Invest4Health

Hard but not impossible:

Scaling what works in health promotion, disease prevention and integrated health and care through the ‘missing middle’.

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Disclaimer

Deliverable summary

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Preface

This White Book asks why do good ideas in health and care so often disappear when the funding runs out?

There is no good system for carrying what works from a funded project into lasting everyday practice. That gap is both about money (current funding systems are not built for this) and about who is responsible. There is rarely anyone whose job it is to make sure the transition happens.

This this gap is structural, and that closing it requires deliberate investment in governance, financing, and relational conditions that current architectures rarely provide. The evidence supports conclusions and a focused set of credible next steps. Associated scientific & policy papers, briefings, podcasts and events will contain the fuller analytical treatment for readers who need that depth.

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Foreword

Health and Care Systems in Europe are facing huge challenges resulting in an inevitable need for transformation. Several European initiatives - funded projects, programmes and partnerships – are each joining forces in order to contribute to the change for the better. The results are gaining sharpness and range when several initiatives manage to share their approaches and knowledge and collaborate.

In late 2025, the EU funded project Invest4Health, the Work Package 9 of the co-funded European Partnership on Transforming Health and Care Systems, and the AAL Programme decided to embark on a collaborative avenue and to co-design an in-person workshop on financing the future of healthcare so that experiences made in pilots and testbeds could be shared. The successful workshop was followed by some common working group activities.

The three initiatives come from different angles: THCS WP9 activities are based on the notion that the actual transformation of HCS needs ecosystems to be in place and operative. Activities focus on better understanding how ecosystems work and their success elements; on supporting funded THCS projects in embracing an ecosystem-wide approach; on reaching out to relevant stakeholders at national, regional and local level to facilitate mutual learning and sharing of information. The AAL Programme focused on funding projects with strong end-users' involvement and strong business participation in order to develop sustainable solutions.

In short, THCS and AAL aim at ensuring that funded projects address real world needs, are strategically embedded and reach out to the larger ecosystem including policy makers and financing institutions in order to support future implementation and scale up. In a complementary way, at the end of its duration, I4H has a deep interest in better understanding the so-called missing middle, the phase after the conclusion of a project, before you could even think of an implementation. While AAL focused on supporting funded partners in their business perspective and taking over ownership of the solution to make the market entrance happen, I4H puts the finger on structural failures that hinder implementation and scale up - which is an incredibly important contribution.

The White Book brings forward conclusions and recommendations, based on analytical work done by the I4H team. THCS WP 9 brought some case examples to the table and contributed to discussions. AAL provided access to the learnings of many years of project funding, including some success stories. The examples serve to illustrate some findings, but of course the analysis put forward by I4H, is based on years of work and experience by the team.

The insights condensed in the White Book are a big treasure for the future work of THCS WP9 in strengthening ecosystems, and more importantly, will help project consortia and innovators to navigate the phase until implementation and scale-up are secured. But most of all, the White Book should serve as an inspiration to close the structural gaps in governance, finance and relational conditions that often hinder the successful implementation and scale up of innovative approaches.

A very warm thank you to all the members of the I4H team. We are very much looking forward to continued collaboration!

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Table of Contents

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Executive Summary

Across Europe, a distinctive pattern repeats itself. An initiative in health promotion, disease prevention, or integrated health and care launches, possibly proves its impact[1] and then struggles to survive when the funding ends. For technology and digital health innovations, exploitation strategies and market development pathways exist and matter. But for the majority of upstream and midstream interventions (pooled governance models, integrated care pathways, community-based prevention programmes) no equivalent mechanism exists. The transition these initiatives require is not into a market but into a public system not designed to absorb them: different budget lines, different governance structures, different accountability frameworks. This is the missing middle: both a functional and a financing gap. It is felt most acutely by the community nurse whose network closes when the grant ends, the coordinator whose coalition works and finds no commissioner, and the person with a long-term condition who briefly had a team around them that understood their whole life and then found it gone.

