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Outcomes-Based Contracting

Financing Early Action and Long-Term Public Value

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EXECUTIVE SUMMARY

Public systems exist to create the conditions for positive social progress. They are expected not only to respond to immediate needs, but also to protect people's long-term wellbeing, independence, and ability to participate fully in society. Yet public systems face a persistent and well-known problem: many of the interventions that create the greatest long-term public value are the hardest to fund through ordinary public budgets. Early action, health promotion, social integration, youth development, brain and mental health support, chronic disease prevention, functional capacity, healthy ageing, and labour-market inclusion all produce value over long periods of time. They **improve quality of life, strengthen social participation, support employment, protect productivity, and increase the capacity of people to remain healthy, independent, and active. Over time, they can also reduce later costs by preventing deterioration and reducing pressure on health, social care, and welfare systems.** Yet these benefits often appear outside the annual budget cycle, outside the department that makes the original investment, and outside the narrow service categories through which public systems are normally managed.

Outcomes-based contracting has emerged as one possible tool to address this structural problem. Its central purpose is not simply to introduce private capital into public services. Its deeper function is to reorganize incentives around measurable outcomes. Traditional public contracting usually pays for inputs, activities, or service volumes. Outcomes-based contracting pays for verified results. It can be implemented through several contractual and financial structures, including performance-based procurement, pooled outcome funds, public-private outcome alliances, Special Purpose Vehicles, blended finance arrangements, and impact bonds among others[1],[2],[3]. In some models, an external funder or investor provides upfront capital; in others, funding remains public, philanthropic, or pooled across several institutions.

In health and social policy, this is especially relevant because many of the strongest opportunities for early action sit outside the healthcare system itself. Health is shaped in daily life: in families, workplaces, schools, neighbourhoods, local services, digital environ-

[1]Macdonald, J. R. (2019). *Awarding outcomes-based contracts*. Government Outcomes Lab, Blavatnik School of Government, University of Oxford https://golab.bsg.ox.ac.uk/toolkit/technical-guidance/awarding-outcomes-based-contracts/

[2] Organisation for Economic Co-operation and Development. (2025). *OECD DAC blended finance guidance 2025*. OECD Publishing. https://doi.org/10.1787/e4a13d2c-en

[3] Government Outcomes Lab. (n.d.). *Impact bonds*. Retrieved SEPTEMBER 11, 2026, from https://golab.bsg.ox.ac.uk/the-basics/social-impact-bonds/

ments, employment systems, food systems, cultural life, social relationships, and community institutions. Healthcare is only one part of the wider system that determines whether people remain healthy, functional, included, and economically active.

The case for outcomes-based contracting is strongest where four conditions are present. First, the problem must have meaningful long-term **human consequences and public costs** if left unaddressed. Second, there must be plausible interventions that can reduce those problems and costs or improve outcomes. Third, outcomes must be measurable in a credible and reasonably timely way. Fourth, there must be an actor capable of orchestrating multiple providers, budgets, data sources, and incentives around a shared goal. Without orchestration capacity, an outcomes contract becomes a financial wrapper around fragmented services. With strong orchestration, it can become a mechanism for system change.

The strongest use cases are not narrow clinical procedures but complex, multisectoral challenges: type 2 diabetes prevention, obesity reduction, cardiovascular risk management, mental health and work ability, youth development, migrant integration, long-term unemployment, healthy ageing, functional capacity, and national capacity. These are areas where existing systems often intervene late, after damage has already occurred. Outcomes-based contracting can help shift the system from corrective action to earlier, more proactive, and more coordinated action.

The model is not without risks. Outcomes-based contracts can be complex and expensive to structure. They require legal work, data infrastructure, outcome definitions, independent evaluation, funder alignment, public-sector commitment, and long-term governance. However, the level and type of complexity depend on the structure selected. Models involving external investors, including Social Impact Bonds, add investor agreements, financial governance, risk allocation, and repayment arrangements. Simpler publicly funded outcomes contracts, pooled funds, outcome alliances, or performance-based procurement may reduce some of this complexity, although they still require credible measurement, coordination, data governance, and accountability.

These challenges are especially visible in Social Impact Bonds[4], which add the additional complexity of investor funding and repayment structures. There are several potential benefits of impact bonds, including bringing together expertise from different fields, supporting prevention or early intervention, enabling new interventions to be tried and evaluated, and allowing greater flexibility and resilience in service delivery. But these also

[4] Organisation for Economic Co-operation and Development. (2016). *Understanding social impacts bonds* (OECD Local Economic and Employment Development [LEED] Papers No. 2016/06). https://www.oecd.org/content/dam/oecd/en/publications/reports/2016/06/understanding-social-impacts-bonds_2b4a9690/7e48050d-en.pdf

come with several limitations, including that impact bonds are not appropriate in all situations, can be complex and expensive to develop, and may involve outcomes that are difficult to define[5]. **But this assessment must be made in relation to the scale of the problem they are trying to address. The relevant question is not only whether the contract is costly to design, but whether those costs are justified when compared with the human consequences, service pressures, and future public expenditure that may result from inaction.** The central question is therefore not whether they are inherently good or bad. The real question is when outcomes-based contracting is the right **approach**, what governance model is appropriate, and whether the system has the maturity to use it well in a way that brings the most value for people, society and business.

This report argues that outcomes-based contracting should be seen as a tool for aligning long-term public value with near-term investment decisions. It is particularly relevant for early action because it can bridge the gap between upfront costs and delayed benefits. However, it should not be reduced to a financial mechanism. Its value depends on whether it creates better problem definition, stronger collaboration, more adaptive delivery, better use of data, and clearer accountability for outcomes that matter. Governance and orchestration should therefore lead the design, while the financial structure should follow the outcome being pursued.

[5] Government Outcomes Lab. (n.d.). *Impact bonds*. Retrieved SEPTEMBER 5, 2026, from https://golab.bsg.ox.ac.uk/the-basics/social-impact-bonds/

Julkisten järjestelmien tehtävänä on luoda edellytykset myönteiselle yhteiskunnalliselle kehitykselle. Niiltä odotetaan paitsi kykyä vastata välittömiin tarpeisiin myös ihmisten pitkän aikavälin hyvinvoinnin, itsenäisyyden ja täysipainoisen yhteiskunnallisen osallistumisen turvaamista. Silti julkiset järjestelmät kohtaavat jatkuvan ja hyvin tunnetun ongelman: monet toimenpiteet, jotka tuottavat suurimman pitkän aikavälin julkisen arvon, ovat kaikkein vaikeimpia rahoittaa tavanomaisista julkisista budjeteista. Varhainen tuki, terveyden edistäminen, sosiaalinen integroituminen, nuorten kehityksen tukeminen, aivo- ja mielenterveyden tuki, kroonisten sairauksien ehkäisy, toimintakyvyn ylläpitäminen, terve ikääntyminen ja työmarkkinoille osallistumisen tukeminen tuottavat arvoa pitkällä aikavälillä. **Ne parantavat elämänlaatua, vahvistavat yhteiskunnallista osallistumista, tukevat työllisyyttä, suojaavat tuottavuutta ja lisäävät ihmisten mahdollisuuksia pysyä terveinä, itsenäisinä ja aktiivisina. Ajan myötä ne voivat myös vähentää kustannuksia ehkäisemällä tilanteiden heikkenemistä ja vähentämällä terveydenhuoltoon, sosiaalipalveluihin ja hyvinvointijärjestelmiin kohdistuvaa painetta.** Näiden hyötyjen vaikutukset näkyvät kuitenkin usein vuotuisen budjettisyklin ulkopuolella, alkuperäisen investoinnin tehneen hallinnonalan ulkopuolella sekä niiden kapeiden palveluluokkien ulkopuolella, joiden kautta julkisia järjestelmiä tavallisesti johdetaan.

Tulosperusteinen sopiminen on noussut yhdeksi mahdolliseksi keinoksi ratkaista tätä rakenteellista ongelmaa. Sen keskeinen tarkoitus ei ole ainoastaan tuoda yksityistä pääomaa julkisiin palveluihin. Syvemmällä tasolla sen tehtävänä on järjestää kannustimet mitattavien tulosten ympärille. Perinteisessä julkisessa hankinnassa maksetaan yleensä panoksista, toiminnasta tai palvelumääristä. Tulosperusteisessa sopimisessa maksu perustuu todennettuihin tuloksiin. Mallia voidaan toteuttaa useilla sopimus- ja rahoitusrakenteilla, kuten tulosperusteisella hankinnalla, yhteisillä tulosrahastoilla, julkisen ja yksityisen sektorin tuloskumppanuuksilla, erillisyhtiöillä (Special Purpose Vehicle, SPV), yhdistelmärahoituksella ja vaikuttavuusobligaatioilla. Joissakin malleissa ulkopuolinen rahoittaja tai sijoittaja tarjoaa ennakkorahoituksen; toisissa rahoitus säilyy julkisena, hyväntekeväisyyteen perustuvana tai usean organisaation yhteisesti rahoittamana.

Terveys- ja sosiaalipolitiikassa tämä on erityisen tärkeää, koska monet parhaista varhaisen toiminnan mahdollisuuksista sijaitsevat varsinaisen terveydenhuoltojärjestelmän ulkopuolella. Terveyteen vaikuttaa jokapäiväinen elämä: perheet, työpaikat, koulut, asuinalueet, paikalliset palvelut, digitaaliset ympäristöt, työllisyysjärjestelmät, ruokajärjestelmät, kulttuurielämä, sosiaaliset suhteet ja yhteisölliset instituutiot. Terveydenhuolto on vain yksi osa laajempaa järjestelmää, joka määrittää, voivatko ihmiset pysyä terveinä, toimintakykyisinä, osallisina ja taloudellisesti aktiivisina.

