Growth and Reform Network

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# Power to Prevent

International lessons on regional funding models for prevention



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Full responsibility for the report and its content remain with the authors.

# About the Growth and Reform Network

The Growth and Reform Network is a partnership between The Future Governance Forum and Metro Dynamics working to support local and combined authorities in driving inclusive growth and public service reform.

Our mission is to bridge the gap between national policy and delivery in local and regional places. We bring together mayors, councils and government to develop the innovative ideas, policy and practice that deliver better services, invest in places and drive good growth.

At the heart of this mission is supporting innovation to increase the trend rate of growth, create better jobs and opportunities for people all over the UK, and improve public service outcomes. The Network exists to support devolution to achieve its full potential, with a more preventative and productive model of local growth and public service delivery.

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# About the Health Foundation

The Health Foundation is an independent charitable organisation. Our mission is to build a healthier UK by putting health and inequalities at the heart of decision making, shaping the future of the health and care system to ensure the best care for all, and building new approaches to testing innovation that could transform health and care.

# 1. Executive Summary

In his Budget on 28th October, the Chancellor put prevention centre stage. "Just as we ringfence capital spending to invest in future success," he told the House, "so at the next Spending Review I will ringfence prevention spending that brings down costs in the future."

This is a welcome step forward. Protected prevention budgets were first proposed by The Health Foundation and Demos[1], and have since been backed by the Institute for Government[2], CIPFA[3] and others[4,5]. Too often, spending that stops problems before they start loses out to the pressure created by today's crises and the need to act now.

But a ringfence is only the beginning. Important questions remain about how PDEL will work in practice and in the context of England's expanding devolution agenda to enable a meaningful shift towards prevention in places.

In considering how to make a reality of prevention at regional and local levels, this research highlights the need for a common definition of prevention, a baseline of current spend, and a way to track the impact and dividends it delivers. These will all be important considerations for PDEL to be a success. In the spirit of devolution and the mission to rewire the state, local and regional government must work hand-in-hand with Whitehall to define prevention budgets and what they should deliver in every type of place, from city regions to coastal towns and those in rural communities.

This report focuses on the funding and governance arrangements that can enable and incentivise a shift to prevention. It distinguishes between funding mechanisms and the conditions that make them work, drawing lessons from both.

There are three key windows of opportunity. In terms of policy, there is a national interest in prevention with recognition of the limitations of reactive and siloed funding models. Institutionally, the expansion and deepening of devolution to Mayoral Strategic Authorities (MSAs) in England, including the development of Integrated Settlements, creates new opportunities for more coordinated approaches to funding and delivering prevention. Finally, MSAs are increasingly working in the area of prevention and there is appetite to learn about what works practically.

To inform this discussion, this report examines 11 international case studies (listed below), grounded in peer- reviewed research and practitioner insight. You can read in detail about these approaches later in the report, from community regeneration in Catalonia, to addressing the housing challenge for veterans in the United States, to the most developed prevention funding strategy currently in operation, in the State of Victoria, Australia.

By looking at what works already, this report puts forward seven recommendations to create the conditions needed for a fiscal system that enables prevention:

### 1. National government must enable and incentivise prevention and system reform

In order to drive a shift to prevention at scale, there should be incentives for places to innovate and redesign public service delivery. Scaling prevention requires enabling conditions such as accountability arrangements and committed funding over longer periods which may require changes to national systems.

This should include multi-year funding settlements, accountability arrangements that prioritise long-term outcomes and system adaptation, and a collaborative approach to PDEL budget setting.

Government should reward places for building prevention capability, not only for short-term outcomes. Funding could be released in stages, as in New York's DSRIP programme, so that agreed capability milestones are supported first and subsequent funding is released against outcomes as regions start to deliver these. This process would incentivise a measured shift in budgeting and delivery which would account for the varying maturity of regional authorities to deliver prevention interventions and savings.

## 2. Agree how costs, risks, and gains will be shared

There must be a clear mechanism for places, as well as central government, to benefit from cashable savings, avoided costs and capacity gains realised through the impact of prevention work at local, regional and national levels, as well as how risks will be mitigated.

Central government must be party to these agreements because many gains fall to national budgets: in the Nurse-Family Partnership, less than 1% of estimated avoided costs to government fell directly to the health service concerned with delivery. In most cases the gain will be a reallocation of resources rather than lower overall spending. While recent signals from government on fiscal devolution have been encouraging, there is much less discussion of how effective reallocation of resources might be assigned. Clear agreements on how this will work is essential and should be addressed quickly, including through the spending review process in 2027.

## 3. Identify prevention spend and measurement using shared definitions and guidelines

Without understanding what prevention spending is, and an idea of its current baseline, further shifting towards up-stream preventative strategies with greater impact will be difficult. Identifying prevention spend and adopting a common definition helps to uncover opportunities and encourage dialogue on what more can be unlocked and how local, regional and national budgets may be used flexibly.

CIPFA and the Health Foundation have begun work to explore the extent to which council spending on prevention can be quantified[6]. This work aims to build a shared definition of preventative activity which can be used to map against current services and identify current levels of spending from which any shift can be measured.

## 4. Invest in collective case making for prevention

A shared commitment to case making for prevention is vital. This means local, regional and national levels working together - not just to agree and deliver on policy, but to develop the specific criteria, processes and individual investment cases for prevention activity. National, regional and local government should build investment cases for prevention together.

In practice this means a joint unit with a shared model of avoided costs (as the case study from Victoria's Treasury sets out), a standard case template or understanding of the aspects of prevention case making, data-sharing agreement(s) locked in before cases are built, agreements between the specific bodies that pay for and benefit from prevention, and independent checking of whether savings have been realised as predicted. This approach goes beyond national-regional cooperation and establishes a clear set of governance and a specialised function to develop effective prevention.

## 5. Align budgeting processes with devolved responsibilities and place-based delivery

Regional devolution presents an opportunity to shape successful prevention strategies that meet place-based needs. This includes flexibility, in some cases significant-to-full autonomy over health and prevention-related budgets, as well as supported and coordinated approaches to place-based measurement and evaluation.

Devolution helps prevention only if places can pool budgets across services, understand local need, and are accountable for outcomes. Budgeting should move from competitive bidding and small ringfenced pots to larger and more flexible integrated settlements, with national-regional co-funding arrangements that reflect places' differing fiscal capacity.

## 6. Broaden the range of funding typologies used at the place level

There are several typologies of prevention funding, including those which are under-utilised within the UK. Approaches such as the blending of departmental funding, the integration of philanthropic funding, and mechanisms such as impact bonds, can bring new funding sources.

More capital and revenue is needed within the system, and places should be proactive in using their convening powers - particularly through Mayors - in order to encourage a greater range of funding sources into prevention strategies. The concept of ‘glue money’ - enabling finance to build networks and explore wider resources - should be used to help pursue this new funding and local capability.

Alternative finance should add to, not replace, sustained core public funding. New and growing sources of funding such as philanthropy, impact bonds and targeted borrowing, can help to test ideas and bring capital forward, but the revenue to run preventative services over the long term has to come from mainstream public budgets.

## 7. Trust and train communities to shape prevention funding and priorities

Communities appear to intuitively support prevention strategies when given meaningful influence over priorities and delivery if given the resources and opportunities to be able to do so. Residents should be involved early, when priorities are being set, as in Edinburgh's Regenerative Futures Fund.

In this report we draw on the following examples:

- Early Intervention Investment Framework, Victoria: builds prevention into the state's annual budget,
- Transformation Space, Clackmannanshire: pooled public and philanthropic funds to address locally identified problems,
- Regenerative Futures Fund, Edinburgh: a 10-year pooled public and philanthropic fund to tackle the root causes of poverty, racism, and climate change in local neighbourhoods,
- HUD-VASH, USA: housing vouchers and clinical support for veterans coordinated through an agreement between two federal departments,
- Prevention Initiative Demonstration Project, Los Angeles: foster care funding redirected to community prevention networks,
- Health Circles, Germany: workplace prevention funded by health insurers and employers,
- Neighbourhoods Law, Catalonia: regional and municipal co-funding of neighbourhood renewal,
- Conditional Cash Transfers, New York: a philanthropically-funded cash transfer pilot to encourage preventative health, employment, and education,
- Stevig Staan (Standing Strong), Netherlands: a Dutch health impact bond for falls prevention,
- Nurse-Family Partnership, USA: home visiting for new mothers funded by blending existing public funding streams,
- Delivery System Reform Incentive Payment, New York: made Medicaid payments conditional on providers redesigning health and care strategy and delivery.

The following diagram shows the case study evidence, key findings, and recommendations. These are expanded in further detail in the report, with full findings, recommendations, and risks in the conclusion.

| CASE-STUDY EVIDENCE | FINDINGS | RECOMMENDATIONS |
|---|---|---|
| **Catalonia** ran multi-year neighbourhood renewal; **Nurse-Family Partnership** uses a defined 2.5-year home-visiting period with longer-term follow-up; **Edinburgh's RFF** is designed as a ten-year fund; **Victoria** embeds proposals in the annual mainstream budget process. | **LONG-TERM FUNDING**<br>Preventive change often takes time to assess and see success. Multi-year financing with routes into mainstream budgeting can give time for changes to embed. | R1<br>**National government must enable and incentivise prevention and system reform.**<br>These changes require enabling conditions such as accountability and funding arrangements which may require changes to national frameworks. Places should be incentivised to innovate and redesign public service delivery. |
| **HUD-VASH** pairs two agencies, HUD for housing vouchers and VA for case management; **Health Circles** combine sickness-fund and employer roles; **Catalonia** uses regional–municipal match funding. | **SHARED FINANCIAL RESPONSIBILITY**<br>Costs, delivery, risks and benefits cross organisational boundaries. Contributions, accountability and risk need to be explicit. | R2<br>**Agree how costs, risks and gains will be shared.**<br>Agree who contributes resources, delivers, benefits, and carries risk, specifying how cash savings, avoided costs, released capacity, and wider outcomes will be measured and used. |
| The **LA PIDP** evaluation resulted in an extension to the programme; **Stevig Staan** clearly stated the intended measurable outcomes from the outset; **Edinburgh's RFF** is working with a learning partner for evaluation and transparently provides updates on their website; **Victoria** builds in measurement to proposals and Victoria's Auditor General reviews progress overall. | **MEASUREMENT AND EVALUATION**<br>Prevention is difficult to measure but evidence of success can unlock new funding, share valuable lessons with other places, and ensure agreed gains and risks are fair. | R3<br>**Identify prevention spend and measurement using common definitions and guidelines.**<br>Identify prevention spend and adopt a common definition to help uncover opportunities and what can be unlocked in local, regional and national budgets. |
| **HUD-VASH** has a clear objective of ending veteran homelessness and supports cross-agency commitment; **Victoria** uses collaborative development of investment cases indicating government backing to the prevention agenda; **Clackmannanshire Transformation Space** developed a shared local vision and resident-led priorities help build ownership; **NYC Conditional Cash Transfers** were renewed with mayoral support. | **A CLEAR, COMMON NARRATIVE**<br>A clear message about what prevention activity aims to achieve, and why it matters, can build buy-in from political leaders, delivery partners and the public. Connecting a shared purpose to local priorities helps sustain commitment. | R4<br>**Invest in collective case-making for prevention.**<br>Collaboratively build cases across national, regional, and local government including across services, delivery partners, and communities. |
| **LA PIDP** funded community networks and relationships through 'glue money'; **DSRIP** built provider coordination and data capability; **Victoria** supports joint investment case-making between departments and the Department of Treasury and Finance. **Edinburgh's RFF** and **Clackmannanshire's Transformation Space** also resonate with this approach. | **INVEST IN ENABLING CAPACITY**<br>Analytical and finance skills, relationships, data-sharing, partnership management and learning are essential delivery infrastructure. 'Glue money' can be used to provide necessary support, relationship-building, and training. | R5<br>**Align budgeting processes with devolved responsibilities and place-based delivery.**<br>Regional devolution can shape prevention strategies that meet place-based needs but they must have the capacity and capability to meet these responsibilities. |
| **LA PIDP** combined targeted funding and ring-fenced Title IV-E waiver reinvestment to build community networks; **Nurse-Family Partnership** blended eligible public funding; **NY DSRIP** used incentives for provider-network redesign. | **FLEXIBLE USE OF EXISTING RESOURCES**<br>Joining up or redirecting resources can connect services and enable redesign in the short-term. This is not the same as net new funding or a demonstrated system-wide shift upstream. | R6<br>**Broaden the range of funding approaches used at place level.**<br>Use pooled, matched, blended, philanthropic, outcomes-based, and mainstream funding where appropriate. Use 'glue money' to build capacity. |
| **Clackmannanshire's Transformation Space** gives residents a role in choosing projects; **Edinburgh's RFF** involves residents with lived experience in fund allocation and supports them to do so; **Catalonia** used neighbourhood bids and local committees; the **Health Circles** involved employees in identifying workplace risks and solutions. | **COMMUNITY PARTICIPATION AND POWER**<br>Evidence suggests communities often intuitively support prevention strategies. Participation matters when residents can influence priorities and implementation, and have the support to take part. | R7<br>**Trust and train communities to shape prevention funding.**<br>Give residents power in shaping prevention priorities, funding and implementations. Support participation through training and access to opportunities |

Figure 1. Case studies, findings and recommendations

# 2. Context and Defining Prevention

Prevention as a term is widely used to describe activities that are designed to stop problems from forming, reduce their severity, or prevent them from recurring. There is difficulty in funding prevention work at large scales for several reasons: funds are being prioritised to acute services, the organisation paying may not be the one to receive the benefit, the results often emerge over many years, departments often work in silos with little collaboration, and inconsistent evaluation can make monitoring challenging.