This Book draws on experience from three European initiatives that have been navigating the missing middle from different directions: I4H, which has tested Smart Capacitating Investment approaches and tools across eight regional testbeds; the Transforming Health and Care Systems (THCS) Partnership WP9, which is strengthening health and care ecosystems; and the AAL Programme, which has over 20 years of evidence on moving innovation from pilot to system uptake. They were selected not because they are the only European initiatives working on health innovation and scaling, but because together they represent three distinct and complementary angles on the same structural/financial problem and because their combined evidence base is uniquely positioned to illuminate it.

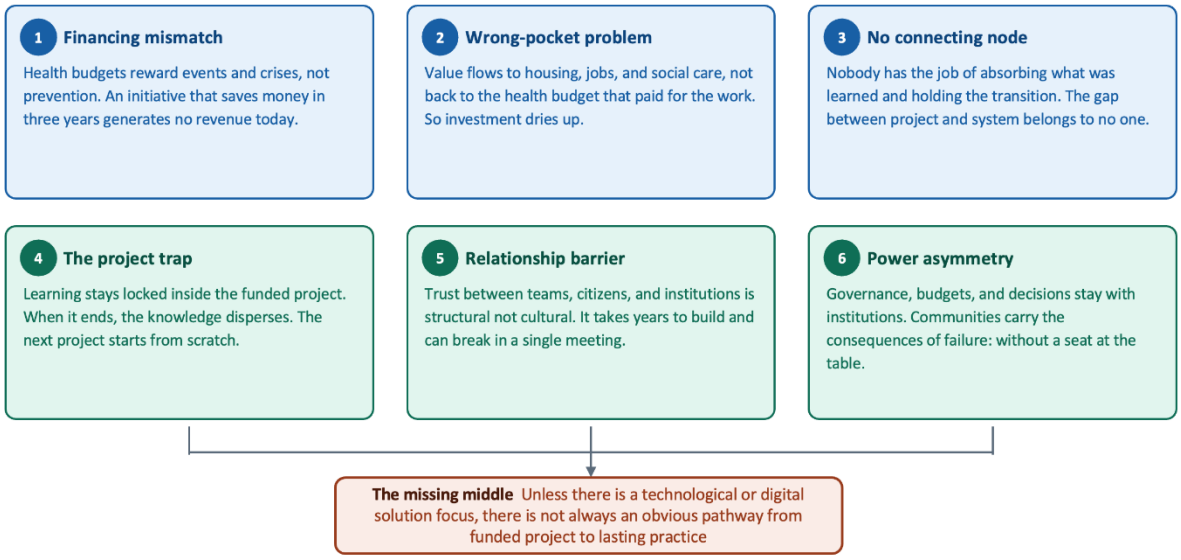

Figure 1: Six reasons health promotion, disease prevention and integrated health and care interventions stall at the missing middle

Five cases illuminate the missing middle in practice. West Wales (I4H) demonstrates what pooling public budgets can achieve and where limits lie. Skåne (I4H) shows how shared infrastructure makes the missing middle navigable without resolving it entirely. Trento (THCS) is a rare case where governance went active before the innovation began. The Finnish Children and Youth SIB (THCS) illustrates outcome-based transition financing and the transition facilitator function. 2PCS (AAL) showed the need to pivot to where demand is regulated and procurement more structured.

Six contingencies for crossing the missing middle. Governance must precede the innovation, not follow it. Patients and citizens having a structural seat at the decision-making table (IPA2 Spectrum collaborate & empower tiers plus WHO 2023). Ownership must be named: a transition facilitator with mandate,

[1] The lack of good scientific sound evidence is often a major barrier. On the other hand, there are also preventive interventions for which there is plenty of evidence (e.g., physical activity in diabetes, smoking cessation etc.)

relationships, and time. Trust and relational infrastructure must be designed for, not assumed. Value must be made visible early. Measurement is part of the crossing, not a post-hoc requirement.

Conclusions and next steps. The missing middle is both a functional and a financing gap: the transition from proven project to embedded practice lacks both the governance architecture to hold it and the financial instruments to capitalise it. The turning point is reached when responsibility and accountability is internalised: when governance, budget lines, and ownership move from the programme to the ecosystem. Projects are not the problem; the learning they generate is rarely structured to survive the transition. Four next steps follow: a joint learning framework across the three initiatives; determining if the SCI approach can be used in other ecosystem sites; developing tools to make upstream impact visible and governable; and bringing the combined evidence to the next relevant European policy moment through multipliers.