Tulosperusteisen sopimisen perusteet ovat vahvimmillaan, kun neljä ehtoa täyttyy. Ensinnäkin ratkaisematta jätetyllä ongelmalla on oltava merkittäviä pitkän aikavälin **inhimillisiä seurauksia ja julkisia kustannuksia**. Toiseksi on oltava olemassa uskottavia toimenpiteitä, joilla näitä ongelmia ja kustannuksia voidaan vähentää tai tuloksia parantaa. Kolmanneksi tulosten on oltava mitattavissa luotettavasti ja kohtuullisen nopeasti. Neljänneksi tarvitaan toimija, joka kykenee kokoamaan useita palveluntuottajia, budjetteja, tietolähteitä ja kannustimia yhteisen tavoitteen ympärille. Ilman tällaista koordinaatio- ja orkestrointikykyä tulosperusteinen sopimus jää hajanaisten palvelujen ympärille rakennetuksi rahoituskehykseksi. Vahvan orkestroinnin avulla siitä voi tulla järjestelmätason muutoksen väline.

Vahvimmat käyttökohteet eivät ole kapeita kliinisiä toimenpiteitä vaan monimutkaisia, monialaisia haasteita: tyypin 2 diabeteksen ehkäisy, lihavuuden vähentäminen, sydän- ja verisuoniriskien hallinta, mielenterveys ja työkyky, nuorten kehityksen tukeminen, maahanmuuttajien integroituminen, pitkäaikaistyöttömyys, terve ikääntyminen, toimintakyky ja kansallinen toimintakyky. Näillä alueilla nykyiset järjestelmät puuttuvat tilanteeseen usein liian myöhään, vasta vahingon jo tapahduttua. Tulosperusteinen sopiminen voi auttaa siirtämään järjestelmää korjaavista toimista kohti aikaisempaa, ennakoivampaa ja paremmin koordinoitua toimintaa.

Malliin liittyy myös riskejä. Tulosperusteisten sopimusten rakentaminen voi olla monimutkaista ja kallista. Ne edellyttävät oikeudellista valmistelua, tietoinfrastruktuuria, tulosten määrittelyä, riippumatonta arviointia, rahoittajien tavoitteiden yhteensovittamista, julkisen sektorin sitoutumista ja pitkäjänteistä hallintoa. Monimutkaisuuden taso ja luonne riippuvat kuitenkin valitusta rakenteesta. Ulkopuolisia sijoittajia hyödyntävät mallit, kuten Social Impact Bond -mallit (SIB), tuovat lisäksi sijoittajasopimukset, rahoitushallinnon, riskien jaon ja takaisinmaksujärjestelyt. Yksinkertaisemmat, julkisesti rahoitetut tulosperusteiset sopimukset, yhteiset rahastot, tuloskumppanuudet tai tulosperusteiset hankinnat voivat vähentää osaa tästä monimutkaisuudesta, vaikka nekin edellyttävät uskottavaa mittaamista, koordinaatiota, tiedonhallintaa ja vastuuvelvollisuutta.

Nämä haasteet näkyvät erityisen selvästi Social Impact Bond -malleissa, joissa sijoittajarahoitus ja takaisinmaksurakenteet lisäävät monimutkaisuutta. Vaikuttavuusobligaatioihin voi liittyä useita mahdollisia hyötyjä: ne voivat yhdistää eri alojen asiantuntemusta, tukea ehkäisyä ja varhaista puuttumista, mahdollistaa uusien toimenpiteiden kokeilemisen ja arvioinnin sekä lisätä palvelujen joustavuutta ja sopeutumiskykyä. Niihin liittyy kuitenkin myös rajoitteita: vaikuttavuusobligaatiot eivät sovellu kaikkiin tilanteisiin, niiden kehittäminen voi olla monimutkaista ja kallista, ja tavoiteltavia tuloksia voi olla vaikea määritellä. **Arviointi on kuitenkin tehtävä suhteessa sen ongelman mittakaavaan, jota mallilla pyritään ratkaisemaan. Olennainen kysymys ei ole ainoastaan se, onko**

sopimuksen suunnittelu kallista, vaan myös se, ovatko nämä kustannukset perusteltuja verrattuna toimimatta jättämisen mahdollisiin inhimillisiin seurauksiin, palvelujärjestelmään kohdistuvaan paineeseen ja tuleviin julkisiin menoihin. Keskeinen kysymys ei siis ole, ovatko nämä mallit itsessään hyviä vai huonoja. Todellinen kysymys on, milloin tulosperusteinen sopiminen on oikea **lähestymistapa**, millainen hallintomalli on tarkoituksenmukainen ja onko järjestelmällä riittävä kypsyys käyttää mallia hyvin siten, että se tuottaa mahdollisimman paljon arvoa ihmisille, yhteiskunnalle ja yrityksille.

Tässä raportissa esitetään, että tulosperusteinen sopiminen tulisi nähdä välineenä, jolla pitkän aikavälin julkinen arvo voidaan sovittaa yhteen lyhyen aikavälin investointipäätösten kanssa. Se soveltuu erityisen hyvin varhaiseen toimintaan, koska sen avulla voidaan kuroa umpeen investointikustannusten ja viiveellä syntyvien hyötyjen välistä kuilua. Sitä ei kuitenkaan pidä nähdä pelkkänä rahoitusmekanismina. Sen arvo riippuu siitä, johtaako se ongelmien parempaan määrittelyyn, vahvempaan yhteistyöhön, mukautuvampaan toteutukseen, tiedon parempaan hyödyntämiseen ja selkeämpään vastuuvelvollisuuteen merkityksellisistä tuloksista. Hallinnon ja orkestroinnin tulisi siksi ohjata suunnittelua, ja rahoitusrakenteen tulisi seurata tavoiteltavaa tulosta.

1. Why Early Action Is Structurally Underfunded

Public systems understand that early action can reduce avoidable disease, protect work ability, improve quality of life, reduce exclusion, and limit future expenditure[6]. **Yet** public budgeting and accountability often favour acute, visible, and legally mandated services over **preventive interventions whose benefits emerge gradually**. Budget decisions are usually assessed within annual cycles and, in practice, rarely extend beyond the current electoral term[7]. Acute care fits this logic because decision-makers can see the patient, define the need, follow a clinical pathway, and assign responsibility[8]. Early action, on the other hand, protects people before harm becomes visible. This creates what could be described as the "nameless beneficiary problem": acute care shows the person saved, while prevention often protects people who may never appear as identifiable beneficiaries of the intervention. This also creates a communication and trust challenge. When the beneficiaries of prevention remain unnamed, communities may struggle to see themselves in the outcomes being measured. If public systems do not explain how **population-level benefits are produced, distributed, and connected to people's daily lives**, the evidence used to justify prevention may appear distant, abstract, or untrustworthy. This reflects the wider distinction between identified beneficiaries and "merely statistical people," a concept used in ethics and public policy to explain why preventive action can receive less attention than treatment, even when it may protect more people[9].

Alongside this problem of visibility is a separate financing problem. Early action asks governments to spend today for benefits that may emerge years later, under another administration, or within another institution's budget. Even when an intervention creates substantial social value, the department that finances it may receive only a small share of the resulting "benefit". This is often described as the "wrong pocket problem": one institution bears the immediate cost, while other institutions or sectors capture much of the

[6] Organisation for Economic Co-operation and Development. (2026). *The health and economic benefits of tackling non-communicable diseases*. OECD Publishing. https://www.oecd.org/content/dam/oecd/en/publications/reports/2026/04/the-health-and-economic-benefits-of-tackling-non-communicable-diseases_6ec94420/e20cbbc3-en.pdf

[7] Hoddinott, S., Davies, N., & Kim, D. (2024, May). *A preventative approach to public services: How the government can shift its focus and improve lives*. Institute for Government. https://www.instituteforgovernment.org.uk/sites/default/files/2024-05/preventative-approach-public-services_0.pdf

[8] McKie, J., & Richardson, J. (2003). The rule of rescue. *Social Science & Medicine, 56*(12), 2407–2419. https://www.sciencedirect.com/science/article/abs/pii/S0277953602002447

[9] Hare, C. (2012). Obligations to merely statistical people. *The Journal of Philosophy, 109*(5/6), 378–390. https://web.mit.edu/~casparh/www/Papers/CJHareObligationstoStatistical.pdf

return. Public finance therefore tends to favour corrective spending over preventive investment, not only because corrective services respond to visible needs, but also because their costs and responsibilities are easier to assign. In healthcare, this imbalance is reinforced by payment models such as fee-for-service, which reward the volume of procedures and treatments rather than high-quality, efficient, and preventive care [10].