The UK policy context is shifting. In the Autumn 2026 budget it was announced that in the next spending review, the government will introduce a new category of ringfenced preventative spending (PDEL), protecting programmes that generate long-term benefits and address problems before they escalate[7]. This builds on the momentum of England's 10 Year Health Plan which prioritises prevention[8], Greater Manchester being designated as the UK's first Prevention Demonstrator, and the English Devolution and Community Empowerment Act 2026 introducing the Statutory Health Duty putting more responsibilities on Mayoral Strategic Authorities (MSAs) to improve regional health outcomes. Alongside this, more power is being given to local leaders; the July 2026 Rewiring the State statement[9] supports place-based empowerment, and the government has announced plans for every MSA to receive greater business-rates retention from April 2027 and a share of local income-tax revenues from April 2028[10].

The Prevention Demonstrator can act as a practical test bed for this report's conclusions. It can provide an example of which of these mechanisms can be achieved within existing devolved powers and the Integrated Settlement, and which require changes from national government through the Spending Review and further devolution. Equally, there are also lessons in this report that can be applied to places who are still in the earlier stages of developing their prevention strategies and are looking to places nationally, such as Greater Manchester and Scotland, and internationally, to learn from.

This report builds on the Growth and Reform Network and the Health Foundation's earlier review on socioeconomic interventions and preventative health outcomes[11]. It examines international funding mechanisms and governance structures in selected case studies, including from Australia, the United States, Germany, the Netherlands, and Scotland, and what we can learn from this in an English context.

## What is meant by prevention

In this report we use prevention to mean activity that reduces, prevents, or delays severity of future demand for reactive activity, and reduces the likelihood of poor outcomes and harm from occurring, worsening, or recurring. Such activities can target the wider determinants of health including (but not limited to) housing, employment, education, transport, and the local environment, as well as early intervention to prevent repeat crisis. The case studies illustrate different pathways of achieving this. For example, Catalonia's Neighbourhoods Law funded improvements to housing, public spaces, and mobility; Germany's Health Circles aimed to improved workplace health and safety, including psychological risks; The Netherlands Stevig Staan programme aimed to reduce and prevent falls in the elderly population; The Los Angeles' Prevention Initiative Demonstration Project funded community networks to strengthen access to family services and improve the welfare of children and pregnant women.

Prevention does not necessarily mean cash savings, nor should that be the only reason for implementing it. Returns may include: freeing up resources to be able to allocate them more effectively; avoided future costs; increased capacity (e.g. free hospital beds, caseworker time); wider social and economic outcomes such as improved health outcomes, educational attainment, and better employment.

In this report we use three terms consistently: **cashable savings** are reductions in budgeted spend, which can be withdrawn or reallocated; **avoided costs** are future spending that would otherwise have occurred; and, **released capacity** is staff time or resources such as beds and appointments freed up for alternative use.

## A spectrum of prevention

The following table sets out how prevention is considered in this report. It is a working framework that also acknowledges that not every activity fits neatly into one category.

| Type | Examples |
|---|---|
| Community resilience / upstream | Addresses wider determinants and underlying risk factors. This may include: housing quality; income security; access to green space; community connections; education; employment pathways; healthy workplaces |
| Emerging need / early intervention | Responds when risks or difficulties begin to emerge, preventing them from escalating. This may include: family support; targeted home visits; fall risk screening and support; help as risks emerge |
| Crisis response / stabilisation and prevention of recurrence | Responds to an existing or recent crisis to stabilise the situation and reduce the likelihood of the problem recurring. This may include: housing support with clinical coordination; action to avoid repeat hospital admittance; interventions to prevent re-referral to child welfare |

Table 1. Prevention typology

# 3. Introduction

Short-term budget cycles, the prevalence of budget management over investment mindsets, the difficulty of connecting whole-budgets across departmental and organisational silos, the challenge of capturing value and impact in prevention reporting, and the historic lack of place-based mechanisms of accountability and planning are all factors that have meant prevention funding has struggled to keep pace with societal need. This report focuses on regional funding and governing mechanisms that enable a shift towards prevention and relevant lessons for places with greater devolution in England.

CIPFA (the Chartered Institute of Public Finance and Accountancy) and other bodies have consistently argued that the UK's public finance system that is based on siloed budgets, short-term funding arrangements, and fragmented accountability can undermine prevention investment[12]. Throughout current approaches to public service reform, local government finance, health integration, and place-based budgeting, it is broadly considered that preventative activity is chronically underfunded and that current funding and accountability system rewards short-term activity rather than long-term outcomes. This report is timely in the wake of the 2026 Budget where it was announced that in the 2027 Spending Review prevention funding will be ringfenced.

The Scottish Government is currently making strides in its prevention agenda, having set up a prevention unit[13], and is piloting a tool to enable the tagging of prevention spending. The tool will categorise spending as primary, secondary, and tertiary prevention. The aim is to retrospectively tag the 2025-26 Scottish Budget to understand how much money is currently being allocated to prevention, and then ensure more spending is going to prevention in future budgets[14].

Rather than re-litigate the current challenge of prevention funding in the UK context, we have examined examples from across comparable countries that have a novel approach to funding, drawing out transferable lessons for overall system approaches that enable and incentivise the shift towards prevention.
This paper responds to three key windows of opportunity:

Policy: Nationally there is interest in prevention, public service reform, and inclusive growth with an increased recognition of the limitations of reactive and siloed funding models. The NHS (and its 10-Year Health Plan) and wider public services are entering a renewed phase of reform with prevention positioned as central to long-term sustainability and population outcomes.

Institutional: The expansion and deepening of devolution to Mayoral Strategic Authorities, including integrated settlements, is continuing. As MSAs assume greater control over funding and delivery, questions over how devolved funding models could best be operationalised for preventative approaches has become more pressing.

Practical implementation: MSAs are increasingly working in this area and there is an appetite to learn from what works, both in English and international settings.

## Research questions

This research is organised around three research questions:

- RQ1: What funding mechanisms accompany sustained investment in prevention in places?
- RQ2: How are savings captured, shared, and reinvested?
- RQ3: What governance and accountability arrangements support preventative budgets?

## Methodology

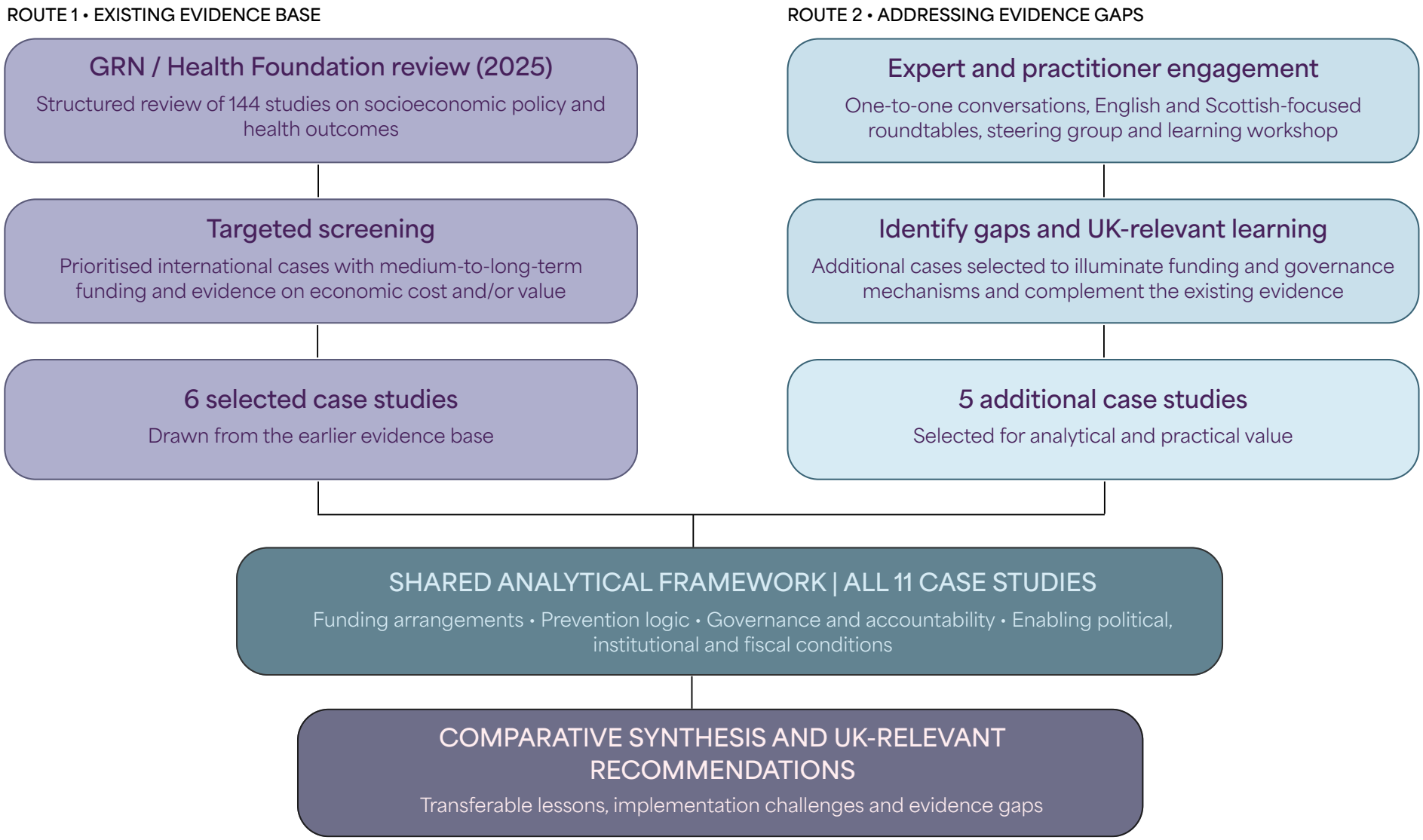
This report draws on 11 purposively selected international case studies of prevention initiatives informed by desk- based research and engagement with experts and practitioners. It builds on an earlier Growth and Reform Network and Health Foundation structured evidence review[15] which synthesised evidence from 144 studies from high-income countries on how socioeconomic policies shape health outcomes. An additional five case studies were identified through expert discussions to address gaps in the evidence and provide further insight on funding and governance mechanisms relevant to England.

This report is not intended to be a systematic review of all international prevention models, and the case studies are not a representative sample. The cases were selected to inform comparative learning and offer illustrative examples of different approaches to funding and governing prevention, as well as some of the opportunities and challenges they present.