1. Introduction: The Missing Middle

Three human moments

Think of the community nurse who spent two years building a social prescribing network in her district, relationship by relationship, and watched it close when the project grant ended. Or the public health coordinator who assembled a cross-sector coalition to tackle childhood obesity, proved it worked, and could not persuade a single budget holder to pick it up. Or the person living with a long-term condition who found, briefly, a team around them that understood their whole life — and then found it gone.

Across Europe, this pattern repeats itself. An initiative launches with enthusiasm. A project demonstrates real impact. Practitioners commit. Communities engage. Evidence accumulates. And then the funding ends, the team disperses, and what was built (the relationships, the learning, the proven approach) struggles to survive: not because it failed, but because (technology and digital health innovations aside) no clear pathway existed to take it further, adapt it to new contexts, or transfer it to other regions. This is the missing middle.

Interventions don't fail because they lack evidence or technology. They fail because we try to finance long-term value through short-term operating budgets.

What is the missing middle?

The gap between funded project and sustainably embedded practice is not accidental[2]. It is structural, and closing it requires deliberate investment in governance, financing, and relational conditions that current programme architectures rarely provide. I4H approaches it from the financing side: its SCI framework is a financing logic developed for scaling health promotion and disease prevention interventions but it can also be used precisely for the transition phase between proven project and sustainable system that current architecture leaves most exposed[3, 4].

The 'missing middle' is the terrain between a funded project and sustainably embedded practice: where governance, financing, and ownership must be deliberately built if what has been learned and proven is to survive. There is evidence that this terrain can be crossed and there are indications of what it takes to do so.

[2] AAL Legacy Study. AAL Impact Assessment https://www.aal-europe.eu/?s=impact+assessment

[3] Lane J, Edwards RT, Babarczy B et al. A protocol for mobilising novel finance models for collaborative health promotion and disease prevention initiatives: taking a smart capacitating investment approach in the Invest4Health project. **Front Public Health**. 2025 Jan 23;12:1426863. doi: 10.3389/fpubh.2024.1426863.

[4] Rutten-van Mölken M, Whiteley H, Babarczy B et al. Broadening sources of finance for health promotion and disease prevention: Smart capacitating investment. **Eur J Health Econ**. 2025 Dec 29. doi: 10.1007/s10198-025-01874-4.

The missing middle sits between two better-understood spaces. On one side are funded projects: they can be novel, disruptive, time-limited, externally supported, focused on solution development, less so on building readiness to adopt and often known only to a small corner of the organisation that hosts them. On the other side are sustainably embedded system functions: routinely financed, institutionally anchored, capable of operating at population scale. Between them lies a territory chronically underserved by the mechanisms that govern both.

In this middle ground, several structural failures converge: governance fragmented across sectors with no actor empowered to orchestrate an initiative through transition; financing misaligned with the multi-year, cross-sector logic that upstream and midstream interventions require; and ecosystem conditions (trust, shared value[5], data infrastructure, shared accountability) still being built as funding windows close.

From the I4H Citizen and Patient Advisory Group

What we experience as patients and citizens is not the missing middle as a policy concept. We experience it as a missing whole. We're missing a team that coordinates around our needs. Or a community resource that reduces our isolation. What we envision/want/ champion is a system that treats our lived experience as evidence- not anecdote.

These things are too often missing - not because they couldn't work or were too expensive, but because no one was accountable to the communities they were meant to serve.

We contributed to this paper because the investment conversation- about what gets funded, what gets sustained, and what gets let go- needs us as co-decision-makers, not just storytellers. Co-governors of what comes next.

The missing middle is also an ecosystem maturity gap. The THCS Partnership's work on strengthening ecosystems distinguishes between micro-level initiatives, meso-level regional ecosystems, and macro-level governance conditions. From the perspective of this White Book's analysis, the missing middle tends to sit at the transition between micro and meso: the moment when a well-functioning local initiative needs the meso-level ecosystem to be ready to receive it and finds it is not.