This imbalance is visible in health expenditure data. In *Health at a Glance 2025*, the OECD reports that total spending on prevention remained relatively stable at around 3% of overall health spending across OECD countries in the decade before the COVID-19 pandemic. This share rose to 6% by 2021, largely reflecting emergency COVID-19 public-health measures, but then fell back to pre-pandemic levels by 2023. By that year, preventive spending ranged from 6–7% of total health spending in Canada and the United Kingdom to less than 3% in Poland, Belgium, Iceland, France, Switzerland, Portugal and Japan[11] **The pattern shows that prevention remains a small and fragile part of health expenditure, even though many major health and social costs are shaped long before people enter acute care.**

At the same time, this is not an argument for limiting prevention to the health system. Much of prevention takes place outside healthcare and through policies concerning education, employment, housing, urban planning, transport, food environments, culture, physical activity and social participation[12],[13],[14],[15]. The challenge is not only the level of investment in preventive healthcare, but also the difficulty of coordinating and financing

[10] Rosenthal, M. B. (2008). Beyond pay for performance—Emerging models of provider-payment reform. *The New England Journal of Medicine, 359*(12), 1197–1200. https://doi.org/10.1056/NEJMp0804658

[11]Organisation for Economic Co-operation and Development. (2025). *Health at a glance 2025: OECD indicators*. OECD Publishing. https://www.oecd.org/en/publications/2025/11/health-at-a-glance-2025_a894f72e/full-report/health-expenditure-on-prevention-and-primary-healthcare_e65bf24a.html

[12]Fancourt, D., & Finn, S. (2019). *What is the evidence on the role of the arts in improving health and well-being? A scoping review* (Health Evidence Network synthesis report No. 67). WHO Regional Office for Europe. https://www.who.int/europe/publications/i/item/9789289054553

[13]World Health Organization Regional Office for Europe. (2023, September 28). *Health is everyone's concern: WHO guidance supports action across sectors*. https://www.who.int/europe/news/item/28-09-2023-health-is-everyone-s-concern--who-guidance-supports-action-across-sectors

[14]World Health Organization. (n.d.). *Promoting Health in All Policies and intersectoral action capacities*. https://www.who.int/activities/promoting-health-in-all-policies-and-intersectoral-action-capacities

[15]World Health Organization. (2025, May 6). *Social determinants of health*. https://www.who.int/news-room/fact-sheets/detail/social-determinants-of-health

preventive action across institutions with different mandates, budgets, objectives and accountability arrangements. Evidence on intersectoral health promotion identifies separate funding streams, organizational budget silos, inflexible funding arrangements, restrictions on the use of funds and differences in sectoral objectives as important barriers to investing in and sustaining preventive action[16],[17].

This is not an argument for replacing ordinary public responsibility. Governments should still fund routine public health functions, vaccination, screening, regulation, primary care, health promotion, and core social services through ordinary public budgets. **Rather, it shows where complementary financing models may be useful to reduce the strain in current existing systems.** Outcomes-based models become relevant when conventional budgets fail to support proactive, integrated action because benefits arrive late, spread across sectors, or resist simple attribution.

This financing challenge is also a design challenge. Early action exposes a design problem: Type 2 diabetes risk, mental health, work ability, obesity, and cardiovascular risk **do not usually sit within one service, one budget, or one accountable institution.** Public systems still divide responsibility across departments, services, and professions that rarely match people's lives. Early action needs horizontal structures, shared accountability, adaptive learning, and pooled resources around defined outcomes. Outcomes-based contracting can help by defining the outcome that matters, creating incentives for cooperation, and linking earlier investment to verified results.

[16]World Health Organization. (2023). *Working together for equity and healthier populations: Sustainable multisectoral collaboration based on health in all policies approaches*. https://www.who.int/publications/i/item/9789240067530

[17] McDaid, D., & Park, A.-L. (2016). *Evidence on financing and budgeting mechanisms to support intersectoral actions between health, education, social welfare and labour sectors* (Health Evidence Network Synthesis Report No. 48). WHO Regional Office for Europe. https://www.ncbi.nlm.nih.gov/books/NBK391062/

2. What Outcomes-Based Contracting Actually Is

Outcomes-based contracting links payment to predefined outcomes rather than delivered activities, such as improved wellbeing and fewer avoidable healthcare contacts, improved vision following cataract surgery, or better self-management and reduced hospital use[18],[19],[20]. The Global Partnership for Results-Based Approaches defines outcome-based financing as an approach that links funding to independently verified results measured at the outcome level, rather than through system actions, inputs, activities, or outputs, with the aim of supporting greater impact for beneficiaries[21]. The model asks what changed for people and whether that change can be measured credibly. It links funding to results, shares delivery risk, allows adaptation, and changes how public systems define problems, commission services, measure progress, and hold actors accountable.

A simplified outcomes-based contract includes an outcome payer, service providers, an orchestrator or project administrator, an independent evaluator, and, where needed, a funder or investor. Some of the options to implement it include social impact bonds, outcomes funds, public-private outcome alliances, special purpose vehicles, pooled funds, blended finance structures, and performance-based procurement.

This structure can help public systems address a fundamental timing problem: early action requires investment today, while many of its benefits emerge only later. Outcomes-based contracting can bridge this gap by making capital available upfront, allowing services to adapt during implementation, independently measuring progress, and linking payment to verified results. However, the financial structure is only one part of the model. The more difficult task lies in building a credible impact ecosystem around it by defining

[18]Government Outcomes Lab. (n.d.). *Ways to Wellness (INDIGO-POJ-0120).* Retrieved SEPTEMBER 5, 2026, from https://golab.bsg.ox.ac.uk/knowledge-bank/indigo/impact-bond-dataset-v2/INDIGO-POJ-0120/

[19]Government Outcomes Lab. (n.d.). *Cameroon Cataract Bond (INDIGO-POJ-0016).* Retrieved SEPTEMBER 5, 2026, from https://golab.bsg.ox.ac.uk/knowledge-bank/indigo/impact-bond-dataset-v2/INDIGO-POJ-0016/

[20]Government Outcomes Lab. (n.d.). *Provision of a social prescribing framework and offer at scale across Northamptonshire (INDIGO-POJ-0228).* Retrieved SEPTEMBER 5, 2026, from https://golab.bsg.ox.ac.uk/knowledge-bank/indigo/impact-bond-dataset-v2/INDIGO-POJ-0228/

[21]Global Partnership for Results-Based Approaches. (2020). *An introduction to outcome-based financing: GPRBA's Outcomes Fund MDTF*. World Bank Group. https://documents1.worldbank.org/curated/en/230581623054776388/pdf/An-Introduction-to-Outcome-Based-Financing-GPRBA-s-Outcomes-Fund-MDTF.pdf

the appropriate outcomes, target population, baseline, metrics, data arrangements, governance, trust relationships, and scope for adaptation. Poorly designed outcomes-based contracting can become costly, rigid, and administratively burdensome. When designed well, however, it can provide a platform for continuous learning, earlier intervention, adaptive delivery, and wider system change. Which is why we need to consider not only the design of the contract, but also the nature of the problem it is intended to address.

3. Challenges Where Outcomes-Based Contracting Can Support Early Action

Outcomes-based contracting is most relevant where the consequences of inaction develop over time, responsibility is divided across institutions, and the benefits of intervention extend beyond the organisation that initially pays for it. The following areas illustrate these conditions. Although they differ in their populations, services, and outcome measures, they share a common challenge: early action can create substantial long-term public value, but conventional funding and accountability arrangements often struggle to recognise, coordinate, and finance it.

Type 2 diabetes, obesity, cardiovascular disease, hypertension, and related metabolic risks create long-term costs for healthcare systems, employers, families, and public finances. Outcomes-based contracting can align primary care, community services, digital tools, employers, food environments, physical activity systems, and local networks around shared results.

Mental health and work ability also fit. Costs spread across healthcare, social care, employers, social insurance, disability benefits, and lost productivity. Outcomes-based models can make this value visible by linking interventions to sustained employment, reduced sick leave, improved work ability, reduced service use, or better functioning. A 2021 systematic review found that several school-based and youth-focused prevention programmes offered good value for money, particularly screening plus psychological interventions such as Cognitive Behavioral Therapy. Reported examples included US$13,586 per QALY for CBT among at-risk adolescents and $16,744 per Quality Adjusted Life Years for the Olweus Bullying Prevention Programme, both below commonly used willingness-to-pay thresholds[22].

Youth development and early support require longer time horizons. The Finnish Children and Youth SIB illustrates this logic through a planned implementation period from SEPTEMBER 2018 to December 2031. The initiative was built on the impact-investing work initiated by the Finnish Innovation Fund Sitra in 2014 to pilot the Social Impact Bond model in Finland. It involved five Finnish municipalities and focused on children, young people, and families needing welfare support. Around 750 children and young people have participated to date. The fund has approximately EUR 5.5 million in capital, while

[22]Le, L. K.-D., Esturas, A. C., Mihalopoulos, C., Chiotelis, O., Bucholc, J., Chatterton, M. L., & Engel, L. (2021). Cost-effectiveness evidence of mental health prevention and promotion interventions: A systematic review of economic evaluations. *PLOS Medicine, 18*(5), e1003606. https://doi.org/10.1371/journal.pmed.1003606

around EUR 12.3 million has already been invested in different activities and EUR 8.3 million paid in outcome bonuses, reflecting the circulation of capital through the model. By the end of 2031, total investment is expected to reach approximately EUR 17 million, with outcome bonuses estimated at EUR 19 million [23].

Migrant integration and labour-market inclusion provide a major example. Implemented by the Finish Innovation Fund Sitra, and the Ministry of Economic Affairs and Employment, from 2016 to 2019, the Finnish KOTO Social Impact Bond combined short language training, individualised support and employer contact to accelerate employment. The evaluation included 3,662 eligible immigrants: 2,636 were randomised to the intervention group and 1,026 to the control group. Provider remuneration depended on verified additional value, measured through tax revenues and unemployment-benefit savings over three years. Compared with the control group, KOTO-SIB increased earned income by EUR 4,500, or 18%, raised taxes paid by EUR 1,330 and reduced transfers received by EUR 1,340, producing average public-sector savings of EUR 2,670 per person. [24],[25]. Beyond these fiscal results, the model demonstrates why employment outcomes should distinguish entry into work from sustained, meaningful, and secure labour-market participation.