In alignment with the previous evidence review, this report adopts a broad understanding of prevention, acknowledging that socioeconomic policies can improve health, even when that is not the primary or intended purpose. Employment, housing, education, and the built environment, for example, can influence the wider conditions that shape health and wellbeing. This approach reflects an understanding that to embed prevention work requires a system-wide shift that goes beyond health policies exclusively.

For the six case studies chosen from the previous evidence review, the selection process prioritised interventions outside the UK, with a medium-long term funding timeline, and studies that reported economic cost or value. When reviewing the evidence, we ensured that there was clear information on what the intervention was, what the outcomes were, and the funding and governance mechanisms. The examples were chosen because of the useful lessons they demonstrated, not because they had necessarily demonstrated success in their outcomes. The five additional examples were assessed using the same overarching approach. Across all cases, the analysis examined the nature of each intervention, its outcomes, funding arrangements, governance mechanisms, and the political, institutional and fiscal context.

In addition to the desk-based case study research, we consulted with a range of expert practitioners and those involved in designing prevention strategies within local and regional authorities across the UK through one-to-one conversations, an English-focused and Scottish-focused roundtable, expert group meetings, and a learning workshop. These conversations helped shape the recommendations and provided useful context into the barriers currently facing the UK in the prevention landscape.




Note: purposive selection for comparative learning; not a representative sample or a comperehensive systematic review of all prevention models.

Figure 2. Case study selection approach

# 4. Case Studies

5

### Prevention Initiative Demonstration Project

Los Angeles, US · 2008–2013

**Child abuse and neglect**
'Glue money' built community networks around existing services for families at risk.
Funding: Title IV-E waiver reinvestment (US$10m)

10

### Nurse-Family Partnership

US (national) · since 1977

**Pregnancy and early childhood**
Nurse home visits for first-time, low-income mothers until the child turns two.
Funding: Blended existing public funding

4

### HUD-VASH

US (national) · since 1992

**Veteran homelessness**
Housing vouchers paired with VA case management to keep veterans housed and prevent repeat homelessness.
Funding: Interagency agreement, HUD and VA

2

### Clackmannanshire Transformation Space

Clackmannanshire · since 2025

**Community-led reform**
A resident panel sets priorities and chooses which local projects are funded.
Funding: Scottish Government, Hunter Foundation (£1.34m)

3

### Regenerative Futures Fund

Edinburgh · since 2025

**Poverty, racism and climate**
Paid, trained residents with lived experience decide grants to grassroots groups over ten years.
Funding: Blended philanthropic, public, private (£15m)

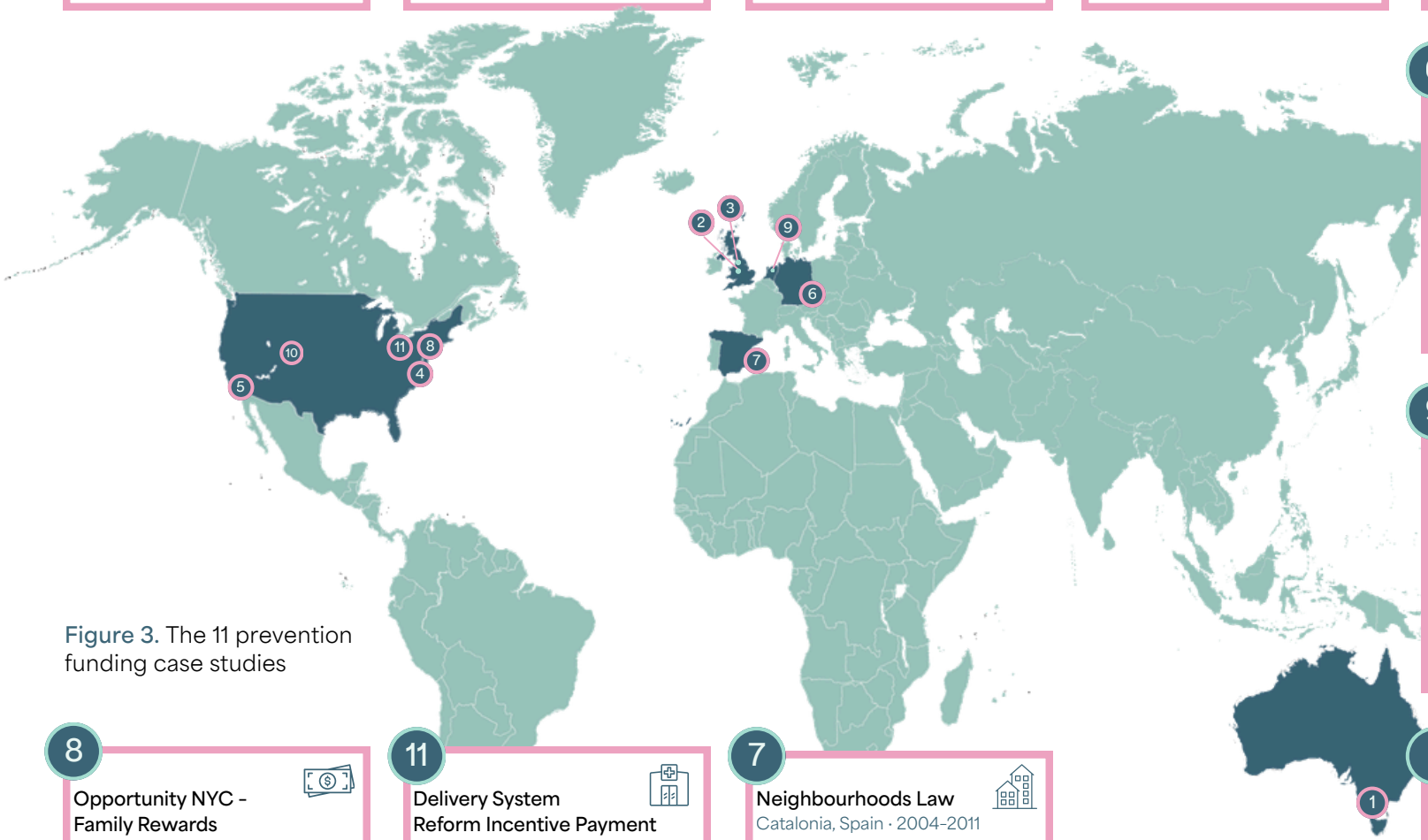



Figure 3. The 11 prevention funding case studies

6

### Health Circles

Germany · since 1989

**Workplace health**
Employees identify health risks at work and propose changes for joint steering committees to implement.
Funding: Statutory health insurers and employers

9

### Stevig Staan (Standing Strong)

Limburg · since 2023

**Falls among older people**
Screens 7,000 people aged 70+ and supports 2,500 at high risk; investors are repaid if falls are reduced.
Funding: Health impact bond (€2.8m)

8

### Opportunity NYC – Family Rewards

New York City · 2007–2010

**Family poverty**
Cash rewards for meeting education, preventive health and work goals, tested in a randomised trial.
Funding: Philanthropy (US$20.6m)

11

### Delivery System Reform Incentive Payment

New York State · 2014–2020

**Avoidable hospital use**
Payments to provider networks that redesign care and reduce avoidable hospital admissions.
Funding: Medicaid incentives (up to US$6.42bn)

7

### Neighbourhoods Law

Catalonia, Spain · 2004–2011

**Neighbourhood renewal**
Co-funded municipal plans to improve around 143 disadvantaged neighbourhoods.
Funding: Regional–municipal match funding (€1.3bn)

1

### Early Intervention Investment Framework

Victoria · since 2021

**Early intervention**
Treasury funds early intervention on modelled avoided costs and claws back the expected savings.
Funding: Treasury invest-to-save

The examples we have drawn on for this report are documented below in no particular order. **Expanded case studies are provided in the next section, including context on regional devolution arrangements that provide the underpinning for the funding design and delivery of the relevant programmes.**

| Case Study | Location/Date | Primary Funding Mechanism | Scale of Investment (2026 GBP equivalent) |
|---|---|---|---|
| Victoria Early Intervention Investment Framework | Australia (2021 - Present) | Treasury "invest-to-save"/clawbacks | A$3.46 billion (£1.8 billion) |
| A Treasury-led model that funds early intervention initiatives and is embedded into annual budgeting. | | | |
| Clackmannanshire Transformation Space | Scotland (2025 - Present) | Pooled public, private and third sector funds | £1.34 million |
| Brings community, funding and public services together to tackle problems facing the local community with a focus on prevention. | | | |
| Regenerative Futures Fund | Scotland (2025 - Present) | Pooled philanthropic, public, private and third sector funds | £15 million |
| A 10-year Edinburgh-based initiative aimed at tackling the root causes of poverty, racism, and climate change in local neighbourhoods. | | | |
| HUD-VASH | USA (1992 - Present) | Interagency agreement | Annual budget of $1.1 billion (as of 2025) (£825.5 million) |
| A joint national initiative designed to end veteran homelessness by combining long-term housing vouchers with clinical case management and healthcare support. | | | |
| LA PIDP | USA (2008 - 2013) | Title IV-E Waiver / Capped reinvestment | $10 million (2008 dollars) (£11.73 million) |
| A Los Angeles child welfare initiative designed to prevent child abuse and neglect before social services intervention occurs. | | | |
| Health Circles | Germany (1989 - Present) | Statutory health insurance / Employer co-investment | Variable |
| A workplace health promotion model in Germany where employers and health insurers establish joint employee committees to identify and address workplace health and safety hazards. | | | |

| | | | |
|---|---|---|---|
| Catalonia Neighbourhood Law | Spain (2004 - 2011) | Regional and municipal match funding | €1.3 billion over 6 years (£1.75 billion) |
| A major urban renewal programme aimed at revitalising socioeconomically disadvantaged neighbourhoods by combining physical infrastructure improvements with targeted health and employment services. | | | |
| NYC Conditional Cash Transfers | USA (2007 - 2010) | Private philanthropic investment and public-private matched funding | $20.6 million (2007 dollars) (£25.09 million) |
| A conditional cash transfer initiative designed to reduce family poverty and increase long-term investment in children's education, healthcare, and parental employment. | | | |
| Stevig Staan (Standing Strong) | Netherlands (2023 - Present) | Health Impact Bond | €2.8 million total cost (£2.34 million), €1.8 million capital raised (£1.5 million) |
| A targeted fall-prevention programme in Limburg, Netherlands, designed to reduce emergency room visits, injuries, and deaths among high-risk elderly residents. | | | |
| Nurse family partnership | USA (1977- ongoing) | Blended funding | $8,000 per family (2003 dollars) (£10,879 per family) |
| Targeted prenatal and early childhood home visits by nurses to improve parental behaviours and environmental conditions. It is designed for low-income mothers who have had no previous live births. | | | |
| New York DSRIP | New York State (2014 - 2020) | Performance incentives | $6.4bn allocation (£4.76 billion) |
| Delivery System Reform Incentive Payment - a major reform initiative for the Medicaid delivery system, offering funding to provider networks that demonstrate system transformation and reduction in avoidable hospital use. | | | |

Table 2. International case studies of prevention funding mechanisms

Note: The investment figures in the table above are included to illustrate the range and scale of funding in the case studies. The purpose is not to provide direct comparisons of expenditure between case studies, or with the English context. The purpose of these case studies is not to assess their success in achieving their outcomes, but to present different examples of funding and governance mechanisms.

An important distinction to note is that some examples primarily finance individual initiatives for example: HUD- VASH, Nurse-Family Partnership, Health Circles, Catalonia's Neighbourhoods Law, LA PIDP, and the Scottish initiatives. Others more directly seek to change the wider system's approach to preventative spending, such as Victoria's Early Intervention Investment Framework and New York State's DSRIP. Funding a specific preventative programme does not shift mainstream spending alone, and changing budget rules does not guarantee that funded initiatives will be effective. Both types of approaches need to be assessed to understand what can be learnt and applied to the English context.

# 4.1. Early Intervention Investment Framework, Victoria

Victoria, Australia, introduced in the 2021-2022 budget, mainstream prevention budgeting.