But the missing middle is visible not only as a health system problem. It is equally a wellbeing economy and innovation economy problem. The value destroyed when initiatives stall shows up in employment, housing, and regional economic resilience long before it appears in health expenditure reduction. The 2PCS case illustrates this. The actors with a stake in closing the missing middle extend beyond health commissioners to innovation agencies, regional development authorities, and health technology clusters.

This raises a question that runs through the White Book: who owns the missing middle? Projects end. System functions belong to institutions. The terrain between them belongs, in practice, to no one. What is missing is not just governance or finance, but a function (a connecting node) whose purpose is to absorb what has been learned, mainstream what has been proven, and help patients, citizens and practitioners identify together what should be prioritised and invested in next. There are three types of ownership to be considered here: the solution owner, a transition facilitator and a citizen/community co-governance owner with a mandate to guide the legitimacy and accountability of the crossing.

What this White Book does and does not claim: This focuses specifically on the missing middle as one consequential challenge within the broader THCS, I4H, and AAL agendas. It draws on five case examples (two from I4H testbeds, two from THCS ecosystem initiatives, and one from the AAL Programme) woven into the analysis by I4H (with THCS providing exemplifying case examples) rather than presented as a systematic evidence review. It argues for grounded action at the micro and meso level. The evidence base supports conclusions and a focused set of next steps. Related papers and resources will contain the full case evidence, cross-cutting lessons, business model analysis, and tools assessment for readers who need that depth.

[5] THCS WP9 Deliverable D9.4. Strengthening Ecosystems: Shared Value Approach: https://www.thcspartnership.eu/deliverables/deliverables.kl

2. Why Promising Interventions Struggle to Scale

The failure of promising interventions (upstream, midstream, downstream)[6] to move beyond the project stage is one of the most documented and least resolved problems in European health policy. Before naming the structural failures, it is worth acknowledging what the three initiatives collectively underestimated: the complexity of the systems these initiatives are trying to change; the institutional inertia that makes even well-evidenced innovation difficult to absorb; and the depth of incentive misalignment that causes actors who agree on goals to pull in different directions when budgets tighten. These were not design failures. They were honest encounters with the structural reality of health systems. Each of these challenges also produced learning: about what governance conditions need to be built before an intervention is tested or launches, what ownership means in practice, and what honest timelines for health innovation look like. The cases woven into this White Book are evidence of that learning, in the context of five identifiable and overlapping structural failures that account for most cases in which promising initiatives stall. Each requires a different response. Each has a human face that structural language can obscure.

2.1 Financing logic incompatible with prevention's value profile

The community health worker, the social prescriber, the school nurse (the people doing the quiet, sustained work of prevention) are operating in a financing system that was not built to see the value they create. That system rewards events: procedures performed, beds occupied, crises managed. An initiative that reduces hospital admissions in three years generates no revenue today. A programme that keeps people well produces savings in social care, employment, and housing budgets: not in the health budget that funded it. The system actively penalises finding problems early. The West Wales testbed generated one of the clearest available accounts of what public budget pooling can achieve within these constraints and what governance conditions are still needed even when pooling succeeds.

Case 1
Midstream
West Wales, UK
I4H

What pooling public resources and risk sharing can achieve and where the limits lie

The Hywel Dda testbed joined three nationally funded but separately managed programmes (an exercise referral scheme, a diabetes prevention programme, and social prescribing) for the first time in Wales. Rather than create new money, the team pooled existing public budget streams, reducing the wrong-pocket problem by aligning investment and benefit within a shared funding pot. Governance held because all stakeholders were included in regular working group meetings and risks were shared transparently. The initiative has since been adopted into routine practice. The honest account: pooling resolved the financing problem within the public sector, but did not generate the transitional governance infrastructure that more complex initiatives require.

