successes

The SIB raised £1.65 million, and collaboration between general practitioners (GPs), the CCG, voluntary organisations and investors was described as "unprecedented" (Ronicle and Stanworth, 2015). All outcomes targets were exceeded - wellbeing scores improved by 3.2 points and secondary care costs fell by 27% (GOLab, 2025c; Ronicle and Stanworth, 2025).

Challenges

- Complex contracting and cross-sector collaboration was resource intensive and time consuming to maintain (Ronicle and Stanworth, 2025).
- Designing outcome metrics to capture patient benefit and financial savings was difficult and ultimately some benefits (e.g. to primary care) were not measured or rewarded (Ronicle and Stanworth, 2015, 2025).
- During the SIB, the NHS introduced a separate link worker model which overlapped with the Ways to Wellness intervention, complicating the subsequent rollout attempt and reducing perceived need (Ronicle and Stanworth, 2025).
- Economic evaluations were limited to diabetes patients, only a subset of the total population targeted by the intervention and did not capture the broader value - for example to primary care settings and productivity gains for patients and carers. As a result, it was deemed not cost effective (Moffatt et al., 2023).

Learnings

- Developing an SIB is a complex process which requires a strong project management team and early involvement of procurement and contracting experts (Ronicle and Stanworth, 2025).
- Insights from expert interviews highlighted that not enough time was spent integrating the intervention into the existing system after the SIB was complete. As a result, it remained confined to a small subset of GP practices rather than being rolled out nationally. The limited integration coupled with entrenched deprioritisation of prevention meant it was too easy to cut funding when budgetary pressures increased.

Outcome

The project provided critical evidence that secured social prescribing's inclusion in the NHS Long Term Plan and, although Ways to Wellness itself was not rolled out nationally, it continues as an independent charity supporting the Newcastle area (Ronicle and Stanworth, 2025). It is currently funded through government contracts, grants and private donations (Charity Commission for England and Wales, 2025).

Box 4 Zero HIV SIB

Context

In 2015, Lambeth, Southwark and Lewisham (all districts within London) had the highest rates of HIV in the UK. To address this, extensive testing and proactive outreach to re-engage patients who had dropped out of treatment was required. However, commissioners responsible for testing were disincentivised from investing due to a fragmented funding system which meant the savings accrued elsewhere in the system. Moreover, constrained budgets could not accommodate the additional resources required to prioritise re-engagement activities (Stanworth, 2024).

To overcome these barriers, the Zero HIV SIB funded opt-out HIV testing in emergency departments, GP surgeries and community settings, alongside outreach programmes to re-engage patients who were 'lost to follow-up' i.e. had not received HIV care for more than 12 months (Stanworth, 2024).

SIB structure

Investment came from philanthropic sources, social investors and a private sector provider. Unlike most SIBs, the outcome payer was not only a government body but EJAF, a philanthropic foundation, supported in the early phase by the National Lottery. Payments were triggered when each new HIV case was identified and linked to HIV care, or when a patient 'lost to follow-up' was re-engaged in treatment (Stanworth, 2024).

Successes

The SIB provided a unified structure and aligned incentives across previously siloed NHS prevention, testing and treatment budgets. This was key to overcoming long-standing barriers to implementation, even though the effectiveness of the intervention was already well established (Stanworth, 2024).

£1 million was raised and outcome performance was strong enough for all investors to be fully repaid 12 months before the project ended, with over 250,000 tests completed, and 465 people entering or re-engaging with treatment (Stanworth, 2024).

Challenges

- NHS commissioners and local boroughs declined to fund outcomes, although they committed to contribute time and resources. As a result, the Elton John AIDS Foundation assumed multiple roles as co-commissioner and investor to ensure the SIB could be launched (Stanworth, 2024).
- Strict health sector governance required comprehensive data sharing agreements. While common in any collaborative project, the additional requirements of SIB outcome tracking made these more difficult to organise (Stanworth, 2024).