Prevention type: The EIIF is a funding framework rather than an intervention so the prevention pathway varies across the initiatives it supports.



**Main lessons:** A treasury-led framework can make prevention part of mainstream budgeting. Budget reductions tied to the department expected to receive benefits from interventions can address the 'wrong pocket' problem. However, reducing budgets based on estimated savings can be risky if savings are not verified or reached. Data is especially important for this approach, both for forecasting and in measuring if initiatives delivered the predicted savings.

**About:** Victoria is perhaps the most prominent example of regional government that has institutionalised prevention within its core budget process. The Early Intervention Investment Framework (EIIF) is a Treasury-run budgeting mechanism that funds early intervention initiatives by modelled avoided costs and clawing back a share of those costs from departmental budgets over time[16]. The EIIF was introduced by the Department of Treasury and Finance (DTF) in the 2021-22 Budget and is now the default route by which Victoria funds early intervention initiatives through its annual state Budget[1718]. It aims to provide timely help to individuals as problems emerge, stop unsustainable expenditure to reduce demand and alleviate pressure, and provide a more balanced service system.

**Devolution context:** Australian health funding is shared between the Commonwealth and the states, with Victoria managing the public hospital system and most public health functions. Prevention in Victoria is anchored in the Public Health and Wellbeing Act 2008, which requires each of the 79 local councils to prepare a municipal public health and wellbeing plan every four years, aligned with the statewide Victorian Public Health and Wellbeing Plan (the current plan covers 2023-2027). Councils must work with local health services and community partners, and may integrate the plan with their council plans, which link health to planning, transport, open space and local economic development. This embeds a "health in local policy" duty in local government.

**Funding and governance:** The EIIF is a decision-making and accounting framework applied within the annual budget process. Departments submit business cases, with support from the Department of Treasury and Finance (DTF), that include outcome measures and estimates of savings expected over a 10-year horizon. The DFT assesses these and advises government, which then decides funding through the Budget process[19]. Treasury has developed an in-house avoided cost model using service data from the Victorian government and supports departments to produce avoided cost estimates based on this model.

From year 3 after approval, the government applies an ongoing budget reduction to the relevant departments based on 5% of the initiative's 10-year estimated savings, recurring annually[20]. Because savings from one department's initiative often fall on another department's budget (e.g. a justice-system initiative reducing health or housing demand), budget reductions are frequently applied to departments that did not design or deliver the initiative, in 2025-2026 this applied to 54.9% of the estimated savings[21].

Departments retain 50% of the benefits accrued through economic impact to use as a buffer for savings estimations and to support gainshare as interventions begin to deliver impact. For initiatives which do not realise expected savings, there is no automatic protection for departmental budgets. Since 2025, requests can be made to adjust budget reductions if an initiative achieves less than 50% of its expected outcomes.

**What the evidence shows:** The Victorian Auditor-General's June 2026 audit reports that from 2021-22 to 2025-26, the Victorian Government funded 105 EIIF initiatives totaling A$3.46 billion (3.5% of all new-initiative funding in the state Budget over that period). Departments estimate these initiatives will generate A$2.41 billion over 10 years in avoided costs from reduced service demand, plus a further A$1.03 billion in other economic benefits. The government has reduced departmental budgets by A$162.9 million by 2025-26, with a further A$441.3 million in reductions committed by 2029-30.[22] It is important to separate what the EIIF expects to save from what it has saved. The A$2.41 billion is the departments' forecast of avoided costs, with the related budget reductions calculated from forecasts, not from measured reductions in demand. In 2024-25, 10 of the 57 initiatives required to report had no savings outcome measure, and a further 13 had measures but no results. As of April 2026, no budget reductions have been adjusted on the basis of evidence of actual savings, and no minister had used the 2025 option to request an adjustment. In effect, forecast avoided costs are being treated as cashable savings, and departments carry the risk if they do not materialise.

Victoria reported on the Framework in June 2026 and identified a significant challenge in demonstrating the real savings realisation that is underpinning ongoing budget cuts to departments. The EIIF needs clearer requirements to measure service demand, calculation of actual savings at both initiative and whole-of-framework levels, and better communication of risks and evidence gaps in advice to the government[23].

## 4.2. Transformation Space, Clackmannanshire

Scotland, UK, launched in 2025, place-based pooled funding with resident-led priorities

Prevention type: Emerging need/early intervention



**Main lesson:** Pooled public and philanthropic funding can support priorities chosen by residents. While it is too early to know the outcomes, there are lessons to be learnt about the conditions needed for implementation such as the need for 'behind-the-scenes' work to build trust, shared objectives, and legal and governance arrangements.

**About:** The Clackmannanshire Transformation Space, established in June 2025, aims to connect public services and community partners around locally identified problems. To date it has funded 24 projects around four different themes[24]. The first was for prevention of homelessness where funding was awarded for projects that included preventing homelessness among young people, reducing risks of eviction, and helping people stay housed through paid work placements and life skills workshops. The second round was for better mental health and young people, those projects included delivery of a befriending service for children aged five to nine years and covering the costs of guitar lessons and bike training of young people seeking to improve their mental wellbeing.

The third round focused on support for women and girls which included projects such as establishing a Violence Against Women and Girls lived experience panel to inform strategic planning, delivering a women's only soccer project, and providing accessible sessions for women and girls addressing abuse and gender-based violence. The fourth round focused on employment which lifts people out of poverty and included projects such as supporting a green energy sector employment programme, providing training for people facing barriers to work, and funding hospitality and sports coaching programmes[25].

Devolution context: Scotland has a devolved Parliament[26] with responsibility for the NHS, public health, social care and local government. This enables the Scottish Government to shape health policy and priorities. The Community Empowerment (Scotland) Act 2015[27] provided a statutory framework for partnership working across local authorities, NHS boards and partners. Recently, Scotland's Population Health Framework 2025-2035[28], embedded prevention in planning, service delivery, budgets and accountability as a priority[29].

Funding and governance: Led by Clackmannanshire Council, the transformation space has raised £1.34 million from the Scottish Government, Clackmannanshire Council, and The Hunter Foundation - a philanthropy venture focused on systemic issues related to poverty reduction and educational enablement[30]. Residents on the Community Voice panel shape priorities and decide which projects are backed. This goes beyond consulting the public, providing residents with real power to make change.

Funded projects are delivered by local and national third-sector organisations and organised into themed rounds of delivery. In the homelessness round, awards were given to Action for Children, Barnardo's, Clackmannanshire Citizens Advice Bureau, and Change Please Foundation. In the women and girls round, awards went to organisations including Victim Support Scotland, and Street Soccer and Resilience Learning Partnership. This support is naturally offered around emerging need and before any crisis event such as an eviction and family breakdown, thereby seeking to reduce later demand on homelessness, social work and justice services.

Project outcomes are tracked, and regular updates are provided. The Transformation Space partnered with a learning partner early in the process to ensure that process and outcome indicators were developed and could be regularly reported on.

It took five years of work before the Transformation Space was approved by the council and set up. In their "10 steps to set up a transformation space" guide[31], they describe the early important steps to be around creating the conditions needed by building trust, aligning local leaders and stakeholders around a shared purpose, and agreeing clear, measurable, community-owned objectives.

What the evidence shows: While it is too early to draw conclusions about the outcomes, the way that this example has approached early implementation offers useful learning. A panel of residents' shape prevention funding priorities, supported by an oversight board, and the model brings together public and philanthropic funding to support local priorities. They share regular learning updates on their website[32].

## 4.3. Regenerative Futures Fund, Edinburgh

Scotland, UK, ten-year spend-down funding, pooled and long-term grant-making that is led by residents

Prevention type: Community resilience/upstream .



**Main lessons:** A long-term pooled fund created through philanthropy and public funding can support long-term work that is informed by resident's lived experiences. The funding design of long-term, featuring community decision-making, transparent learning and drawing on philanthropic money to support implementation is central.

**About:** The Regenerative Futures Fund is a £15 million spend-down 10-year initiative[33]. Blending philanthropic, public, and private sector finances and resources, it funds grassroots organisations who work across interconnected themes of poverty, racism, and climate change. These are upstream issues that shape health, opportunities, and resilience. Eleven organisations were selected to receive ten years of funding. These projects include tackling stigma around poverty and building financial security in the Sikh community, supporting paid opportunities for Black creatives to address structural barriers in the arts sector, co-designing local food and medicine production, improving local housing conditions, and supporting community-led climate focused activities, and engaging communities on heat networks[34]. The preventative logic is upstream, tackling poverty, poor housing and exclusion, which are drivers of ill health and of demand for services, rather than responding to a specific emerging need.

**Devolution context:** The devolution context for Scotland is explained in the previous case study.

**Funding and governance:** It is a ten-year pooled fund worth £15 million. Funders include a mix of philanthropic foundations, community foundations, and local government, including City of Edinburgh Council, Esmée Fairbairn Foundation, The National Lottery Community Fund Scotland, The Robertson Trust and Turn2us Edinburgh Trust - with Foundation Scotland hosting the FundFunding has been provided for 10 years to enable the deep work needed to address the root problems and embed change.

The Regenerative Futures Fund describe their approach as an 'ecosystem'[35] which includes the cohort of funded organisations, funders, decision-making panel, staff, and an oversight board. Residents from the local area who have lived experiences of poverty and inequity act as decision makers. A practitioner involved in the project told us that they discovered when giving residents a choice of which problems and projects to prioritise, they would naturally be drawn to the preventative measures. The resident group are provided with training to build their skills to work together and make the necessary decisions, they meet regularly and are paid for their time. The fund also offers to cover translations costs, childcare and travel to enable residents to take part. This is an example of inclusive capacity building which enables residents to participate and influence change.

They are working with partners to create a monitoring, evaluation, and learning framework. Rather than waiting to share big outcomes, they regularly post "doing and learning" updates on their website, providing transparency over progress the fund has made and its next steps, putting iterative learning at the centre of their model.

**What the evidence shows:** It is too early to know the Fund's long-term impact and outcomes, however they do regularly post 'doing and learning' updates on their website. The lessons they have been able to share so far primarily refer to their early implementation phase including the value in allowing time for relationships to develop, sharing responsibility, the importance of evaluation, and the inclusion of residents in decision-making.

## 4.4. HUD-VASH, USA

United states, launched in 1992, cross-department funding and delivery

Prevention type: Crisis response/stabilisation and prevention of recurrence



**Transferable lesson:** A formal agreement between two agencies can combine services using existing infrastructure rather than building new outreach networks and capabilities from scratch. The project was made possible by an interagency agreement between HUD and VA that enabled each agency to provide different parts of the service delivery and financing. This is coordination rather than pooling of funds. Each agency funds and runs its own part of the intervention, with their collaboration aligning the agencies around the same cohort of people.

**About:** The HUD-VASH programme was established in 1992 and supports veterans who are experiencing homelessness through housing support and mental health clinical support. It is a joint effort between the US Department of Housing and Urban Development (HUD) and the US Department of Veterans Affairs (VA). It is a crisis stabilisation and recurrence prevention programme, with a preventative purpose to keep people housed and stop repeated homelessness, crisis use of hospitals and shelters, and contact with the criminal justice system. Eligible participants were veterans who have been homeless for at least one month at the time of assessment and had a diagnosis of a major psychiatric disorder and/or an alcohol or drug abuse disorder.

**Devolution context:** The United States uses a federal government system where state governments have constitutional powers over public health, shaping the delivery of health and social services. Some powers are delegated to local authorities by the state. The federal government also influences provision through national legislation.

**Funding and governance:** The initiative involves pairing intensive case management services provided by VA clinicians, with HUD Section 8 housing vouchers, which help people in need afford housing in the private market by partially covering rent. This structure enables two agencies to share the costs of prevention, and risks, without needing to formally pool budgets. Each agency pays for its own component with HUD allocating vouchers to local public housing agencies and VASH staff assessing clinical eligibility, making referrals and providing case management. In 2025, the budget for this programme was $1.1 billion, which accounts for nearly 34% of overall Veterans Affairs Homeless Programs budget[36].