This distinction is equally important in programmes addressing long-term unemployment. Outcomes contracts are particularly relevant in this area because administrative data can measure employment status, earnings, benefit use, and tax contributions, making it possible to link payment to observable changes in labour-market participation. However, a strong outcome framework should extend beyond whether a person has entered employment. It should also consider job quality, earnings progression, skill acquisition, health status, employment sustainability, and long-term independence from public support where these outcomes are relevant and measurable.

A similar logic applies to healthy ageing and functional capacity. Outcomes-based contracting could support interventions that reduce frailty, prevent falls, delay entry into long-

[23] Government Outcomes Lab. (2021, July 16). *Children's welfare social impact bond, Finland*. Blavatnik School of Government, University of Oxford https://golab.bsg.ox.ac.uk/knowledge-bank/case-studies/childrens-welfare-social-impact-bond-finland/

[24]Karinen, R., Koivula, N., Koivula, T., Oosi, O., Pesola, H., Sarvimäki, M., & Virkola, T. (2024). *Koto-SIB -kokeilun vaikutukset ja käytännön toteutus* [Impacts and practical implementation of the Koto-SIB experiment] (Työ- ja elinkeinoministeriön julkaisuja 2024:33). Työ- ja elinkeinoministeriö. https://julkaisut.valtioneuvosto.fi/server/api/core/bitstreams/3c53cf50-b6a5-4e8d-aaa6-d81056d0c21a/content

[25]Ministry of Economic Affairs and Employment. (n.d.). *Integration SIB project*. Retrieved SEPTEMBER 5, 2026, from https://tem.fi/en/integration-sib-project

term care, maintain work ability, reduce loneliness, or help people continue living independently. These outcomes create value for health systems, social care budgets, families, employers, and communities. Their measurement is nevertheless more complex because meaningful results may take years to emerge and are often influenced by several providers, services, and social conditions. Strong modelling, fair attribution, risk adjustment, and the use of credible intermediate outcomes are therefore essential .

The same preventive logic can also be extended beyond health and social care. Early action affects national capacity and long-term public value through labour supply, economic participation, education, defence readiness, food security, crisis preparedness, demographic sustainability, and community productivity[26]. Community-based outcomes are central to this wider framing, as collaboration among local organisations, public institutions, stakeholders, and residents can produce locally grounded and culturally responsive solutions that improve quality of life, well-being, and community resilience. This wider framing can bring new outcome payers into the model, including employers, defence institutions, municipalities, insurers, pension funds, and regional development actors, which may have a direct interest in investing in early local action that generates wider and longer-term social and economic value.

Across these areas, outcomes-based contracting can make long-term, multisectoral, and often invisible value more concrete. It can help decision-makers recognise benefits that traditional budgets often overlook because they emerge later, appear across several sectors, or take the form of avoided harm. But the model only works if metrics are chosen with discipline. Narrow metrics can distort behaviour by rewarding what is easy to count rather than what matters. Overly broad metrics can make payment difficult to justify. The central task is therefore to define outcome measures that are meaningful, measurable, fair, and aligned with long-term public and economic value.

[26] Lane, J., Tudor Edwards, R., Issar, U., Hato, S., Rutten-van Mölken, M., Babarczy, B., Nagy, B., van Bemden, A., Feito Allonca, L., Davies, J., & Wright, S. (2026). *Financing productive health capacity: Reframing prevention as public infrastructure* [Unpublished manuscript]

4. From Late Intervention to Proactive Systems

4.1 Corrective, Early, and Proactive Action

The challenges described in the previous section differ in their populations, service pathways, and outcome measures, but they reveal two closely connected structural problems. Responsibility and value are often distributed across several institutions, while intervention frequently begins only after risk has become visible or harm has already occurred. Outcomes-based contracting can help align institutions around shared results, but it does not automatically lead to earlier or more preventive action. Its effect depends on the outcomes being rewarded and on where the intervention is positioned along the causal pathway. A contract may improve the coordination of services delivered after a problem has emerged, or it may redirect attention and resources towards preventing that problem from developing in the first place. Understanding this difference requires a clear distinction between corrective, early, and proactive action.

Corrective action responds after harm has already occurred. In health, it includes advanced disease treatment, complication management, hospital care, disability support, and crisis intervention. These services remain essential because people will always need care, protection, and support when problems become severe. However, corrective action operates late in the chain of causality, often after avoidable deterioration has already taken place.

Early action moves one step earlier. It identifies risk before harm becomes severe and tries to intervene while the problem is still manageable. It includes screening, early detection, lifestyle support, risk-factor management, targeted assistance, early treatment, family support, employment support, and community-based intervention. This approach moves closer to the source of the problem than corrective care, but it often still begins only once risk has become visible to the system.

Proactive action works further upstream. It strengthens the conditions that help people stay healthy, functional, independent, included, and able to participate in social and economic life. Rather than waiting for risk to appear, it improves the environments and capabilities that shape risk in the first place. This includes daily living conditions, social connection, family capacity, physical activity, food environments, community resources, meaningful work, and functional capacity across the life course.

Many systems nevertheless describe interventions that respond to an already identifiable risk as preventive or proactive. Screening for high blood pressure is early action; reducing the social, behavioural, environmental, and commercial conditions that drive hypertension is proactive. Treating prediabetes is early action; changing the food, activity, work, and community environments that increase diabetes risk is proactive. Supporting a

young person after school exclusion may be necessary, but it responds late; strengthening family, school, community, and mental health conditions before exclusion occurs is proactive.

These categories have direct implications for the design of outcomes-based contracts. They shape the outcomes selected, the actors who need to participate, the time required for results to emerge, and the evidence needed to demonstrate progress. Contracts linked only to service completion or short-term risk reduction may improve existing interventions without changing the wider conditions that produce the problem. A genuine shift upstream requires outcome frameworks that connect immediate and intermediate progress with longer-term changes in people's lives, communities, and public systems.

4.2 Why Outcomes-Based Contracting Can Support the Shift Upstream

Outcomes-based contracting can support this shift when it pays for meaningful outcomes rather than narrow service outputs. Contracts that reward activity often reproduce fragmentation because each organisation is paid for delivering its own part of the service, whether or not the wider problem improves. Contracts that reward changes in people's lives, system performance, or population outcomes can create stronger incentives for co-operation across sectors.

However, attribution becomes harder as interventions move upstream. It is relatively easy to prove that a patient received a service, attended a session, or completed a programme[27]. It is much harder to prove that a local system reduced avoidable deterioration, improved work ability, delayed dependency, or strengthened social participation. The more upstream the intervention, the more outcomes depend on several actors, wider social conditions, and longer time horizons.

This is why a strong model must start with a clear theory of change[28] [29]. The theory of change should connect the long-term public value being pursued to a set of measurable intermediate outcomes. A type 2 diabetes model, for example, can track risk identifica-

[27]Guerrero-Ruiz, A., Ridenour, S., Khan, N., Cuesta-Cobano, A., Levey, Z., & Jensen, D. (2025). *Outcomes-based financing in the new financing for development architecture: Lessons and opportunities for governments, development partners, and multilateral development banks* (OECD Development Co-operation Working Papers No. 119). OECD Publishing. https://doi.org/10.1787/badd168e-en

[28]Center for Theory of Change. (n.d.). *What is theory of change?* Retrieved SEPTEMBER 5, 2026, from https://www.theoryofchange.org/what-is-theory-of-change/

[29]United Nations Development Group. (2017). *Theory of change: UNDAF companion guidance*. https://unsdg.un.org/sites/default/files/UNDG-UNDAF-Companion-Pieces-7-Theory-of-Change.pdf

tion, physical activity, weight reduction in high-risk groups, blood pressure control, glycaemic markers, participation in early support, and reduced transition from prediabetes to diabetes[30] [31]. Over time, these indicators can then be linked to fewer complications, lower healthcare costs, higher productivity, stronger functional capacity, and better quality of life.

Modelling is therefore a central part of outcomes-based contracting and can be as important as the practical implementation itself. It creates a shared information base from which stakeholders can develop a common understanding of the phenomenon, its underlying causes and causal pathways, the target population, and the desired future they are collectively seeking to achieve. This includes defining the outcomes that are both desirable and realistically achievable, the longer-term impact to which they are expected to contribute, the intervention logic, the data sources, the responsibilities of different actors, and the payment model. Modelling can create solid starting points for the entire process by helping municipalities, governments, public institutions, and investors define the social benefit they want to achieve, adapt outcomes to local needs, and align commissioners, providers, investors, administrators, communities, and other relevant stakeholders around a shared framework. It should also remain active during implementation, allowing assumptions to be tested and the model to be refined as evidence and experience accumulate. The contract should follow that process rather than precede it.

[30]Diabetes Prevention Program Research Group. (2002). The Diabetes Prevention Program (DPP): Description of lifestyle intervention. *Diabetes Care, 25*(12), 2165–2171. https://doi.org/10.2337/diacare.25.12.2165

[31]Parker, E. D., Lin, J., Mahoney, T., Ume, N., Yang, G., Gabbay, R. A., ElSayed, N. A., & Bannuru, R. R. (2024). Economic costs of diabetes in the U.S. in 2022. *Diabetes Care, 47*(1), 26–43. https://doi.org/10.2337/dci23-0085

5. Essential Actors and Their Roles

Successful outcomes-based contracting depends on a clear ecosystem of roles.