Learnings

- Branding the project as an SIB increased stakeholder engagement and momentum for the project that a conventional funding model may not have generated (Stanworth, 2024).
- Political advocacy was highlighted in an interview as a critical success factor for the adoption of opt-out testing beyond the SIB. The Elton John AIDS Foundation was an essential advocate and leveraged the global HIV eradication agenda to push for policy change.
- Commissioner buy-in must be secured early through contractual commitment, otherwise they may engage in discussions without agreeing to pay for outcomes (Stanworth, 2024).

Outcome

Sufficient evidence was generated to directly influence NHS England to fund opt-out testing nationally, and expand it to include other blood borne viruses (Stanworth, 2024).

The case studies show that outcomes depend not only on the quality of the intervention but on whether there is wider system support. Ways to Wellness delivered against its targets but integration into routine clinical practice was complex due to a parallel NHS programme and a narrow economic evaluation. In contrast, a key driver of success of Zero HIV was national policy, opt-out testing pathways and stakeholder advocacy which aligned with the SIB. These examples illustrate that, even when SIBs are well designed for their context, providers need to consider and be ready to adapt to the changes in the health system and political landscape for the desired outcomes of the intervention to be realised in the long-term.

Checklist for success

Through examining the lessons learned from real-world examples of SIBs used for preventative healthcare we developed a checklist for success. This checklist presents the factors required for implementation which policy makers should consider when deciding whether an SIB is appropriate in their context.

Figure 9 Social impact bond checklist for success

Intervention

- Credible theory of change linking activities to outcomes to secure initial investor buy in, evidenced where possible
- Specific target population
- Measurable outcomes that are attributable to the intervention, policy aligned and meaningful to commissioners

Systems

- Robust data systems to establish baseline service use, forecast uptake and predict appropriate outcome targets
- Data systems to track performance link verified outcomes to payments
- Supportive legal and procurement framework that enable flexible contracting and co-design

Stakeholders

- Robust data systems to establish baseline service use, forecast uptake and predict appropriate outcome targets
- Data systems to track performance and link verified outcomes to payments
- Supportive legal and procurement framework that enable flexible contracting and co-deign

Agreement Structure

- Relational contracting to structure agreements which emphasise collaborative relationships
- Opportunities for re-negotiation built into the contract for when unforeseen challenges arise

Intervention

We have not identified specific therapeutic areas or interventions that are uniquely suited to SIBs. Rather, the distinctive characteristics of these models — outcomes-based contracting and stakeholder collaboration — make them particularly effective for prevention interventions, where barriers to investment are especially pronounced. In these contexts, SIBs help overcome challenges such as fragmented budgets, delayed realisation of benefits and lack of visibility of impact. The following list of attributes highlights where an SIB is more likely to be justified.

The intervention faces structural barriers that traditional commissioning has struggled to overcome. SIBs offer a potential solution in populations with complex or cross-sector needs who often fall outside standard commissioning routes, or preventative interventions where multiple barriers impede funding (Fraser et al., 2023; Aarhus, 2021; Ronicle and Stanworth, 2025; Social Ventures Australia, 2025). Individuals at risk of chronic disease or living with long-term physical or mental health conditions often have needs spanning multiple services which traditional 'one size fits all' care pathways cannot accommodate. By shifting payment based on prescriptive delivery to agreed outcomes, SIBs allow providers flexibility in how those outcomes are achieved, enabling them to tailor support for individuals and naturally incentivising collaboration across otherwise fragmented health services (Fraser et al., 2023; Aarhus, 2021; Social Ventures Australia, 2025). Similarly in prevention, the impacts of an intervention can span multiple sectors and there are few incentives to encourage cross sector collaboration or cost sharing to fund these (Alami et al., 2023; Wouterse, Santos and Hiligsmann, 2025b). SIBs can overcome this barrier of siloed budgets, while also making the value of prevention visible, removing short-

term pressure and protecting funding from reallocation to acute care under budgetary pressures.

The intervention has a credible evidence base and is supported by a clear theory of change. Commissioners and investors must have confidence that the intervention activities will produce the agreed outcomes because returns depend on demonstrable results (Ronicle et al., 2017; Fraser et al., 2023). Although SIBs are often framed as mechanisms for innovation, they depend on a sufficient foundation of evidence to attract risk-bearing capital. In practice they are better suited to scaling or adapting interventions with demonstrated effectiveness than for testing highly experimental approaches where risk of failure is high (Olson et al., 2024).