**What the evidence shows:** This agency-specific approach, with a pair of agencies mapping out specific ways of coordinating their efforts has led to supporting over 250,000 veterans into housing and is still running today[37].

In an independent three-year evaluation it was found that HUD-VASH veterans spent 25% more days housed than a standard care group, they developed larger social networks, but there was no significant difference in mental health and substance abuse. It was found that HUD-VASH was $6,200 (15%) more costly than the standard care[38]. A randomised trial at four sites (following 460 veterans' progress after three-years) found that HUD-VASH increased days housed and reduced days homeless by 35-36% compared with case management alone or standard care, although it did not improve psychiatric or substance use outcomes.

## 4.5. Prevention Initiative Demonstration Project, Los Angeles

Los Angeles, US, launched in 2008, flexible prevention funding that joins community networks.

Prevention type: Emerging need/early intervention with prevention of recurrence



**Transferable lesson:** The flexible use of existing funds, in this case, the designation of Title IV-E Waiver funds for preventative work, can be used as 'glue money' to coordinate existing community infrastructure.

**About:** In 2008, the PIDP project sought to achieve a systems change approach that established relationships between public child welfare, allied public agencies, and community-based networks, knitting together existing services to better serve families[39]. It was aimed at families who were considered 'in need' but had not been referred to child welfare, those who had been referred but not had a case opened, and those whose children were returning after being in foster care. PIDP was a way to develop work that supported a public health approach that is mindful of prevention and early intervention systems to improve life chances for people at risk of, or returning to, care. The programme had three strands of work: decreasing social isolation, increasing economic stability, and integrating the existing community-based services and support.

**Devolution context:** California's child welfare system is supervised by the state but delivered by each county according to local needs while following state and federal regulations[40]. In 2006, Los Angeles County's Board of Supervisors began the development of a prevention system which led to the Department of Children and Family Services to establish PIDP[41]. The time-limited federal Title IV-E waiver was approved for California in 2006, allowing participating counties to use federal foster care funding more flexibly[42]. This shows a route from pilot to mainstream funding, with evaluation findings from the programme used to redesign the county's mainstream prevention contracts.

**Funding and governance:** The cost of the programme totalled $10 million over the first two years, with step-down funding planned in the following two years against a departmental budget of over $1.8 billion (roughly 0.3%). The positive results from the evaluation extended the programme for another year. The initial $10 million investment included savings from a previous intervention, funding received from First 5 LA, a funder focused on children and family wellbeing in the state, and $3.76 million from Title IV-E Waiver capped reinvestment funds. These funds are traditionally used by the federal government to reimburse states for foster care costs. The Title IV-E Waiver allowed states to use that money more flexibly, including using it on prevention before a child is removed from home.

Funding was allocated across eight Service Planning Areas based on the number of child abuse referrals and the total population of families living in the area. This funding was not used to pay for services directly. Instead, it was used to build community-based relationships and networks so that they could make better use of the services they already have.

**What the evidence shows:** A peer-reviewed evaluation reported the programme improved protective factors for families including participants reporting having greater social support, reduced isolation, greater empowerment, and improved economic optimism and quality of life. Nearly 300 residents were trained and placed into jobs; over 1000 people received pro bono legal assistance. Four of the PIDP networks helped families secure over $4.4 million in tax credits and refunds. There was a reduction in child welfare re-referrals and improved outcomes for children in foster care. The evaluation acknowledges that not all outcomes can be directly attributed to PIDP with confidence but supports cautious learning about network-building and flexible funding[43]. The evaluation compared PIDP families with randomly selected local comparison groups. Re-referrals fell significantly in Compton (12% compared with 23% in control groups) but not in Lancaster or the San Fernando Valley, and children in two areas were significantly more likely to leave foster care.

## 4.6 Health Circles, Germany

Germany, developed from late 1980s, insurer and employer investment

Prevention type: Community resilience/upstream



**Main lessons:** Employer and insurer contributions can fund and support changes to workplace conditions that have been identified by employees.

**About:** Health Circles in Germany was a nationwide workplace health initiative running from the late-1980s. Health circles were implemented across a range of industries and sought to improve physical and psychosocial conditions by involving employees in identifying problems and developing solutions. It emerged in response to criticism of conventional occupational health models, which concentrated too narrowly on physical hazards at the expense of stress and other psychosocial health determinants. The model aimed to improve work conditions to reduce sickness absence and turnover. Its preventative logic is that reducing physical and psychosocial strain at work prevents ill health, which in turn reduces sickness absence and its costs to employers and insurers. Health Circles involved bringing together employees during work hours to identify hazards and propose solutions that the employer could then implement. This shift was reinforced by a 1989 law requiring statutory health insurers to expand preventative health coverage, as well as by other legal changes that strengthened the emphasis on workplace conditions.

**Devolution context:** Germany's federal structure divides responsibility. The 16 Länder are responsible for the public health service (ÖGD, delivered by local health offices) and hospital planning. Federal law governs statutory health insurance (SHI), which is run by around 90 non-profit sickness funds.

The 2015 Prevention Act (Präventionsgesetz) requires sickness funds to spend a minimum per-capita amount each year on prevention and health promotion. Part of this must go to settings-based health promotion, such as schools, workplaces and communities. This creates a statutory, protected prevention funding stream that does not depend on discretionary public budgets.

Governance and the relationship between national government and the 16 Länder is built around negotiation. A National Prevention Conference sets joint national recommendations, and each Länder agrees a framework agreement (Landesrahmenvereinbarung) with the sickness funds, pension and accident insurers, and local authorities. These agreements set regional priorities and allocate how funds are used. Länder also operate state health conferences and local health networks, and many cities join the Healthy Cities Network.

Funding and governance: The approach was funded by both Germany's statutory health insurance system and participating employers. The 1989 law required the insurers to expand their prevention programmes, incentivising them to develop health circle programmes, some of which they directly conducted themselves. Companies also directly invested in health circles, investing in implementation and allowing the circles to take place during working hours.

Governance relied on collaboration between multiple stakeholders: statutory sickness funds supported workplace prevention activities; companies were responsible for implementing changes in individual organisations; unions and occupational safety representatives participated; employees were involved in identifying the problems they faced and developing solutions. Joint steering committees were often set up to oversee each health circle and coordinate decision-making.

In practice, a health circle began with an agreement between management and employee representatives. The sickness fund produced a health report from its absence data, often followed by an employee survey. A group of employees, sometimes joined by supervisors, a safety officer and the company doctor, then met six to ten times during paid working hours with a trained facilitator, and passed its proposals to a steering committee responsible for making changes. The whole process took about 15 months, and around 60% of proposals were typically implemented within six months of the last meeting[34].

What the evidence shows: A 2004 review identified 11 studies covering 81 health circles[44]. In general, it was suggested that the participatory approach of involving employees in the decision making was viewed as worthwhile by those involved. The review suggested that the circles were ‘found to be an effective tool for the improvement of physical and psychosocial working conditions’. The evaluations that the review drew on found evidence of reduced sickness absence and reduction in employee turnover, resulting in savings for the employers. However, the review notes that there was limited data quality among many evaluations as most relied on retrospective before-and-after comparisons, and few used control groups, resulting in a call for more rigorous studies. This speaks to a wider concern around evaluation quality of preventative initiatives.

## 4.7. Neighbourhoods Law, Catalonia

Catalonia, Spain, introduced in 2004, match-funded neighbourhood regeneration

Prevention type: Community resilience/upstream



**Main lessons:** Regional and municipal match-funding can align investment with local social and economic needs. Residents involved helped the proposals reflect important problems they were facing. Match-funding enabled local municipalities to implement change while also having financial buy-in. Match-funding should account for unequal fiscal capacity so that poorer places are not disadvantaged.

**About:** The Catalonian government's 2004 Llei de Barris (Neighbourhoods Law), provided for a series of urban renewal in 143 neighbourhoods across Catalonia by 2011, including 12 in Barcelona. Its relevance to prevention is the combination of changes to the built environment and access to social, health, and employment support which can shape wellbeing. Examples included investing in green spaces and commercial developments, building community and events spaces, and improving transport infrastructure. The renewal programmes attempted to improve the physical and mental health of local residents, shaping their health, life quality and access to opportunity. The aim was to address and prevent social problems by targeting areas with lower resources and worse physical infrastructure.

**Devolution context:** Spain devolved health to its autonomous communities in 2002, and amongst these Catalonia has the most developed regional system. Catalonia can decide how to allocate health spending between prevention, primary care and acute care, rather than following centrally prescribed budget lines.

Prevention is led by the Public Health Agency of Catalonia. Its flagship cross-sector mechanism is the Interdepartmental and Intersectoral Public Health Plan. It sits within the Health Plan and commits departments such as education, urban planning, environment, labour and social welfare to shared health objectives. This is an explicit Health in All Policies approach, backed by regional government authority over those departments. Local action runs through municipalities with community health promotion integrated into primary care teams.

**Funding and governance:** The regional government normally contributed 50% of project costs with municipalities paying the remainder, though the regional share could be higher (up to 75%) for smaller municipalities. With bids submitted by municipalities for specific neighbourhoods through annual competitive calls, interventions were able to be tailored to neighbourhood-specific needs. For example, mobility infrastructure was prioritised in the Roquetes neighbourhood, due to its steep terrain and ageing population. Individual project budgets ranged from €20,000 to €4m. Each annual call had a budget of €99 million, and the law extended this kind of regeneration to smaller towns with less capacity to fund it themselves[45]. This co-funded grant model created shared ownership of projects between the two levels of government. The programme was suspended in 2012 after a change of regional government.

As part of the process a Management Committee was created, composed of different government and municipal departments and urban sustainability professionals. Each local area also established a committee of local residents and public workers to set up project management, monitoring, and evaluation methods.

**What the evidence shows:** An independent evaluation worked with 45 residents in two neighbourhoods to explore the perceived effects of renewal[46]. The initiatives were found to have improved self-perceived physical and mental health and wellbeing among residents affected and had positive effects on health-related behaviour and equity. Another independent study found that participating municipalities showed positive trends with average scores of neighbourhood issues dropping and public perception of conditions in their neighbourhood improving[47]. A long- term evaluation showed that self-rated health improved for manual workers and more women met walking requirements compared to the comparison neighbourhoods, helping to narrow health inequalities in the area[48].

## 4.8. Conditional Cash Transfers, New York

New York City, United States, 2007-2010, Philanthropically funded conditional cash transfers

Prevention type: Emerging need/early intervention



**Main lessons:** Philanthropy can fund a time-limited test of incentives intended to increase preventative health and education engagement. The evaluation of the programme resulted in the launch of a second version funded by a federal grant with private contributions and mayoral support. In a UK context, philanthropy is more likely to play this test-and-learn role than to fund prevention at scale.

**About:** Opportunity NYC-Family Rewards was a city-level conditional cash transfer (CCT) programme that ran in New York City from 2007 to 2010. The programme provided cash rewards to low-income families who improved their employment (e.g. by achieving stable employment), preventative health visits, and education (e.g. by ensuring their child's school attendance and increased academic attainment)[49]. It aimed to alleviate immediate poverty of low- income families with children living in six high-poverty districts through direct financial support, while simultaneously improving long-term social and economic outcomes by incentivising human capital investments[50].

**Devolution context:** Public health in New York is shared between the State Department of Health and 58 local health departments (mostly county-based), which receive state aid for core public health services under Article 6 of the Public Health Law. The state's main prevention framework is the Prevention Agenda, a five-year plan with measurable targets. It is built on a Health Across All Policies approach, which engages sectors such as housing, transport, education and the economy. Local health departments and hospitals produce Community Health Assessments and Improvement Plans aligned with it, and hospital community benefit spending is expected to support these priorities.

**Funding and governance:** The initial programme cost $20.6 million in cash reward payments over three years. This funding was provided through private philanthropic investment, specifically a consortium of major foundations and private donors. The programme was initiated and sponsored by New York City's Center for Economic Opportunity. Across the programme, participating families received an average of approximately $8,700 over the course of the intervention.

The programme employed a cross-sector governance model. Strategic leadership came from the NYC Center for Economic Opportunity, while delivery was led by non-profit organisations (MDRC and Seedco) working alongside a network of local community-based organisations supporting recruitment and implementation. MDRC was also responsible for the programme's management and evaluation.