The Outcome Payer

The outcome payer defines the outcomes that matter and pays when verified results occur. To perform this role effectively, it should take a system-wide and long-term perspective, considering what society needs to support positive and sustainable development rather than focusing only on savings within a single budget or sector. Public authorities usually hold this role, but insurers, employers, philanthropic foundations, development agencies, regional authorities, pension funds, and pooled public-private funds may also participate. Since early action spreads benefits across sectors, a single payer rarely captures the full return. The selected outcomes should therefore reflect both the direct results of the intervention and the wider value it may create by strengthening the conditions for further positive change and indirectly supporting other sectors. A diabetes intervention, for example, can create value for health systems, employers, municipalities, benefit systems, and wider public finances while also improving work ability, household resilience, social participation, and the longer-term capacity of communities and public services.

The Orchestrator

The orchestrator brings together service providers, data systems, investors or funders, public authorities, community actors, and evaluators. It manages the ecosystem, tracks performance, reallocates resources, and adapts the service model.In the ideal situation, the orchestrator could operate based on the near-real time data, when e.g. in a case of non-responding individuals provided interventions could be changes and/or intensified as needed. This kind of data-driven adaptive approach might have higher chances to maximize the expected outcomes. Licensed healthcare organizations may help when clinical data and care adjustments matter. Third-sector organizations, patient organizations, public-interest entities, and neutral intermediaries may build trust and connect formal services with community realities. The orchestrator needs authority to adjust budgets, change providers, respond to data, and adapt delivery.

The Financial Structuring Entity

The fund manager or financial structuring entity manages capital flows, investor relations, financial governance, reporting, and compliance. Formal Social Impact Bond or investment fund models require financial expertise. Financial structuring must serve the outcome logic. Strong orchestration and transparent data governance prevent the financial

layer from dominating operations. Some models can use public outcome funds, philanthropic first-loss capital, pooled public budgets, employer contributions, foundation grants, or blended finance instead of a full investment fund.

Public Administration

Public administration defines eligibility, ensures legal accountability, authorizes data access, protects public value, aligns the model with procurement rules, and ensures compatibility with existing services. It must prevent exclusion, gaming, excessive complexity, and transfer of essential public responsibility away from government. It must also protect political continuity, because health, youth, employment, and functional capacity outcomes may require from five to ten years or even longer.

The Independent Evaluator or Auditor

The independent evaluator or auditor verifies outcomes, baselines, risk adjustment, and payment conditions. This protects the public sector, funders, providers, and beneficiaries. The role matters especially in early action because many benefits are counterfactual: avoided deterioration, delayed dependency, prevented exclusion, or reduced service use. Evaluation should support learning during implementation and final verification. Ongoing outcome monitoring can also support learning and adaptation during implementation, while independent evaluation provides formal verification where this is required.

The Service Ecosystem

The service ecosystem includes formal providers, NGOs, community organizations, employers, schools,private companies, patient associations, technology providers, and local public services. These actors should operate as a coordinated coalition rather than as a collection of separate providers, with close collaboration, shared responsibility, and complementary capabilities directed towards common outcomes. A strong outcomes contract treats this ecosystem as adaptable and rebalances providers and resources according to their contribution to outcomes.

Funders and Investors

Funders and investors may include foundations, impact funds, pension funds, banks, family offices, insurers, corporations, and public investment vehicles. Some models use private upfront capital; others rely on public, philanthropic, or pooled capital. The best-aligned investors have long time horizons and accept moderate returns linked to public value. Pension funds align with long-term health, productivity, work ability, and population-level capacity, although regulation may limit participation. Capital should solve an intertemporal financing problem.

Communities and People Affected

Communities and people affected by the intervention should help define meaningful outcomes, identify barriers, interpret lived experience, and assess real value. Community knowledge matters because many determinants of health, function, participation, and inclusion sit outside formal systems. Administrative data can show service use, employment status, hospital admissions, or benefit claims, but it may miss safety, trust, access to support, social isolation, and fit with daily life. Community participation strengthens legitimacy and performance.

6. Structural Models for Outcomes-Based Contracting

Outcomes-based contracting can use several structures, and the right choice depends less on the label of the model than on the nature of the problem, the maturity of the data, the provider landscape, the legal environment, and the level of adaptability required. Some of the possible approaches are an alternative investment fund or Social Impact Bond structure, a Special Purpose Vehicle structure, or the outcome alliance or pooled outcome fund, which can be particularly relevant for place-based public value, early action, and cross-sector challenges.

In an alternative investment fund or impact bond structure, investors provide capital through a fund or financial vehicle, which then finances service delivery. The public sector repays the fund if agreed outcomes are achieved. A fund manager is responsible for financial governance, while an orchestrator coordinates delivery across providers and stakeholders. **This model is useful when the intervention requires flexibility, several providers, and the ability to adapt over time.** The fund and orchestrator can adjust the service mix, reallocate resources, work with different delivery partners, and scale what appears to be effective. **This flexibility is valuable for early action, where the intervention pathway may need to evolve as evidence accumulates.** However, this model also creates complexity. It requires legal structuring, investor agreements, outcome payment contracts, evaluation frameworks, data-sharing agreements, procurement alignment, and active performance management.

A Special Purpose Vehicle structure follows a more direct logic. The orchestrator and core service providers create a joint entity, and external funders or investors provide capital to that entity. The public sector pays the SPV when outcomes are verified, and the entity distributes funds according to its governance model. **Compared with a fund-based structure, the SPV can be easier to understand and more direct to govern.** It may also be cheaper to establish, especially when the number of partners is limited and the delivery model is already well defined. Its weakness is rigidity. If the main providers hold shares in the SPV, replacing underperforming actors can become difficult. **This can be a serious limitation for early action models, where learning, adaptation, and provider substitution may be necessary over time.**

For problems that cut across several budgets or institutions, an outcome alliance or pooled outcome fund may be more suitable. In this model, several buyers align around a shared outcome and pool resources, commitments, or payment obligations. A public or publicly steered orchestrator coordinates the service ecosystem, while private, philanthropic, or public investors may provide upfront capital. **This structure fits outcomes that create value for more than one institution and where no single payer captures**

enough of the benefit to justify funding the intervention alone. For example, improved mental health among working-age people may benefit healthcare systems, municipalities, employers, social insurance institutions, and economic development agencies. The same logic applies to place-based public value, including type 2 diabetes risk, youth mental health, long-term unemployment, functional decline among older adults, and avoidable hospital use. A pooled fund can finance digital tools, service redesign, community interventions, data infrastructure, workforce training, coordination roles, and targeted support.

The choice between these models should therefore follow the outcome, not precede it. **Decision-makers should first define the target population, the causal pathway, the delivery ecosystem, the data needed to measure progress, and the type of value the intervention is expected to create. Only then should they decide which structure is most appropriate.** Orchestration capacity matters more than the financial form. A sophisticated Social Impact Bond will fail without strong orchestration. A simple SPV can work if the partners share a clear mission and the delivery model is stable. A pooled outcome alliance with trusted governance may outperform both when the problem is multisectoral, place-based, and dependent on long-term coordination.

Where private capital is involved, the structure should also diversify risk appropriately. Rather than relying on a single activity, provider, or causal pathway, the delivery model may combine several complementary workstreams that contribute to the same outcome while remaining partly independent. This can reduce the risk that the failure or delay of one component undermines the entire programme, while allowing resources to be shifted towards the approaches that perform most effectively. However, diversification should strengthen the outcome logic rather than create a fragmented portfolio of disconnected activities. The guiding question should therefore be: What structure gives us the best chance of achieving the outcome, protecting public value, diversifying risk appropriately, adapting intelligently, and learning over time?

7. Defining, Measuring, and Governing Outcomes

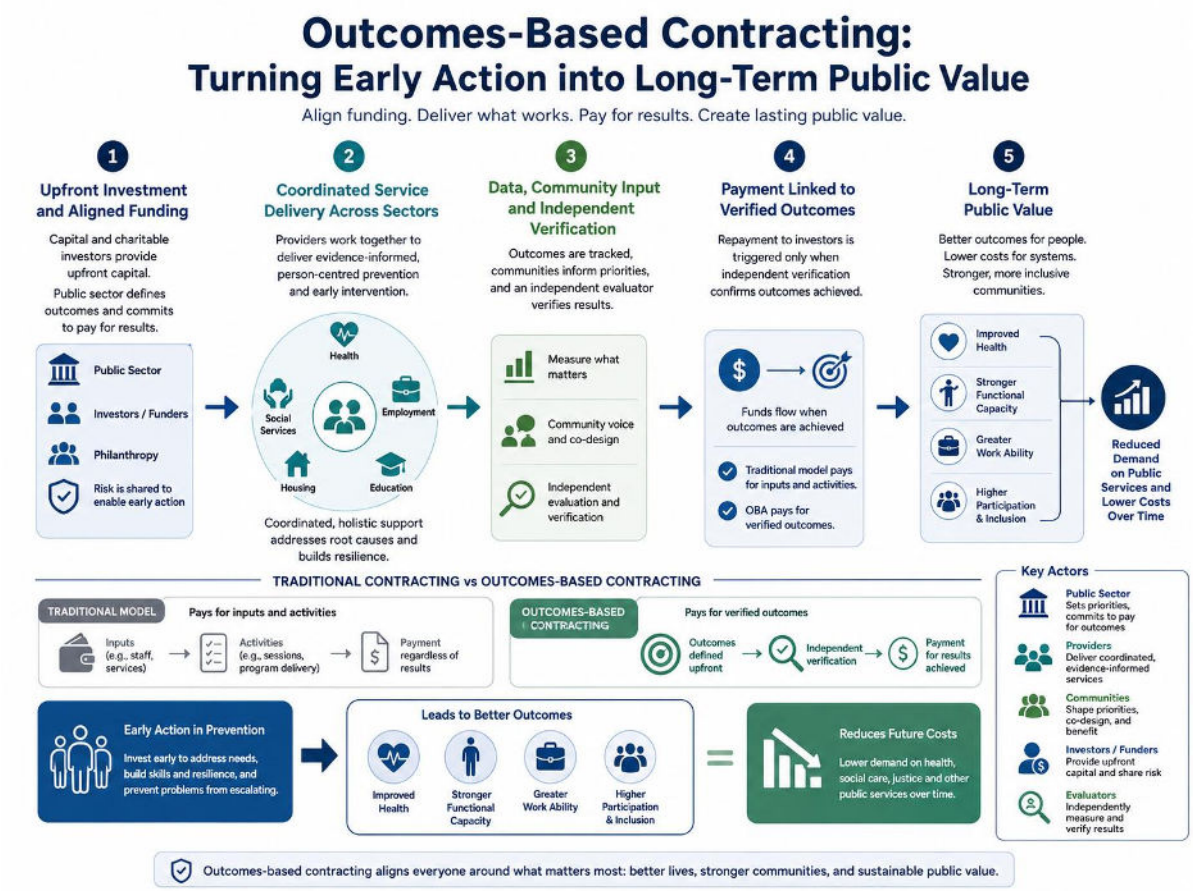

Figure 1. Outcomes-based contracting: turning early action into long-term public value.