The target population is clearly defined and individually trackable. SIBs depend on identifying participants, monitoring outcomes at the individual level and linking these outcomes to payment triggers. They are most effective for defined cohorts that can be identified, tracked and whose behaviour can potentially be changed within a reasonable time frame (Ronicle et al., 2017; Fraser et al., 2023).

Outcomes are aligned to policy priorities. Alignment to policy priorities is important so that outcomes are meaningful to commissioners and relevant to wider system goals. Projects that meet these criteria are more likely to demonstrate value and therefore influence future commissioning (Fraser et al., 2023).

Outcomes are measurable and attributable using validated indicators. Repayment depends on performance so outcomes must be clear, measurable and attributable to the intervention to maintain accountability and avoid disputes over payments (Ronicle et al., 2017; Fraser et al., 2023). SIBs work best when intermediate outcomes (e.g. service engagement, reduced hospital admissions etc) are strong predictors of long-term impact and can be observed over a shorter time frame (Ronicle et al., 2017).

Systems

Robust data infrastructure, forecasting and outcomes measurement capability. Before implementation, data are needed to establish baseline service use and forecast uptake to set realistic outcome targets (Ronicle et al., 2017). If targets are too low, commissioners risk paying for outcomes which add little value, if set too high, outcomes may not be met and investors will lose confidence in repayment (Ronicle, Stanworth and Sasse, 2025). During service delivery, data systems must track performance and link verified outcomes to payment mechanisms in a transparent way to ensure accountability (Fraser et al., 2023). Reliable data is needed across both phases for the SIB to demonstrate value and secure stakeholder trust.

Procurement and legal frameworks allow flexible, negotiated agreements. SIBs rely on early collaboration between stakeholders to co-design outcome metrics and delivery models. This requires procurement processes that allow flexible contracting and negotiation (GOLab, 2023; Fraser et al., 2023). In addition, legal frameworks must permit public bodies to engage with private investors and outcomes-based payments without restriction, so that organisations with interest and capacity can participate fully in the design, funding, or delivery of the SIB (GOLab, 2023; Aurisicchio, 2019). In Buenos Aires for example, rigid public bidding rules and tax regulations prevented non-governmental organisations (NGOs) becoming social investors which reduced the pool of available funds and complicated the launch of the SIB (Aurisicchio, 2019). In contrast, in the UK, dedicated government initiatives such as the Outcomes Fund and the Life Chances Fund provide grants to launch SIBs, creating an enabling environment for SIB development (GOV.UK, 2012; DCMS, 2026).

Stakeholders

Strong commissioner leadership and continuity. Commissioners play a central role in maintaining coordination and supporting collaboration between providers, investors and intermediaries. When they leave or lose confidence in the project, SIBs can stall or collapse (Ronicle et al., 2017; GOLab, 2025a).

Stakeholders have a shared understanding of the problem and intended outcomes. Alignment around goals reduces the risk of fragmentation and helps to sustain collaborative partnerships (Ronicle et al., 2017; GOLab, 2025a; Fraser et al., 2023).

Technical expertise and organisational capacity for financial modelling, contracting and performance management. SIBs have complex contractual requirements so knowledge and experience in the contracting, financial modelling, and performance management are vital (Ronicle et al., 2017; Fraser et al., 2023). Sustained administrative effort is also required to support the multi-stakeholder governance structures, performance management and adaptive contracting. Without this administrative and technical capacity, projects struggle to design workable agreements or manage delivery and often fail to launch (Fraser et al., 2023).

Agreement Structure

Capacity to sustain relational contracting. A successful SIB relies on shared responsibility and trust between stakeholders. Relational contracting is a way to structure agreements which emphasise strong, collaborative relationships and are critical to balance learning with accountability (GOLab, 2025b). In practice, mechanisms for re-negotiation are built into the contract for when unforeseen challenges arise, stakeholders are expected to work together to find solutions rather than defaulting to penalties for under-performance, as in traditional contracts (GOLab, 2025b). Experts involved in the Ways to Wellness SIB commended this approach because it supported open communication and the ability to adapt while the SIB was ongoing to sustain collaboration.