**What the evidence shows:** A randomised controlled trial found that the programme reduced poverty during its operation and caused modest positive improvements in several education, health, and employment outcomes. For example, it increased the use of preventive services and insurance coverage[51], with a later study also finding a large increase in the use of preventive dental care[52]. Parents' perception of health also improved, while the intervention may have also had positive impacts on the incidence of chronic disease[53]. However, many outcomes also showed little or no significant change[54]. This suggests that within this context, the conditional transfers had uneven effects, being more successful at encouraging preventive health approaches, and alleviating immediate hardship than strengthening labour market performance.

Following the evaluation of the first Family Rewards programme, a second version was launched in 2011 in New York City and Memphis. This updated model offered fewer rewards in each target area, narrowed their applicability, paid rewards more frequently, and offered personalised guidance to families. The programme's effects were weaker than those of the first version. This second version was delivered through a grant to both the Mayor's Fund to Advance New York City and the New York City Center for Economic Opportunity. The grant was provided by the Social Innovation Fund, which is a programme of the federal Corporation for National and Community Service. This resulted in a public-private model in which public funds were matched by private and local contributions.[55]

## 4.9. Stevig Staan (Standing Strong), Netherlands

Limburg, Netherlands, launched in 2023, outcomes-linked social investment (health impact bond).

Prevention type: Emerging need/early intervention



Transferable lesson: An impact bond can provide upfront funding and shared risk when there are clear ways to measure the success of an intervention and case that long-term savings should be made. Risk is cushioned by the caveats of a certain percentage of falls needed to be reduced before the money needs to be repaid.

About: The Standing Strong programme (Stevig Staan), launched in January 2023, is a large-scale fall prevention initiative for elderly residents over five years in seven cities in Limburg - a Dutch province with a fall rate three times more than the average in the Netherlands[56]. In the Netherlands, around 100,000 elderly people visit the emergency room annually due to a fall incident resulting in over 5,000 fatalities and an estimated cost of €1.2 billion. The programme involved screening 7,000 people aged 70+ and 2,500 of those identified as high-risk received intervention and support[57]. Interventions include participating in one of two programmes delivered by healthcare professionals including physiotherapists[58].

Devolution context: Municipalities in the Netherlands (about 340) have a statutory duty under the Public Health Act to promote local public health. They deliver this through regional Municipal Health Services, which are joint municipal bodies. Since 2015, municipalities also run social support, youth care and participation services. These are funded mainly through the general-purpose Municipal Fund, which is not ringfenced. Councils can therefore pool prevention, social care, housing, sport and economic policy in local integrated approaches. The National Institute runs a recurring population survey that produces municipal-level data. This lets local authorities set priorities and track progress locally.

Funding and governance: The programme is worth €2.8 million and is funded by the Netherlands first health impact bond. It is a collaboration between health providers, health insurance companies, municipalities, social investors, and a long-term care administrator[59]. The bond combines social investment from BNP Paribas Social Impact Bonds Fund, Bridges Outcomes Partnerships, Rabobank, and crowdfunding from private investors via Oneplanetcrowd[60,61]. If falls are reduced by 43% in six years, investors will see a return on investment of 27.4%[62]. The participating municipalities and health insurers will repay the investors based on the long-term cost-savings they will achieve as a result[63,64].

What the evidence shows: While there is not yet a published finalised report on the results of fall reductions, the programme has published clear details on the finance structure and measurement plan. This example shows the possibilities of a health impact bond for raising money for interventions and what the repayment criteria may look like.

# 4.10. Nurse Family Partnership, USA

United States, launched in the 1970s, blended public funding.

Prevention type: Emerging need/early intervention



**Main lessons:** A blended model approach that assembles funding from existing public sources, rather than creating a new standalone stream, shares the risk across services but also requires clarity on governance and reporting. Prevention programmes should be scaled up only when supported by robust evidence, the scale up should be done gradually, investing in where the returns are highest, and existing funding streams should be used to distribute the financial responsibility.

**About:** This programme was created in response to problems such as infant mortality, preterm delivery, low birth weight, neurodevelopment impairments in children, and parental life course[65]. The programme involves prenatal and early childhood home visits by nurses to improve parental behaviours and environmental conditions. It is designed for low-income mothers who have had no previous live births. The family receives 2.5 years of service beginning during pregnancy and continuing until the child's second birthday. The Nurse-Family Partnership national office provides implementation support and quality assurance, but local organisations operate the programme. This programme has been rolled out across several countries including England, the Netherlands, Norway, Australia, British Colombia, and Bulgaria, however we are only presenting the US context in this report.

**Devolution context:** The devolution context for the US and been included in a previous case study, but relevant to this example is that five years prior to the launch, Medicaid was established in 1965[66] as a federal-state partnership where states implement programmes following federal requirements with some flexibility over programme design.

**Funding and governance:** The cost was approximately $8,000 per family (2003 dollars) for 2.5 years of service[67]. An economic evaluation was conducted as a 15-year follow up study which found that for unmarried, low-income mothers, the savings to government and society exceeded the cost of the programme by a factor of 4 over the life of the child. For mothers who were married and of a higher social class, there were no net savings. The follow-up study[68] was based on one site, Elmira, where the programme cost was around $6,000 (in 1996 dollars) per child. Two years after the programme ended the analysis showed there were net savings to government of $180 per child. For high-risk families, 15 years after the programme finished the net savings were $18,611, over four times the cost of the programme. However, with the lower risk group there were no net savings to government (the programme cost $2,307 more than the savings). It should be noted that this analysis is limited to 15 years after the child was born and therefore does not account for future benefits, such as that child's future workforce participation.

Rather than creating a new funding stream, it was funded by blending existing sources of government programmes including: Temporary Assistance to Needy Families, Medicaid, the Maternal and Child Health Block-Grant, and child- abuse and crime-prevention dollars.

This approach shared the cost across agencies to avoid concentrating the burden on a single budget. In 2023, Medicaid supported part of the programme in 23 states, and around 80% of enrolled parents were covered by Medicaid[69].

**What the evidence shows:** Trials across three sites[70] reported benefits for some maternal and child outcomes including: improved parental care, fewer verified cases of child abuse and neglect; fewer emergency department visits; home environments rated as safer and more conducive to cognitive development; improved child neurodevelopment, and improved maternal life course as mothers had fewer subsequent pregnancies, longer intervals between births, and greater workforce participation. The greatest impact of the programme was seen in the population at greatest risk.

## 4.11. Delivery System Reform Incentive Payment, New York

New York State, United States, April 2014 - March 2020, Medicaid reinvestment and performance incentives

Prevention type: Emerging need/early intervention, with recurrence prevention



**Main lessons:** Medicaid performance incentives can build regional provider networks, encouraging collaboration, and reward service redesign.

**About:** New York's Delivery System Reform Incentive Payment (DSRIP) program was a major Medicaid delivery- system reform initiative operating from April 2014 to March 2020. Its central idea was to change the way Medicaid-funded healthcare was organised and paid for, making substantial payments conditional on providers collaborating to change care delivery, improve population health, and reduce avoidable hospital use.

**Devolution context:** The devolution context for the US is described in the previous case study. Flexibility in Medicaid spending has been an important driver of change towards prevention, as profiled in the case of the Delivery System Reform Incentive Payment (DSRIP) programme allowing the state to redirect Medicaid funds into regional provider networks that were rewarded for reducing avoidable hospital use and addressing social determinants.

**Funding and governance:** DSRIP targeted a 25% reduction in avoidable hospital use over five years, with the state allocated up to $6.42 billion specifically for incentive payments. The programme primarily funded providers within regional networks called Performing Provider Systems (PPSs), which could include hospitals, primary-care providers, behavioural-health organisations, community organisations and other providers, encouraging them to operate as a coordinated delivery system rather than as separate institutions. The funding came from reinvesting US$8 billion of federal savings generated by earlier Medicaid Redesign Team reforms, through an amendment to the state's Medicaid waiver

The state worked with a broad definition of “avoidable hospital use”, including readmissions that could have been prevented, and also hospital admissions that might have been avoided if patients had received appropriate preventive care. This encouraged a range of network development, capacity building and interventions in areas such as improving chronic-disease management, identifying high-risk patients, coordinating care after hospital discharge, and strengthening community-based services.

Providers first had to establish the organisational capability to coordinate care, for example, developing integrated systems, data capabilities and partnerships. PPSs selected projects designed to change how care was delivered, with payments increasingly dependent on whether providers achieved specified performance milestones and outcome measures. The state's evaluation design explicitly distinguished between payments for achieving project-progress milestones and payments tied to improvement milestones.

What the evidence shows: New York reported improvements during the programme. In 2019, preventable hospital admissions had fallen 17% over the first four years of DSRIP. However, interpreting causality within the complex system is more difficult so the clearest lessons are on the design of performance incentives and provider-network capability.

# 5. Funding Mechanisms, Savings and Governance

### Funding mechanisms

The case studies present a wide range of approaches to funding prevention. There are differences in who provides the investment, whether money is pooled or used within existing budgets, and whether savings are captured or linked to the funding. While it is useful to understand the different types of funding models that have been used in these case studies, it is important to note that success in these mechanisms also rely on the conditions that make them work, such as capacity, flexibility, accountability and collaboration. The funding typologies below are overlapping and not mutually exclusive.

## 5.1. Funding typologies

Match-funding: Catalonia Neighbourhood Law provides an example of regional and municipal match funding. Individual neighbourhood projects ranged from €20,000 to €4 million. Typically, 50% of the funding came from the regional government of Catalonia and 50% from participating municipalities, although among smaller municipalities the regional contribution went as high as 75%. The model created shared ownership between regional and municipal government while providing neighbourhood-investment.

Ringfenced funding: The Los Angeles Prevention Initiative Demonstration (LA PIDP) combined dedicated investment with greater flexibility in how existing public funding could be used. The programme cost $10 million over its first two years with step-down funding provided afterwards. Within the programme there were eight service areas who were each assigned a share of the money based on a needs-based criteria (the number of referrals and total population of families living in the area). The initial investment included savings from a previous intervention and $3.76 million from Title IV-E waiver capped reinvestment funds. The waiver allowed funding that would ordinarily support foster care costs to be used more flexibly for prevention before children were removed from home. The money was not used to purchase new services but was used to build community relationships and networks so that existing services could be used more effectively.

Mainstream budgeting and performance incentives: Victoria's Early Intervention Investment Framework (EIIF) is the clearest current example of prevention being built directly into government budgeting. Departments apply for government funding for early intervention initiatives on the expectation that reduced demand for acute services will generate future savings. The government then reduces the budgets of departments expected to benefit from those savings, addressing the "wrong pocket" problem. The Victorian government has invested A$3.46 billion through the EIIF and expects A$4.5 billion as a return in economic benefits. The framework has become an embedded part of the annual state budgets.

New York's DSRIP used incentivising payments to encourage providers to redesign care and reduce hospital usage. These models show how prevention or system reform can become a part of mainstream decisions, rather than being limited to one-off pilots.

Cross-departmental and cross-sector funding: HUD-VASH is an example of two departments joining together to fund an initiative. The US Department of Housing and Urban Development and the Department of Veterans Affairs combined resources for supported housing. HUD provided Section 8 housing vouchers and VA provided case management from clinicians.

The interagency agreement between the two enables them to contribute different components while sharing the risk and resources of funding and delivering the overall programme.

Health circles in Germany were funded through statutory health insurance and participating employers. A 1989 law required insurers to expand prevention programmes, while employers enabled the health circles to take place during work hours and helped to implement the changes identified. These two examples show how partners can contribute difference resources without needing to pool money into a new fund.

Pooled and blended funding, including philanthropy: New York City's conditional cash transfer programme illustrates the role of philanthropy and public-private matching. The programme cost $20.6 million in cash reward payments over three years, funded through private philanthropic investment from foundations and donors. A subsequent version of the scheme involved public and private contributions.