Key lesson: *Pooling existing public budget streams is the lowest-friction route into the missing middle — but it addresses the institutional wrong-pocket problem, not the governance gap.*

[6] In this paper, the use cases represent upstream (prevention) and midstream (prevention and integrated health and care) interventions. A good working definition for each of these can be found at: https://www.canada.ca/en/public-health/services/funding-opportunities/grant-contribution-funding-opportunities/call-for-applications-intersectoral-action-fund/glossary-additional-resources.html

2.2 The wrong-pocket problem (institutional and community)

Even where value is clearly generated, it mostly does not flow back to the actor who generated it (value misappropriation). A municipality that invests in early childhood support reduces future demand on health, social care, criminal justice, and housing. In each case, savings materialise in a different budget, organisation, or tier of government. Prevention budgets are therefore among the first cut under financial pressure: the actor who owns the budget owns the risk of overspend, but not the benefit.

There is a second, less visible dimension. Communities absorb costs that appear in no budget line: the time families spend navigating fragmented services, the informal care provided by neighbours, the civic energy invested in initiatives that prove their worth and then disappear. These costs fall disproportionately on communities already carrying the greatest health disadvantage. Any honest account of the wrong-pocket problem must include them (see 3.3). This is also a power gap. Institutions retain control over budgets, definitions of evidence, and continuation decisions. Communities carry the consequences when those decisions go wrong: but rarely hold the power to change them. Capacity building can help bridge this gap, but it must be reciprocal: communities need support to engage meaningfully with governance, finance, and evidence systems; and institutions need both the capability and the obligation to share power, not only to consult. Without reciprocity, capacity building reproduces the asymmetry it claims to address.

2.3 Governance fragmentation and the missing connecting-node function

Projects have sponsors. Operational services have commissioners. The missing middle has neither. What this terrain demands is something more complex than a handover: absorbing the lessons that projects generate; mainstreaming proven interventions; and identifying investment priorities in genuine collaboration with patients and citizens. This is the connecting-node function. In most European health ecosystems, it is either entirely absent or too thinly resourced to perform its role when it matters most. The Skåne testbed generated important learning about what an ecosystem can build when it deliberately invests in shared infrastructure rather than waiting for governance to emerge, and about what that investment reveals still needs to be created.

Case 2 Upstream
Skåne, Sweden
I4H

What shared infrastructure can build and what it reveals about the conditions still needed

The Skåne testbed set out to scale Early Coordinated Interventions for children across childcare, schools, social services, healthcare, and police. A system in which no single body holds the mandate, budget, or data for the whole pathway. Rather than create a new organisation, the testbed built shared infrastructure at county level: common governance, stakeholder mapping, readiness gap analysis, and collaborative platforms. Use-cases were co-designed with the I4H Citizen and Patient Advisory Group. The testbed has focused on strategic development and prototyping; its value has been creating alignment and a shared understanding of what collaborative system investment actually requires. Challenges remain: fragmented institutions, data-sharing constraints, and uneven capacity across 33 municipalities.

Key lesson: *Where no single body holds the full mandate, building shared infrastructure at the layer above individual organisations can make the missing middle navigable. But it requires investing in the conditions for collaboration before attempting to resolve the financing question.*

2.4 The project trap: learning that rarely survives the transition

Funded projects are designed to learn: testing assumptions about user needs, intervention design, technological and /or implementation readiness, and financial viability. But is the learning they generate structured to survive the transition? The AAL Programme's legacy study offers a rare honest longitudinal account of what navigating the missing middle in health technology actually requires.

Case 3
Midstream
Innsbruck / Vienna, Austria
AAL

From wearable safety to wireless infrastructure

2PCS started as an AAL-funded project. In the beginning the focus was on developing a multifunctional security watch that combined emergency communication with indoor and outdoor locating, enhancing safety and autonomy for older adults. The core technology was market-ready at the project end. While the initial wearable device had limited uptake, over time, the solution evolved into a robust wireless nurse call system now used in care facilities across Europe.

The long time to market was a big challenge. It took almost four years after project completion to begin sales. The reasons were manifold: product casing delays; certification needs; but also, customer scepticism towards a new player in a conservative market sector. Another major barrier was the lack of willingness to pay for advanced safety and localisation features in the care sector, mainly because public and private care providers lacked funding mechanisms to deploy such innovative approaches. Implementation was possible only when addressing the nurse call system market, where demand is regulated and procurement more structured.