Outcome Definition, Data, Trust, and Long-Term Political Commitment

Outcome definition is the core design challenge in outcomes-based contracting. A weak outcome makes the contract unstable. A narrow outcome encourages metric-chasing and weakens public value. A broad or distant outcome makes payment and risk harder to manage. A short-term outcome may fail to support early action. For this reason, the outcome framework should not be treated as a technical annex to the contract. It should be the foundation of the model.

One way to strengthen this foundation is to treat outcome definition as a structured assessment process before the contract is designed. In this context, an outcome should be understood as a positive and measurable change that is necessary to move towards the intended longer-term impact. These changes may include intermediate outcomes that demonstrate progress, as well as final outcomes that more directly reflect the desired future. An adapted double materiality assessment could help identify which outcomes matter most for public value, communities, service users, investors, and delivery partners,

while also clarifying which outcomes create financial, operational, or reputational risk for each actor[32]. This process should also be co-designed with the stakeholders affected by the intervention. Its quality should be measured directly, including whether the right voices were included, whether trade-offs were made explicit, whether communities understood the proposed outcomes and how they contribute to the intended impact, and whether partners reached a shared definition of success. This relational work should be treated as a fundable pre-contract phase,consistent with the 40-20-40 model, [33]rather than as a preparatory cost that individual partners are expected to absorb

A strong framework starts with a theory of change. It defines the intended impact, intermediate outcomes, intervention pathways, target population, risk factors, timeline, and data needs. Public authorities, providers, community actors, evaluators, and people affected by the issue should build it together. This shared process clarifies the logic of the intervention, the assumptions behind it, and the evidence needed to judge whether progress is real.

The first step is to separate final outcomes from intermediate outcomes. Final outcomes may include lower disease incidence, fewer hospitalizations, sustained employment, greater independence, reduced disability, better quality of life, lower long-term public expenditure, stronger functional capacity, and greater participation in education, work, and community life. These are the outcomes that matter most, but they may take years to appear.

Intermediate outcomes make that long pathway manageable. They show whether the model is moving in the right direction before final impact becomes visible. They may include engagement, risk-factor control, reduced sick leave, improved functioning, adherence, social connection, faster access to support, better coordination, participation in early support, and reduced escalation into costly services. This matters especially in areas such as diabetes, youth support, mental health, and functional capacity, where interventions may need years before they reduce complications, exclusion, dependency, or long-term care needs.

Because these outcomes depend on different starting points, the framework also needs risk adjustment. Without it, providers may select easier cases and avoid people with complex needs. Risk adjustment should consider baseline risk, socio-economic status, comorbidities, age, gender, region, prior service use, employment history, disability

[32]PwC Netherlands. (n.d.). *CSRD—Double materiality assessment*. Retrieved SEPTEMBER 5, 2026, from https://www.pwc.nl/en/topics/sustainability/esg/corporate-sustainability-reporting-directive/csrd-double-materiality-assessment.html

[33] Münter, L., Drachmann, D., Ghanem, M., Prinzellner, Y., Smits, C., Werner, K., Bulsink, V., Schwaninger, I., Van Velsen, L., & Faber, N. H. (2023). Transforming health systems with design health literacy: Presenting the 40-20-40 model for digital development. *Computer Methods and Programs in Biomedicine Update, 4*, 100122 https://doi.org/10.1016/j.cmpbup.2023.100122

status, and other relevant factors. Its purpose is to reward real change rather than population selection. It also protects public legitimacy by showing that the model does not succeed by excluding the people who need support most.

Measurement should then combine administrative data with human evidence. Administrative data can include registries, healthcare use, employment records, tax data, benefit use, school attendance, clinical indicators, service use, and validated outcome scales. These sources are essential because they allow contracts to track change over time and link payments to evidence. But they are not enough on their own. Lived-experience data, community narratives, and qualitative insight show whether people trust the intervention, whether formal systems miss important barriers, and whether the measured outcomes matter in daily life.

This combination is important because the same numerical result can hide very different realities. Employment data may show that a person entered work, while qualitative evidence can show whether that job is stable, safe, compatible with health needs, and likely to support long-term participation. Clinical indicators may show better risk control, while lived experience can show whether the intervention feels acceptable, accessible, and sustainable. Strong measurement therefore needs both discipline and context: enough quantitative evidence to justify payment, and enough human understanding to know whether the intervention is actually improving lives.

Health economic metrics can help connect these outcomes to wider public value. QALYs and Disability-Adjusted Life Year (DALYs) remain widely used in health evaluation, especially when the main concern is health gain, disease burden, or quality of life [34]. Productivity-Adjusted Life Years (PALYs)[35], can provide additional insight when early action influences people's capacity to participate in economic and social life. As a complement to QALYs and DALYs, PALYs quantify the impact of ill health on productive life by capturing losses in both paid and unpaid productivity over time[36]. This includes absenteeism, presenteeism, reduced work ability and labour-force participation, as well as unpaid contributions such as household activities, caregiving, voluntary work, and other forms of social participation.

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[34] National Institute for Health and Care Excellence. (2026). *NICE technology appraisal and highly specialised technologies guidance: The manual* (PMG36). https://www.nice.org.uk/process/pmg36/chapter/economic-evaluation-2

[35] Ademi, Z., Ackerman, I. N., Zomer, E., & Liew, D. (2021). Productivity-adjusted life-years: A new metric for quantifying disease burden. *PharmacoEconomics, 39*, 271–273. https://link.springer.com/article/10.1007/s40273-020-00999-z

[36] Lavikainen, P. T., Lehtimäki, A. V., Heiskanen, J., Luoto, R. M., Ademi, Z., & Martikainen, J. A. (2025). "The Impact of Chronic Conditions on Productivity-Adjusted Life-Years in Both the Workplace and Household Settings in the General Adult Population in Finland." *Value in Health, 28*(3), 379–388. https://www.valueinhealthjournal.com/article/S1098-3015(24)06647-6/fulltext

In simple terms, PALYs estimate the amount of productive life lost when health conditions reduce an individual's ability to contribute to society through paid or unpaid activities. This perspective is particularly relevant for chronic diseases and preventive interventions whose benefits often extend beyond healthcare utilisation and accrue over long time horizons. However, PALYs should be interpreted alongside other measures of value. They do not imply that economic productivity defines the value of health. Rather, they complement clinical outcomes, quality-of-life measures, equity considerations, functional capacity, fiscal impacts, and lived-experience evidence to provide a broader understanding of long-term public value.

Once the outcome framework is defined, governance must support adaptation. Outcomes contracts should include review points, dashboards, learning cycles, escalation mechanisms, and rules for modifying the service mix. This is especially important in chronic disease risk, mental health, youth support, functional capacity, and labour-market inclusion, where needs and barriers differ across people and places. A contract that cannot adapt may protect the payment model but weaken the intervention.

Independent evaluation should then support both learning and accountability. A useful model separates formative learning, which improves delivery during implementation, from summative verification, which determines whether payments are justified. Strong outcomes contracts should act as learning systems. They should test, adapt, and scale earlier action around outcomes that matter, rather than lock providers into a fixed delivery model that may stop working as conditions change.

Data is the foundation of this learning system, but it is also a source of trust, governance, and legitimacy. Since payments depend on results, all actors need confidence in the baseline, measurement approach, data sources, and independent evaluation. A reliable baseline comes first. Before pricing or measuring an outcome, the system must understand what would likely happen without the intervention, current costs, service patterns, affected groups, regional and socio-economic variation, and cost distribution across healthcare, social services, employers, individuals, and families.

Without this baseline, the model becomes fragile. Outcomes may improve for reasons unrelated to the intervention, or results may appear weak because the target population had greater complexity than expected. A poor baseline can therefore create unfair payments, weak accountability, and loss of trust. A strong baseline creates a more credible contract because it makes the counterfactual, the expected cost trajectory, and the value of avoided harm more transparent[37].