The Clackmannanshire Transformation Space brought together public, private, and third-sector funding and initially raised £1.34 million. Edinburgh's Regenerative Futures Fund is a blended model of £15 million as a 10-year spend- down initiative combining philanthropic, public, and private sector finance and resources.

The Nurse-Family Partnership in the USA blended existing government funding including Temporary Assistance to Needy Families, Medicaid, the Maternal and Child Health Block Grant, and child-abuse and crime-prevention funding.

This approach spreads financial responsibility across stakeholders and can connect services that would otherwise be working independently. Philanthropy may support innovation and capacity building but should not be treated as adequate core funding.

Outcomes-linked impact bonds: The Netherland's Stevig Staan (Standing Strong) programme uses a health impact bond. The programme is worth €2.8 million and brings together health providers, health insurers, municipalities, social investors, and long-term care administrator. The financing combines social investment with crowdfunding from private investors. Repayment of the funds only occurs if the agreed and measurable goals are met.

## 5.2. Capturing of savings and reinvestment

There are different types of savings that can occur. Cashable savings are a reduction in budget requirements that can be withdrawn or reallocated. Avoided costs are when future expenditure is lower than it would usually be. Released capacity, such as on staff time, appointments, hospital bed availability, can be reallocated to meet other needs but might not reduce overall budget. Wider outcomes, such as health and wellbeing outcomes, employment, and life changes are also valuable but may not translate into direct fiscal savings. Capturing the savings of prevention initiatives is considerably difficult, especially because there are many types of savings, they can take years to materialise and often produce savings in different departments than where the initiative originated from.

The Victoria EIIF provides an explicit link between forecasted savings and future budgets. Three years after funding is provided, the government applies a budget reduction to the department expected to realise savings: 5% of the initiative's 10-year savings, recurring annually and indefinitely. 40% of each initiative's estimated 10-year savings is held by the Department of Treasury and Finance to support future EIIF initiatives, making the funding sustainable. This approach establishes a direct reinvestment mechanism and addresses the wrong pocket problem.

However, there is a risk to this approach. If the estimated savings do not materialise, the budget reduction will not reflect the actual reduction in expenditure. The Victorian Auditor-General's office highlighted this issue in June 2026, finding that departments were not consistently collecting the evidence needed to demonstration reductions in service demand and that actual savings were not being systematically calculated against expectations. In response to those findings, the VAGO called for clearer requirements around measuring service demand, calculating actual savings, and communicating risks and evidence gaps when predicting cost savings. The Victoria example highlights an important tension for prevention funding – that a prevention funding mechanism is only as credible as the evidence used to establish whether savings have actually occurred and how this translates into budget reductions.

Some of the examples in this report show how savings captured does not necessarily mean that money is available for reinvestment. For example, the Netherlands' Standing Strong health impact bond links financial repayment to measurement outcomes. The participating municipalities and health insurers will repay investors from the long-term cost savings associated with the intervention. The programme agrees that if falls are reduced by 43% in six years, investors are expected to receive a 27.4% return on investment. Therefore, this funding approach acts as a way to pay for a programme when the funds would otherwise be unavailable, but the savings accrued will initially go to repaying investors. It is not clear what the expected outcome of savings is expected to be once the investment is repaid.

Some of the case studies did not include ways to capture and reinvest savings but did collect data on the estimated savings from the intervention. A 15-year follow up of the Nurse-Family Partnership found that for unmarried, low- income mothers, the savings to government and society exceeded programme costs by a factor of four over the child's life. However, the results varied by risk and social groups.

Higher-risk families generated net savings, whereas lower-risk families did not. The analysis was limited to 15 years after study so also did not capture potential future benefits such as workforce participation, nor did it describe where the savings were used.

Schemes require a credible approach to capturing savings to be established, that details the expected outcomes (including the different types of savings), and data needed to capture the results. When measuring outcomes, forecasts should be compared with actual savings to be transparent in any differences, with a guideline of how to address discrepancies, this is particularly important if expected savings are linked to budget reductions.

These case studies highlight the ongoing challenge of measuring the financial and economic return from prevention. The benefits of these initiatives can take place over long periods, develop in different departments or organisations, include outcomes that may have been unexpected and therefore not measured, and include valuable outcomes that do not translate into a direct cash saving (such as avoided demand and improved service capacity). Robust measurement needs to be agreed on and designed into the funding model from the outset, with clear expectations about what will be measured and how evidence of savings will be used in future budget decisions.

## 5.3. Governance and accountability arrangements

Governance serves several functions including: coordinating across different organisations and departments, connecting funding decisions to local priorities, assigning accountability, and supporting monitoring, evaluation and reporting. The examples in this report showcase a range of governance arrangements, from formal interagency agreements and cross-sector collaborations to participatory models that include residents.

### Cross-sector governance and shared accountability

The LA PIDP involved a relationship across public services and community organisations. The Los Angeles County Department of Children and Family Services worked with community and faith-based organisations to create prevention networks from pre-existing services. The Department, in partnership with a national foundation, funded an evaluation, and the evaluation board included representatives from the eight PIDP networks. This evaluation was successful in granting the programme an additional year of funding.

The conditional cash transfer programme used a cross-sector governance model where the Center for Economic Opportunity provided strategic leadership and non-profit and community organisations led the delivery. Programme evaluation was led by a delivery partner. Another key feature of this example was that it received mayoral buy-in.

Victoria is slightly different in that it uses a mainstream budget process but is an example of collaborative case-making between departments and Treasury, with the government offering support in building the proposals.

## Multi-level and participatory governance

The examples in Catalonia, Scotland, and Germany highlight ways of giving people who are closest to the issues a role in decision-making. The Catalonia Neighbourhoods Law example created a management committee that brought together government and municipal departments, alongside experts in urban sustainability and regeneration. At the local level, committees of residents and public workers were set up for understanding resident needs, project management, and monitoring and evaluation.

The two Scottish examples place community participation most centrally. In Clackmannanshire local problems and aspirations are identified by a resident panel. The Transformation Space board then decides which projects align with the local priorities and provides funding to them. Outcomes are tracked due to a partnership with a learning partner and regular updates are provided. The Edinburgh Regenerative Futures Fund describes its governance as a non-hierarchical ecosystem that includes the funded organisations, funders, a decision-making panel, a host organisation, and an oversight board. The funding decisions are made by local people with lived experience of poverty and inequity. Residents receive training on how to make these decisions, are paid for their time, and can receive support for childcare, travel and translation, ensuring that participating is accessible.

The Health Circles in Germany were built on a collaboration between statutory health insurers, employers, unions, occupational safety representative, and employees. The health insurers' sickness funds supported the prevention activity, but companies were responsible for implementing the changes within their organisations. Joint steering committees were often used to oversee individual health circles and coordinate decisions. Employees themselves were involved in identifying problems and proposing solutions.

There is a common thread in these governance arrangements in that they are often place-based, connect funders with delivery organisations and communities, they feature joint decision-making, and build monitoring and evaluation into the programme.

# 6. Conclusion

## 6.1. Key findings

This report draws together the selected case studies and conversations with experts and practitioners and seven themes have emerged:

### 1. Long-term funding

These findings support the argument that interventions need to be funded long-term or embedded into mainstream budgeting to enable preventative benefits to emerge. Multi-year financing with routes into mainstream budgeting can give prevention work more time to embed. All of the examples in this report provide either long-term or embedded funding to prevention activity and recognise that prevention and system re-design requires a long-term plan, something that was also echoed in our conversations with experts.

Long-term funding enables organisations more time to build trust and partnerships with local communities, service delivery partners, and local leaders. Clackmannanshire's Transformation Space and Edinburgh's Regenerative Futures Fund are at too early stages to know their impact, but both examples are championing the value of having time to build those relationships. Multi-year funding also gives organisations more time to build a rigorous evaluation baseline and embed how outcomes can continue to be measured.

Additionally, pilot funding can test a model, but where evidence and delivery capability exist there needs to be a credible rout to long-term changes in the way existing services work and funding streams are allocated. This is where the work Victoria are doing, embedding preventative spending in mainstream budgeting, is valuable to learn from.

### 2. Shared financial responsibility

Prevention work often crosses organisational and service boundaries. Sharing investment can reduce the risk of the organisations involved; however, this will also require clear governance structures and agreement on how savings and benefits will be shared. Pooled, matching, blended, and cross-departmental/interagency approaches share the upfront cost and risk rather than placing it on a single budget.

HUD-VASH aligns housing vouchers funded through the Department of Housing and Urban Development with clinical case management from the Department of Veteran Affairs. Health Circles combine insurance-based sickness- fund support with employer participation. The Nurse-Family Partnership has drawn on multiple pre-existing public funding streams, and Catalonia's Neighbourhoods Law used regional-municipal match funding. Such arrangements distribute the contribution across stakeholders to unlock more funding than they may be able to achieve alone, share risk, and enable buy-in of multiple actors.

Each agreement should be clear on who pays for what, what the governance structures will be, who is accountable for delivery, who may benefit (and what those benefits may be), how risks are managed if the predicted outcomes are not achieved, and what are the incentives to contributing.

This report has presented several models that involve shared financial responsibility including pooled budgets, match-funding, sharing service delivery, and repayment on the basis of achieved outcomes. There is no one model that has been proved most effective. Instead, it is important to establish what works best for the individual context but ensure that the terms and agreements are clear from the start.

### 3. Measurement and evaluation

Prevention is difficult to measure, but evidence of success can unlock new funding and share valuable lessons with other places. Measurement and evaluation were common challenges across many of the case studies. Evaluation should be built into the funding design from the start with clear measures that match the intended outcomes of the intervention. Being able to measure and evaluate is a sticking point in prevention interventions but is key to being able to make correct budget decisions and avoid the wrong pocket problem. The LA PIDP shows how evaluation can support programmes, as its positive evaluation extended the funding for an additional year.

The evidence of financial and cash savings is particularly important, especially if the model intends to claw back that resource, as is the case in Victoria. This can create problems, for example Victoria's 2026 Auditor-General review found that realised savings were not routinely calculated against the expected savings which the budget reductions were based on.

### 4. A clear and common narrative

A shared narrative can help encourage buy-in and sustain political and institutional commitment. To commit to prevention in the long-term, resisting short-term pressures to deviate towards primary interventions or other expenditure, requires a strong central narrative around prevention strategies. This also requires a clear and shared understanding of opportunity cost of what can, or cannot be funded, and the resulting forgone benefits.

The HUD-VASH case study is an example of a topic (helping veterans) that is high on the US political agenda, and the NYC Conditional Cash Transfer programme was renewed due to mayoral interest. Victoria also shows how government backing to prioritising prevention can help it become embedded in mainstream budgeting processes.

Conversations with experts during this research highlighted the value of identifying prevention spend and developing a common case for change across local, regional, and national government. The narrative should connect place-level priorities with a clear delivery pathway and realistic outcomes, creating a shared purpose for the multiple stakeholders involved.

### 5. Invest in enabling capacity

Using 'glue money' to provide support, relationship-building, training, and management of partnerships can help places deliver change and should not be overlooked. Prevention work, in the UK's current system, will often involve work that is difficult to fund through the usual annual budgets and come across problems around collaborative work, data-sharing across services and geographies, staff capacity and capability and managing relationships with local organisations. Investing in enabling capacity can help support this work. This type of funding provides practical resource for the required relationships, capabilities, and learning that is needed for system change.

LA PIDP's investment in community networks used "glue money" to make existing services more accessible and connected. The Edinburgh Regenerative Futures Fund have also invested in building relationships and training. In the Victoria case study, Treasury works with departments to develop and test their proposal.

As fiscal devolution develops and regions are given more powers, it is important that a funding framework includes resources to provide staff and delivery providers with time, capacity, and capability to support the required changes.

### 6. Flexible use of existing resources

Pooling resources and assessing where existing resources could be used in new ways can support in the short-term and provide insight into future service redesign. Several examples showcase using existing funding streams and services rather than creating new funds. LA PIDP used dedicated Title IV-E reinvestment funds to develop community networks and improve access to support. The Nurse-Family Partnership blended pre-existing public funding streams to support the delivery of services. Flexibly using existing resources can be a way of shifting the status quo to a more preventative way of working and local leaders should be given the powers to use their funding more flexibly for that reason. However, existing resources are not cost-free, the reallocation of funds has opportunity costs, and so this needs to be done mindfully.