Box 5 Kangaroo Mother Care DIB

Context

Cameroon experiences high infant mortality and morbidity due to low birth weight. Kangaroo Mother Care (KMC) is a WHO-recommended health practice for low birth weight and preterm infants which involves skin-to-skin contact, exclusive breastfeeding, and early discharge with follow-up (GOlab, 2022; Social Finance, 2022).

Cameroon lacked the infrastructure, management systems and training to implement KMC effectively so used a DIB to finance the roll-out in 10 hospitals and test viability at scale (GOlab, 2022).

Structure

Investment was provided by a philanthropic organisation called Grand Challenges Canada. The outcome payer was a global development partner called Nutrition International. Outcome payments were made based on the number of hospitals that successfully provided KMC, the number of infants receiving care before discharge, and follow-up outcomes at 40 weeks (GOlab, 2022).

Successes

Investment raised by the DIB was used to equip 10 hospitals and train 47 neonatal clinicians and 121 community health workers. Quality KMC was delivered to 1,221 babies, exceeding the target by 28%.

Learnings

- A steering committee with one representative from each stakeholder group was key for flexible governance, it enabled efficient decision making, issue resolution and contract updates (Social Finance, 2021).
- Data systems must fit into existing workflows to be sustainable and service delivery teams need to have data management experience, not just clinical expertise. Data capacity should be a consideration from the start and ongoing training should be provided to ensure consistent data collection (Social Finance, 2021).
- Outcome metrics should reflect real-world delivery and avoid over optimistic targets. Using sliding scales or tiered targets can introduce flexibility, rewarding incremental progress and helping to ensure that good performance is still recognised even if the ideal outcomes are not achieved (Social Finance, 2021)

Outcome

Three centres of excellence were established, alongside a pool of certified trainers and KMC practices are now integrated into Cameroon's health system (Social Finance, 2022).

SIB summary

The evidence on SIBs and DIBs shows that they are best suited to interventions with a credible evidence base, where benefits span multiple budget holders and where commissioners need risk transfer before committing to routine funding. These features align closely with the needs of prevention financing; they help to align incentives, bridge budget siloes, and demonstrate short-term, tangible impact. However, their complexity at every stage, from design and implementation to integration into mainstream commissioning creates high transaction costs which mean they are not a universal solution. Instead, they offer a targeted method for catalysing change which is most successful when supported by strong advocacy, institutional capability and sustained political or donor commitment.

5 Summary of findings

Prevention delivers substantial health and economic returns yet remains chronically underfunded across health systems globally. This is driven by four universal barriers borne from the misalignment between the characteristics of prevention and existing governance and financing systems. Prevention generates long-term benefits, but political and budgetary cycles are short and reward immediate results. Benefits are also far reaching, often spanning multiple societal sectors yet funding structures are organised in silos which creates misaligned incentives. Success is defined by the absence of illness, which makes outcomes difficult to measure and attribute, and because acute care is more visible and politically salient, it is consistently prioritised over prevention. Although a range of funding models exist that could help to overcome these barriers, they are rarely implemented effectively and underinvestment in prevention persists.

In this research we have identified financing mechanisms both within and outside traditional healthcare funding methods. Categorised as either protecting, growing or diversifying funding, these approaches must not be considered as sequential, and are most effective when used in combination. Protecting prevention budgets can stop further erosion but cannot close the funding gap if the baseline investment is already insufficient. Growth mechanisms can expand funding but without protection they remain vulnerable to reallocation when budgetary pressures increase. Diversification can bring in new sources of capital, but without protection and growth, these will replace rather than supplement existing investment. Real-world implementation should therefore use a combination of models, adapted to local contexts, to strengthen and sustain funding for prevention.