[37] Gustafsson-Wright, E., Massey, M., & Osborne, S. (2020). *Are impact bonds delivering outcomes and paying out returns? Measuring the success of impact bonds*. Brookings Institution https://www.brookings.edu/wp-content/uploads/2020/09/Are-impact-bonds-delivering-outcomes-and-paying-out-returns-FINAL-2.pdf

The data model must also match the problem. Outcomes-based contracting often needs data across healthcare, social care, employment, education, tax, benefits, community services, local government, employers, insurers, pension systems, and voluntary organizations. This is necessary because the causes of the problem and the benefits of intervention often spread across several systems. Early action makes this even more important. Work ability may decline before formal disability. Social isolation may deepen before service use. Family stress may grow before child protection involvement. Functional decline may begin before long-term care.

For this reason, data governance must allow useful linkage while protecting privacy, dignity, and public confidence. Clear safeguards, accountability, and transparent rules are essential. Without them, the model may appear to turn people into data points or financial risks. With them, data can help identify need earlier, coordinate support better, and make invisible value more visible.

Outcomes contracts also need regular feedback. Dashboards, registries, shared data environments, and AI-supported coordination tools can show where an intervention works, where uptake remains weak, which groups the model misses, and where delivery needs adjustment. These tools should not be used only for reporting at the end of a contract. They should help the delivery ecosystem learn while the intervention is still active.

Future systems may need AI-supported coordination layers for cities, regions, or service ecosystems. These systems could connect stakeholders and delivery systems, trigger information flows, and identify weak engagement, provider underperformance, broken referral pathways, or unequal effects across populations. Better infrastructure can reduce administrative burden and help professionals focus on relationships, judgement, and frontline work. However, infrastructure alone will not create legitimacy.

Trust remains central. Its foundations should be built during the modelling process, through two closely connected components: rigorous analysis of the available data and genuine co-creation among experts, public authorities, stakeholders, prospective service providers, community actors, and people with lived experience of the issue being addressed. Together, these processes can create a shared understanding of the problem, the desired outcomes, the assumptions behind the model, and the responsibilities of each actor[38].

Automation cannot replace transparency, shared purpose, clear rules, relationships, and time. Stakeholders need to see that the model invests earlier, protects public responsibility, and avoids narrow indicators. Long-term health, youth development, work ability,

[38] Münter, L., & Skali, A. (2026). *The trust equation: How to build, measure, and scale collaboration that lasts*. https://www.wellbeingacademy.dk/2025/07/28/the-trust-equation-a-new-framework-for-building-collaboration-that-lasts/

functional capacity, social participation, and inclusion require cooperation across institutions, communities, and sectors. Patient and sustained relationship-building across municipalities, ministries, providers, communities, and other stakeholders is therefore essential. Outcomes-based contracting gains legitimacy when actors present it as a way to invest earlier, protect public value, improve accountability, and support adaptive delivery. Outcomes contracts should include a trust diagnostic at the design stage, mapping which trust relationships are intact and which are fractured and using these findings to shape the modelling, co-creation, communication, and governance processes from the outset. Structured diagnostic frameworks for this purpose and its implications for trust are still underdeveloped in outcomes-based contracting and represent a priority area for future methodological work.

This trust must also survive political change. Long-term outcomes need political durability. Many outcomes take five years or more. Youth, health, employment, ageing, and functional capacity outcomes may need ten or more years. Political cycles are shorter, and new administrations may abandon previous models before outcomes become visible.

Long-term outcomes contracts therefore need cross-party support, administrative embedding, legal continuity, and a scale-up pathway from the start. The model should define what happens after year two, five, or ten: whether ordinary budgets absorb the intervention, outcomes funds expand, successful providers enter standard procurement, data infrastructure remains, public outcome payments continue, and other regions or population groups adapt the model. Without this pathway, pilots may generate evidence without changing resource allocation.

Finally, trust also depends on data justice and human understanding. Administrative data often reflects existing institutional biases. It may record service use while missing dignity, informal care, social connection, perceived safety, trust in services, daily barriers, and the experience of people who avoid formal systems. If an outcomes contract relies only on institutional data, it may reward what is easy to measure while missing other relevant information.

Voluntary organizations, patient associations, community actors, and local institutions can gather complementary evidence from older people, marginalized groups, families, young people, migrants, people with disabilities, and others who conventional datasets may underrepresent. This evidence does not replace quantitative measurement. It helps interpret whether numbers reflect real improvement.

AI systems and outcomes contracts that rely on narrow institutional data may reproduce existing blind spots. They may reward visible populations, prioritize outcomes that are easier to count, and miss people who are less connected to formal services. Future

models should therefore combine hard data with human understanding: enough discipline to justify investment, enough context to protect fairness, and enough trust to improve lives over time.

8. Strategic Recommendations

Recommendation 0: Identify the need and opportunity for change

Public authorities, municipalities, and other responsible organisations should begin by identifying undesirable trends, unmet needs, or patterns of deterioration that could be prevented. They should assess why these developments are occurring, who is affected, what is likely to happen without action, and where there is a realistic opportunity to create positive change. Only then should they consider how the identified need can be translated into practical action.

Recommendation 1: Begin with the Outcome, Not the Instrument

Once the problem and opportunity for change have been established, assess whether outcomes-based contracting offers a suitable response. Start by defining the outcome that matters and examining why the current system fails to achieve it. A Social Impact Bond can help, but it should never become the goal. Define the outcome first, then choose the most appropriate mechanism: an impact bond, Special Purpose Vehicle, outcomes fund, outcome alliance, pooled payment model, procurement reform, or standard publicly funded programme.

Recommendation 2: Use Outcomes-Based Contracting Where It Fits Best

The model fits outcomes that matter, can be measured, and remain underfunded because benefits arrive late, accountability is fragmented, or budgets cannot connect present costs with future value. Avoid it when outcomes cannot be measured, the target population cannot be defined fairly, public responsibility must remain unconditional, or transaction costs exceed likely benefits.

Recommendation 3: Invest in Orchestration Capacity

The orchestrator turns financial design into real change. It coordinates stakeholders, uses data, adapts services, manages providers, protects trust, and keeps the system focused on outcomes. In health and social policy, this role may need to be public, publicly steered, or mission-locked. It needs trust from authorities, providers, communities, and funders, plus authority to adjust delivery when evidence shows weak performance.

Recommendation 4: Use Risk-Adjusted Outcome Metrics

Outcome metrics should reflect context and baseline differences. Without risk adjustment, providers may select easier cases, avoid complex populations, or chase quick gains.For example, in the case of Health Impact Bonds or other outcomes-based preven-

tion models, risk adjustment should focus primarily on the baseline characteristics of participants and their expected probability of reaching the target outcome at the start of the intervention. For example, this could include the baseline risk of developing type 2 diabetes, experiencing a cardiovascular event, or progressing to a higher-risk disease stage Risk adjustment should consider baseline risk, socio-economic status, age, gender, comorbidities, disability status, employment history, service use, region, and prior outcomes. The aim is to reward real change, not easy population selection. Safeguards against gaming and cherry-picking should protect effectiveness and fairness.

Recommendation 5: Create Pooled Outcome Payment Models for Cross-Sector Challenges

Many long-term outcomes benefit several institutions at once, so a single department may lack incentive to fund the full intervention. Diabetes prevention can reduce healthcare costs, improve productivity, reduce disability benefits, support employers, and improve quality of life. Youth mental health can benefit education, social services, future employment, families, and healthcare. Functional capacity among older adults can reduce hospital use, delay long-term care, support family carers, and improve independence. Pooled payment models can align municipalities, healthcare payers, employers, insurers, social insurance institutions, ministries, foundations, pension funds, and investors. To make this alignment work in practice, the model should also consider the community-level effort needed to implement and sustain the intervention, especially when working with populations facing complex social needs. Communities often contribute time, trust, local knowledge, informal coordination, and civic energy that do not appear in institutional budgets. If these contributions are not recognised, there is a risk that the model pools institutional value while leaving part of the real implementation cost outside the payment structure. Accounting for these community co-investment costs can help prevent underfunding, protect trust, and make the pooled model more credible and sustainable over time.

Recommendation 6: Combine Financial and Non-Financial Measures of Public Value

Fiscal savings matter, but public value reaches further than cost reduction. Early action can improve quality of life, functional capacity, independence, dignity, productivity, social participation, equity, service use, and community resilience. Productivity-Adjusted Life Years can show how illness or functional decline affects work ability, absenteeism, presenteeism, and economic participation outside of health care. In words, the metric estimates productive time lost when poor health prevents people from working fully or consistently. It should complement clinical, fiscal, functional, participation, equity, lived-experience, and system-performance measures.

Recommendation 7: Build Credible Data Infrastructure Before Launching the Contract

Data must come before payment design. The system needs baselines, eligibility data, monitoring data, outcome verification data, learning mechanisms, and governance that protects privacy and trust. Before launch, partners should test whether data exists, whether access is lawful and ethical, whether systems can be linked, whether data arrives fast enough for adaptation, and whether it can support payment decisions. If infrastructure is weak, the first phase should build the baseline, test the data model, validate indicators, and create governance for scale.

Recommendation 8: Design for Political Continuity and Scale from the Beginning

Long-term outcomes contracts need cross-party engagement, legal clarity, administrative ownership, and a plan for success. Political durability should sit inside the design through institutional agreements, multi-year budgets, independent governance boards, transparent reporting, and evidence thresholds for continuation or expansion. It should also be supported by a clear public narrative that frames early action in health as a long-term investment in people, communities, and public systems. Legal continuity can protect the contract, but a shared narrative helps protect the political will to fund, renew, or expand it beyond one political cycle. Scale also needs early planning. A successful pilot should lead into ordinary commissioning, an expanded outcomes fund, regional replication, or procurement reform.