Key lesson: *Long-term success was made possible by sustained collaboration with some ecosystem partners from the funded project. The larger ecosystem was essential for market access and credibility. While the business model developed during the 2PCS project proved rather robust, the company later secured additional funding and strategically repositioned itself in the nurse call system area.*

2.5 The relationship barrier: trust, language, and the limits of shared vocabulary

Upstream and midstream interventions must navigate at least three distinct languages: the scientific and practitioner language of outcomes and evidence; the financial language of return on investment and fiscal risk; and the governance language of accountability and mandate. Improving how practitioners move between them is a genuine and important capability. But the barrier is deeper than vocabulary.

Trust operates as a structural condition at three levels: between institutions that must share risk and resources; between professionals and communities where historical failures have left real scepticism; and between citizens and systems not historically designed around their needs. The working group discussions behind this White Book returned again and again not to tools or frameworks, but to relationships. And to what happens when processes destroy them.

There is also a difference between a consortium that works together and one that merely works side by side: what developmental psychology calls the shift from parallel play to collaborative play and co-production where partners have shared decision-making rights. Coordination produces outputs. Collaboration produces the trust, shared understanding, and mutual accountability that sustain an initiative when conditions change.

These five failures converge on a single gap: the absence of a connecting-node function whose purpose is to absorb learning, mainstream what works, and keep patients, citizens and practitioners in the conversation about what gets invested in next. Without it, well-evidenced initiatives will continue to stall at the boundary between project and practice. That is the specific problem this White Book addresses.

3. Critical Conditions for Crossing the Missing Middle

Drawing on I4H's analytical framework and the case examples contributed by THCS and AAL, six conditions emerge that, taken together, describe what it takes to cross the missing middle. None is sufficient alone. Together they describe what the I4H team have called the turning point: the moment at which ownership, reframing, and translation combine to move responsibility from the programme to the ecosystem. Understanding each condition also means understanding what the three European initiatives have found hardest to build and most consistently underestimated.

3.1 Co-governance from inception

The most durable cases in the three initiatives shared a common feature: the governance conditions that allowed the initiative to function were in place, or were being actively built, before the innovation began. And subsequently have mechanisms that should be dynamic and adaptable as things progress. Relatedly, operations and functions are nested within existing governance structures but do not necessarily have the flexibility to ensure alignment. This is the most counterintuitive and most important finding. The implication is uncomfortable: the conditions for crossing the missing middle often need to be created before there is sufficient evidence to justify the investment in creating them.

Case 4 Midstream
Autonomous Province of Trento, Italy
THCS

When governance holds: political anchoring as the shock absorber

TrentinoSalute4.0 (TS4.0) addresses the gap between health system planning, research, and the implementation of digital health solutions in the Autonomous Province of Trento. What makes it unusual is not any single initiative but the institutional architecture around it. Trento operates as a policy laboratory, with a single local health authority, the TS4.0 competence centre, and the TreC+ citizen-facing digital platform operating under a provincial law that explicitly mandates support for research, development, innovation, and digital care. TS4.0 has functioned as a stable connecting development node: preserving institutional memory, aligning stakeholders across funding cycles, and translating experimentation into services that can endure beyond the pilot phase. Building this collaboration took time and sustained commitment from professionals, service users, research partners (especially the Bruno Kessler Foundation) and policymakers. The commitment of regional administration and policymakers was essential in building trust between actors. Trento has cultivated a regional culture of experimentation in which testing, iteration, and failure are accepted as necessary steps toward system change [7].

Key lesson: *Governance did not follow the innovation: it preceded and protected it. Regional administration and policymaker commitment built the trust between actors that made sustained collaboration possible. The conditions for crossing the missing middle must exist before the innovation begins, not in response to it.*

Where Trento shows what becomes possible when governance holds, Skåne (Case 2) shows what is needed when it does not: patient investment in the shared infrastructure that governance should have provided, without any guarantee that the investment will be sufficient. The lesson from both cases is the same: waiting for governance to emerge from the innovation process is waiting too long.