There are important trade-offs to consider when selecting financing mechanisms to be used because different models address different parts of the prevention funding problem. Simpler approaches such as ring fencing and investment standards are easier to implement and can be integrated into existing processes with minimal additional capacity, but they address a narrow set of barriers that constrain funding. More complex models such as SIBs and BFFs can address multiple barriers simultaneously because they create measurable outcomes, align incentives and mobilise new sources of capital. However, they also impose substantial institutional and administrative demands which limits their feasibility in many settings.

Furthermore, it is important to recognise that even when deployed effectively, innovative financing models do not resolve the underlying structural causes of underinvestment. While mechanisms such as SIBs can temporarily engineer cross-sector collaboration and incentive alignment, these are tied to contractual arrangements and are short-lived by design. Even if an intervention is routinely commissioned after a successful SIB, the system itself is not redesigned so political short-termism, siloed budgets and bias towards acute care remain as barriers. BFFs can provide a platform for sustained long-term investment in a broader range of investments that support the prevention agenda. However, their reliance on concessional capital can leave the funds vulnerable to shifts in political motivations. Long-term progress therefore depends on structural reform and shifts in political and public attitudes. These financing models can be considered a bridge to acquire funding for specific goals, but do not change the factors shaping wider prevention funding.

5.1 Funding for the new age of prevention

A sustainable approach to prevention financing requires selecting a combination of mechanisms that are most appropriate for local contexts and for preventative interventions that are determined to be of value in their context. Policy makers should first

identify the most prominent barriers to investment and use the findings in Chapter 3 of this report to determine the funding models that overcome these. Before implementation, consideration must be given to the merits and disadvantages of each approach, balancing the number and type of barriers overcome against the institutional capacity required for effective implementation.

In most countries, protect and grow mechanisms will form the foundation of any prevention financing strategy. These are relatively simple to adopt compared to diversifying options and in many countries can be embedded within existing budgetary processes with limited additional institutional capacity. Although they address a narrow set of barriers, they have the potential to increase the baseline level of investment and, through ensuring any of the funds raised through the grow mechanisms are in turn protected, reduce the risk of future displacement.

Diversification mechanisms should be considered where protect and grow approaches are insufficient to address the critical barriers. This is most likely where cross sector incentive alignment is the key constraint, where further evidence is required before broader investment can be justified, or where substantial capital from additional sources is required to fund interventions due to insufficient political willingness to pursue protect and grow approaches. These mechanisms can address barriers that simpler tools cannot but are operationally demanding and resource intensive. They must be designed with sustained implementation in mind. As outlined in the checklists for success in Chapter 4, their effectiveness depends on specific enabling conditions. If these are not in place, these more demanding mechanisms are unlikely to deliver their intended impact.

Consideration should also be given to the funding landscape as a whole. Looking beyond funding for individual preventative interventions, each clinical or geographic context needs an overarching approach that takes clear ownership of funding prevention. This unified, long-term commitment could be delivered through a government ring-fenced fund, a BFF, or a combination of both, depending on local circumstances. In many settings, however, reaching that position will take time — and shorter-term funding models will be needed in the interim to build the evidence base, stakeholder buy-in, and capital required to sustain prevention funding over the long term.

5.2 Next steps

Future work should consider both the effective use of existing models and build upon this research to support successful implementation of funding mechanisms that diversify funding. Strengthening the evidence base for innovative mechanisms is essential as they have the potential to overcome multiple entrenched barriers to funding. BFFs for prevention are particularly underexplored despite their theoretical potential to mobilise additional investment, and while SIBs remain the most documented, there is a lack of practical tools to support effective implementation. Detailed, step by step guides with adaptions to a range of country and health system contexts could support wider adoption of these methods.

To support future use of funding mechanisms that protect and grow existing sources of funding, further work is needed to address underlying structural barriers to funding to enable sustained investment in prevention. This includes developing mechanisms to realign incentives and enable joint commissioning across sectors so that costs are distributed equitably across those who receive the benefits. Furthermore, although this research has intentionally focused on the supply-side barriers, demand side factors merit dedicated future analysis. Increasing the supply of prevention interventions does not guarantee uptake, therefore, understanding public attitudes and behavioural drivers is necessary to ensure funded interventions are able to deliver their intended impact.

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