Recommendation 9: Keep Transaction Costs Proportionate

Formal Social Impact Bonds may suit large programmes, multi-year interventions, or proof-of-concept projects with strong learning value. Smaller interventions may work better through simpler outcome-based procurement, Special Purpose Vehicles, public outcome funds, pooled budgets, or performance-based contracts. Complexity needs justification because legal, financial, evaluation, and administrative costs can weaken efficiency.

Recommendation 10: Integrate Community and Lived-Experience Data

Long-term health, functional capacity, participation, and inclusion develop in daily life. Formal systems cannot see all relevant barriers. Community actors, patient organizations, voluntary-sector groups, local institutions, families, and affected people can help define meaningful outcomes and interpret results. Their role should therefore be seen not only as lived-experience input, but as structural co-investment. When communities help design, deliver, and interpret outcomes, they make interventions more grounded, trusted, and transformative. This contribution should be recognised and resourced within the financing model, not left outside the contract. This matters when administrative data is

incomplete or biased. Data may record service use without trust, employment entry without job quality, hospital admissions without daily barriers, or school attendance without real support. Lived-experience data should inform design, monitoring, and interpretation.

Recommendation 11: Create a Network to Promote and Support Outcomes-Based Contracting

A dedicated network should promote responsible use across policy areas. It should help public authorities, funders, providers, evaluators, community organizations, and investors understand when the model fits, how to design it, and which safeguards it needs. It could develop guidance on outcome definition, risk adjustment, data governance, evaluation design, procurement pathways, and proportionate costs; compare case studies across health, employment, ageing, youth development, social inclusion, and functional capacity; create templates; provide technical assistance; convene stakeholders; train civil servants and providers; and act as neutral learning infrastructure.

Recommendation 12: Treat Outcomes-Based Contracting as a System-Change Tool, Beyond Financing

Outcomes-based contracting can change how public systems define problems, align incentives, collaborate across silos, use data, and learn. Governance and orchestration matter more than financial structure. If actors treat the model as payment design, its value will remain limited. If they treat it as a system-change tool, it can help public systems move from activity-based delivery toward measurable public value.

Ultimately, the purpose of outcomes-based contracting is not to create new financing mechanisms for their own sake. Its purpose is to help public systems recognise, measure, and invest in long-term public value that often remains invisible within traditional budgeting arrangements. This is particularly important for prevention and early action, where benefits may emerge years later, span multiple sectors, and extend beyond healthcare alone.

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Adam Skali holds a Master's degree in Multidisciplinary Research, Biophysics, and a Bachelor's degree in Biotechnology, with additional training in bioinformatics, data science, healthcare innovation, and entrepreneurship. He began his career in biophysics, later founded two digital health start-ups, and now works across digital health, care innovation, interoperability, artificial intelligence in health, regulation, and policy.

He currently serves as founder of The Tower of Innovation, Director of Innovation at the e-Health Innovation Center and as a board member of the Institute for Human Centered Health Innovation. He also works as a consultant, board member, expert, and adviser for organisations and initiatives including EIT Health, Fundación Visible, the Digital Mental Health Consortium, the Scott Morgan Foundation, Danish Life Science Cluster, Health Technology Assessment International, MyHealth@MyHands, ORION Innosuisse, WHO Europe's Public Health Innovation Platform, Joint Action PreventNCD, and the Young AI Leaders Madrid Hub under ITU's AI for Good initiative. He has presented at more than 70 conferences, workshops, and international events, including sessions linked to WHO, OECD, ITU, WSIS, the World Economic Forum, EIT Health, and the World Health Assembly.

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Her research focuses on health technology assessment, economic evaluation, disease prevention, population genomic screening, chronic-disease modelling, and the evaluation of healthcare interventions alongside clinical trials, registries, and observational studies. She is internationally recognised for advancing Productivity-Adjusted Life Years (PALYs), as a measure of how disease and health interventions affect productive life and for incorporating these wider effects into population-level decision-making. Her research has informed healthcare policy and funding decisions in Australia and internationally.

Zanfina holds a Master of Pharmacy, a Master of Public Health in Epidemiology, and a PhD in Epidemiology and Health economics. She previously worked at the University of Melbourne and the University of Basel, where she contributed to Switzerland's national Health Technology Assessment programme. She is a member of the Economics Sub-Committee of Australia's Pharmaceutical Benefits Advisory Committee and a Visiting Professor at the University of Eastern Finland and University of Prishtina. Her research has attracted more than AUD 45 million in competitive funding, and she has authored more than 260 peer-reviewed publications.

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With a PhD in Health Sciences and an MBA in Healthcare Management, her career spans academia, high-level governance, and the private sector across Austria, Slovenia,

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She is a Board Director of Health Technology Assessment International, Co-chair of Working Group 2 of WHO Europe's Strategic Partnership Initiative for Data and Digital Health, and co-founder of the Women in Global Health chapters in Austria and Norway. She is also a Public Health Delegate for the Norwegian Red Cross and founded the SanAstra Foundation to advance digital health literacy.

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Diana Arsovic Nielsen is Chief Executive Officer of Danish Life Science Cluster, Denmark's national cluster organisation for life science and welfare technology. Before assuming this role, she held several executive positions, including Director of the Centre for Regional Development in the Capital Region of Denmark, Head of Innovation in the City of Copenhagen, and Director of the Southern Denmark Health Innovation Centre. She holds a degree in architecture, with a specialisation in industrial design, as well as an HD in Organisation and Management.

As Chief Executive Officer, Diana focuses on fostering strong partnerships among private companies, public institutions, and research environments to promote innovation, growth, and improved healthcare solutions. Her ambition is to support the development of Danish health solutions with global relevance and strengthen the agility and cohesion of the life science sector, ensuring access to talent, funding, and international collaboration.

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Mika Pyykkö holds a Master of Social Sciences from the University of Tampere. His interest in promoting health and wellbeing developed early, even before his first formal position as a researcher at the UKK Institute, because he played table tennis professionally for several years and later served as head coach of the Finnish men's national table-tennis team for three years. He is currently employed by South-Eastern Finland University of Applied Sciences, where he is responsible for developing a health and wellbeing competence hub in Savonlinna.

Since the beginning of his career, Mika has had a strong interest in proactive and preventive approaches, particularly in improving the health, wellbeing, and functional capacity of different population groups so that the need for remedial social and healthcare services can be reduced. From this perspective, he has held leadership positions at the Finnish Heart Association, Sitra (the Finnish Innovation Fund) the Centre of Expertise for Impact Investing within Finland's Ministry of Economic Affairs and Employment, and the Finnish Brain Association. He has also been highly active in international collaboration.

During his time at Sitra and the Centre of Expertise for Impact Investing, the team he led focused particularly on piloting outcomes-based commissioning in Finland using the Social Impact Bond model. During this period, he also held a consultancy contract with the European Investment Bank and served for one year as a Visiting Fellow of Practice at the Government Outcomes Lab in the Blavatnik School of Government at the University of Oxford.

One of Mika's most widely recognised achievements is, besides the first five SIBs in Finland, the Heart Symbol food-labelling system. He led its development and launch while working for the Finnish Heart Association between 1995 and 2003.

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Lars Münter is International Director and co-founder of the Nordic Wellbeing Academy. He holds a Master of Arts in Rhetoric and works across health literacy, empowerment, trust, digital health, self-care, public-health communication, and cross-sector collaboration. His work has included initiatives connected to the Danish Council for Better Hygiene, the Self-Care in Europe Initiative, and the Nordic Health 2030 Movement. Through the Nordic Wellbeing Academy, he contributes to international partnerships, research, policy dialogue, and activities intended to strengthen wellbeing across sectors and national borders. He has authored or contributed to more than 40 peer-reviewed publications and serves as an external ethics adviser to the TRACE Project. He is also Chair of the Public Health Communication & Trust Working Group under WHO Europe's Public Health Innovation Platform for the 2026–2028 period.

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Before joining Linna Business Development, Ville built a career in management consulting, advising public-sector, health, and life science organisations on strategy, innovation, service renewal, ecosystem development, and new operating models. Earlier in his career, he worked at Sitra, the Finnish Innovation Fund, focusing on public-sector transformation and health and wellbeing ecosystems.

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Saara Malkamäki is a digital health and data innovation expert with extensive experience in strengthening health data ecosystems across Europe and the Nordics. Throughout her career, she has advanced health innovation, research, and business by fostering trust-based partnerships, shaping policy recommendations, and developing future-proof business models. She is passionate about creating data-driven healthcare that benefits individuals, society, and businesses alike.

Saara previously worked at the University of Basel Innovation Office, where she led a Swiss-wide public-private partnership on antimicrobial resistance, bringing together data, digitalisation, AI, innovation, and health-economic evidence. Earlier, at Sitra, the Finnish Innovation Fund, she contributed to building Finland's impact-investing market and developing new financing models, including Finland's first Social Impact Bond. From 1 September 2026, she returns to Sitra to work on Data and AI in the International Programmes.

Joanna Lane
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Building on her previous contribution to a High-Level Task Force looking to boost longer-term investment in social infrastructure, Joanna Lane helped lead the development of the Invest4Health Horizon Europe project, led the writing of its proposal, and was lead author for its White Paper: *Hard but not impossible: Scaling what works in health promotion, disease prevention and integrated care through 'the missing middle'*. Invest4Health Deliverable 8.4, 31 May 2026. She is the Founder and MD of Stichting Health ClusterNET (in its 3rd iteration since initial Interreg funding), Chairperson of the Familial Hyperlipidemias European Foundation, part-time Professor in the Centre for Health & Technology at the University of South-Eastern Norway and Co-Chair of the Advisory Board for the Transforming Health & Care Systems European Partnership.

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Disclosure of Generative AI Use

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