### 7. Community participation

Prevention activity can be powerful when residents with lived experience are involved in a way where they can enhance the design of policy implementation, including influencing priorities and resource decisions. When local communities are given power to influence preventative work, it helps ensure the initiatives are rooted in lived experience and target problems most prioritised to the community.

In Clackmannanshire's Transformation Space, a resident panel determines the priorities and makes decisions over which projects to approve. Edinburgh's Regenerative Futures Fund involves residents with lived experience, providing training and support to enable participation and make funding decisions. Catalonia's inclusion of local residents in neighbourhood bids enabled them to respond to local needs impacting the community. Employee involvement in the German Health Circles allowed the employees closest to the problems to help shape the solutions. Participation should involve giving communities genuine power, rather than being consulted after decisions have been made. Enabling participation can come with costs, for example the Regenerative Futures Fund which pays for training alongside covering transport costs, translation needs, and childcare support, in order to be inclusive to participants.

## 6.2. Recommendations

This report proposes seven key recommendations for policy makers and practitioners in England to create the conditions needed for a fiscal system that enables prevention. These recommendations draw on our research which includes: the case studies, expert roundtables and conversations, and input from the project's steering group.

Without addressing these recommendations, there exists significant challenges in delivering preventions strategies at scale in England, and in achieving one of the central goals of the recent 'Rewiring the State' paper: to enable greater alignment and pooling of funding for preventative services and for public services to form a single coherent system built around the priorities of people and places'[71].

These findings point towards a set of recommendations for places, including national government and mayoral strategic authorities:

### 1. National government must enable and incentivise prevention and system reform

In order to drive a shift to prevention at scale, there should be incentives for places to innovate and to redesign public service delivery. Scaling prevention requires enabling conditions such as accountability arrangements and committed funding over longer periods which may require changes to national frameworks. Creating an enabling environment may also require incentives that can support places to build preventative capacity, test approaches, and scale effective programmes.

The status quo of pilot budgets and a traditional approach of double running budgets to enable testing of prevention is more limited in scope than many of the international examples identified in this report, and can discourage the type of systemic reform that is needed. Incentivising places to demonstrate growing capability and delivery of local prevention infrastructure, alongside improvement in outcomes, will enable change at a greater pace.

Government should reward places for building prevention capability, not only for short-term outcomes. Funding could be released in stages, as in New York's DSRIP programme, so that agreed capability milestones are supported first- relating to data quality, partnership building, and establishing integrated pathways for prevention - and subsequent funding is released against outcomes as regions start to deliver these. This process would incentivise a measured shift in budgeting and delivery which would account for the varying maturity of regional authorities to deliver prevention interventions and savings.

For national government this could look like setting multi-year, staged prevention funding (for example within integrated settlements and the new PDEL), and adapt accountability frameworks.

For local and regional government this would include building capability and data infrastructure, agreeing milestones across partners and regularly reporting against them.

## 2. Agree how costs, risks, and gains will be shared

There must be a clear mechanism for places, as well as central government, to benefit from cost savings and capacity gains realised through the impact of prevention work at local, regional and national levels. Before prevention funding and delivery starts, partners must agree who pays, who benefits, what kind of return is expected (cash, avoided cost, freed-up capacity or wider outcomes) and what happens if savings do not materialise.

Central government must be party to these agreements because many gains fall to national budgets: in the Nurse-Family Partnership, less than 1% of estimated avoided costs to government fell directly to the health services concerned with delivery. In most cases the gain will be a reallocation of resources rather than lower overall spending.

This report recognises the difficulty of evidencing this impact and its spread across several departmental and functional lines, however it is vital to incentivise places to bring forward savings and to take calculated risks that will enable a shift towards prevention. While recent signals from government on fiscal devolution have been encouraging, there is much less discussion of how effective reallocation of resources might be assigned. Clear agreements on how this will work is essential and should be addressed quickly, including through the spending review process in 2027.

For national government this would involve agreeing how gains to national budgets (such as DWP and the NHS) are shared, and how shortfalls are handled. These agreements should be made in collaboration with local and regional government.

For local and regional government this would look like setting out the costs, expected returns and risks for each investment, and sharing outcome data using national agreed guidelines.

## 3. Identify prevention spend and measurement using shared definitions and guidelines

Without understanding what prevention spending is, and an idea of its current baseline, further shifting towards up-stream preventative strategies with greater impact will be difficult. Identifying prevention spend and adopting a common definition or set of guidelines helps to uncover opportunities and encourage dialogue on what more can be unlocked and how local, regional and national budgets may be used flexibly.

Places and departments should map their prevention spend using a common method, such as the tool being trialled with the Scottish Government, and classify it against a commonly agreed framework. Our research participants have found it useful to conceptualise prevention funding on a spectrum running from ‘Community Resilience’ to addressing ‘Emerging Need’ to the most significant downstream ‘Crisis Response’. CIPFA and the Health Foundation have begun work to explore the extent to which council spending on prevention can be quantified[72]. This work aims to build a shared definition of preventative activity which can be used to map against current services and identify current levels of spending from which any shift can be measured.

Establishing shared definitions would be a starting point for a practical cycle: A shared definition enables mapping of current spend, which helps identify intervention opportunities, to allow the

modelling of fiscal and economic effects of those opportunities, the changes in funding and incentive arrangements can then be tested, and the realised benefits measured, which informs future allocation.

For national government this would involve agreeing a common definition and method across departments, building on the PDEL as well as CIPFA's work and Scotland's spending tagging.

For local and regional government this would include mapping local spend against the definition and contributing to a shared baseline.

### 4. Invest in collective case making for prevention

A shared commitment to case making for prevention is vital. This means local, regional and national levels working together - not just to agree and deliver on policy, but to develop the specific criteria, processes and individual investment cases for prevention activity. Local, regional and national levels must work together to agree and deliver on policy and develop the specific criteria, processes and individual investment cases for prevention activity. National, regional and local government should build investment cases for prevention together, rather than through bidding and approval. In practice this means a joint unit with a shared model of avoided costs (as the case study from Victoria's Treasury sets out), a standard case template or understanding of the aspects of prevention case making, data-sharing agreement(s) locked in before cases are built, agreements between the specific bodies that pay for and benefit from prevention,and independent checking of whether savings have been realised as predicted. This approach goes far beyond national-regional cooperation and establishes a clear set of governance and a specialised function to develop effective prevention.

The UK has intent for national-regional-local collaboration but has yet to take its work to match the level of coordination seen elsewhere internationally. We should look to move beyond welcome approaches like secondments of staff to the regions and build a more intentionally collaborative approach to case making.

For national government this could include hosting, or co-funding, a joint case-making function with a shared avoided-cost model and independent verification, and providing support to local and regional government in developing proposals for prevention.

For local and regional government this could involve co-developing cases with departments and national government, and contributing to local data and evidence.

### 5. Align budgeting processes with devolved responsibilities and place-based delivery

Regional devolution is needed to shape successful prevention strategies that meet place-based needs. This includes flexibility, in some cases significant-to-full autonomy over health and prevention-related budgets, as well as supported and coordinated approaches to place-based measurement and evaluation. At present the budgeting approaches do not match the government's intent of devolving more power and responsibility for better public service integration and improved local outcomes. Devolution helps prevention only if places can pool budgets across services, understand local need, and are accountable for outcomes. Budgeting should move from competitive bidding and small ringfenced pots to larger and more flexible

integrated settlements, with national-regional co-funding arrangements that reflect places' differing fiscal capacity. The upcoming Spending Review is an opportunity for greater collaboration across geographies in its development of medium-term funding plans.

For national government this could look like extending single-pot settlements, reducing competitive bidding, and reflecting regional differences in fiscal capacity through co-funding and equalisation.

For local and regional government this could involve using flexibilities to pool funding and delivery across services and be accountable for local outcomes.

### 6. Broaden the range of funding typologies used at the place level

There are several typologies of prevention funding, including those which are under-utilised within the UK. Approaches such as the blending of departmental funding, the integration of philanthropic funding, and mechanisms such as impact bonds, can bring new funding sources. However, different funding types suit different jobs. Impact bonds favour quick, measurable outcomes in high-risk groups; philanthropy suits testing ideas; local borrowing suits capital investment such as housing development and urban renewal.

Aside from the recommendations made here about collaboration and systems of delivering prevention funding, more capital and revenue is needed within the system, and places should be proactive in using their convening powers – particularly through Mayors – in order to encourage a greater range of funding sources into prevention strategies. The concept of 'glue money' – enabling finance to build networks and explore wider resources – should be used to help pursue this new funding and local capability. However, it is also important to note that pursuing new avenues of funding should not be a replacement to adequate core public funding.

For national government this could involve maintaining sustained core funding with protection around prevention spending, and set clear rules for regional government around blending budgets, impact bonds, and borrowing.

For local and regional government this may include convening philanthropy and investors, and using alternative finance for testing and capital, but not as a replacement for core revenue.

### 7. Trust and train communities to shape prevention funding and priorities

Evidence suggests that communities intuitively support prevention strategies when given meaningful influence over priorities and delivery if given the resources and opportunities to be able to do so. The idea of prevention spending does not need to sit so distant from the everyday language of people in their communities and early work has found that when involved in local delivery, communities bring forward new and innovative ideas for upstream interventions that can provide long-term benefits. Residents should be involved early, when priorities are being set, and enabled to take part, as in Edinburgh's Regenerative Futures Fund.

For national government this would involve allowing time and flexibility in funding rules for local and regional government to meaningfully engage the public in participation.

For local and regional government this would include involving residents early in priority setting and decision making.

## 6.3. Risks and considerations

The government has stated that it will be possible to review the responsibilities and scope Mayoral Strategic Authorities are given through Integrated Settlements in the 2027 Spending Review. Rewiring the State sets the stage for a wider ambition for place-based empowerment. These are opportunities to consider how funding arrangements can reward a shift in service delivery towards prevention.

However, devolution cannot guarantee successful prevention work or better outcomes alone, there needs to be pathways into better local capability, data-sharing, and long-term resource management. Places need flexibility to adapt delivery to local needs and incentives to do so. Central government can enable this shift by providing incentives, agreeing on shared data mechanisms and enabling pooling of resources, while supporting places to develop safeguards and accountability. For prevention to be prioritised and sustained long-term in England, devolution must also be connected with opportunity for improving local capacity and capability, shared definitions and measurements need to be agreed, and central government needs to collaboratively work with, and support, regional government with this shift.

This research has highlighted the following risks that should be considered and which our recommendations seek to address:

- Overstating or assuming cashable savings: There is a risk of taking a prevention agenda forward on the premise of cash savings which may not materialise. The prevention agenda should be taken forward on the basis of having more effective use of resources for better outcomes. In cases where cash savings are forecasted, they should not automatically become budget cuts without safeguards in place. There are many reasons why predicted savings may not materialise and there needs to be caution applied with how government expects to receive repayment of investments.
- Narrowing the purpose of prevention to cashable savings: There are several valuable outcomes to prevention including improved health and wellbeing outcomes, reduced capacity and demand, and improved service and community resilience. If only cash saving outcomes are measured or incentivised, other outcomes may become undervalued.
- The wrong pocket problem: Clear understandings of risk and reward must be put in place when prevention outcomes span different services. If one department funds and implements an initiative but another receives the benefit, or has their budget reduced consequently, both services should receive suitable support and have a voice in decisions.
- Over relying on short-termism without system reform: Pilots and short-term funding create changes that may not be sustainable. Plans for prevention work should include pathways for long-term sustainability after the initial funding if it is successful.
- Widening of place-based inequalities: Places with fewer resources risk falling behind. Needs-based allocations, equalisation mechanisms, and capacity-building support should be put in place to ensure that access to funding does not widen place-based inequalities.
- Community participation without power: Residents should be aware of opportunities where they can genuinely shape decisions and have the support needed to participate. This involves going beyond consulting the public when decision have already been made, to creating opportunities for local people to influence priorities and implementation.

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