The governance that needs to precede innovation is not only institutional. It must include patients and citizens as co-decision-makers from the outset. Not as consultees brought in after the architecture has been

[7] This description is written based on THCS WP9 case study *TrentinoSalute4.0 - Competence center for digital health* available in the THCS Knowledge Hub: https://knowledgehub.thcspartnership.eu/

Funded by the European Union

designed, but as named participants with a genuine role in shaping what gets funded, what counts as evidence, and what happens to what has been built. The difference between consultation and co-governance is structural: it requires dedicated roles, paid time, and accountability mechanisms that give communities a stake in the outcome, not just a voice in the process. The IPA2 Spectrum's collaborate and empower tiers, and the WHO 2023 framework on meaningful participation, provide practical benchmarks for what this looks like in practice.

3.2 Named ownership and the transition facilitator function

Across all the cases, and in the broader evidence from the three initiatives, a recurring pattern emerges: initiatives that successfully cross the missing middle almost always have at least one individual or organisation whose role (formal or informal) is specifically to orchestrate the crossing. Two distinct but related functions are at work, and both need to be present.

The first is the **solution owner**: a person or organisation with a genuine stake in the survival of what has been built, the capability to keep developing it, and the relationships with end-user organisations to advocate for its adoption beyond the project period. The solution owner is not neutral. They care whether the solution survives – and crucially, that ownership needs to be built during the project, not assumed to emerge afterwards. Too many projects are designed in a way that channels them structurally toward implementation: they expect that a commissioner, a health authority, or a system will pick up what has been built, without ever creating the internal ownership that would allow the initiative to advocate for its own survival. When that structural channel does not materialise (as it often does not) the initiative stops. This is precisely what the THCS ecosystem-wide approach to funded projects seeks to address: making project participants aware, from the outset, that ownership of the solution and its continuation is their responsibility, not a downstream problem for someone else to solve.

Case 5
Midstream
Finland (national programme)
THCS

Outcome-based financing and the coordination function: what the model enables and what it requires

The Children and Youth Social Impact Bond programme comprises eight local multi-actor ecosystems built around shared goals of improving psychosocial wellbeing, preventing school dropout, and reducing child welfare costs. Municipalities and Wellbeing Services Counties commission outcomes; third-sector organisations deliver services; private investors finance project costs through a fund offering a potential 5-8% return at completion. Commissioners pay outcome-based fees only when predefined impact indicators are achieved. Current estimates suggest societal impact generated is multiple times greater than outcome payments made. However, sectoral divisions and short municipal budget cycles have challenged local implementation. Moreover, administrative burden and complexity of collaboration have sometimes exceeded expectations, which in one site generated political resistance. The critical enablers identified by commissioners were: political readiness to experiment, openness to systemic change, organisational commitment with dedicated resources and existing network-based governance capabilities.

Key lesson: *Outcome-based financing can resolve the wrong-pocket problem structurally, but only when three preconditions are already in place: political readiness to experiment, organisational commitment with dedicated resources, and existing network-based governance capabilities. Where these are absent, a model's ambition exceeds what an ecosystem can hold.*

The second is the **transition facilitator**: an actor with enough mandate, relationships, and time to hold the transition period together across institutional boundaries. Where the solution owner cares about what survives, the transition facilitator cares about whether the conditions for survival exist. The form varies: a

dedicated programme administrator, an anchor institution, a bridge practitioner. What is consistent is the function: boundary-spanning, institutional memory, political literacy, and the ability to hold trust relationships across sector lines simultaneously. In the context of the Finnish SIB model, the Central Union for Child Welfare occupies this role as it had most capacity to keep developing it. A report by Kyösti & Airaksinen (2020) highlighted the systemic change in the commissioner's activities after the project ended and commissioner's strong role as an overseer was highlighted as one of the enabling factors (all commissioners for the eight projects were municipalities)[8].

The transition facilitator function also points to something broader: the distinction between an initiative that has an owner (a person or organisation with a genuine stake in the survival of what has been built, the capability to keep developing it, and the relationships to advocate for its adoption) and one that does not. Governance without committed ownership rarely holds. Both the Finnish SIB coordination function and the 2PCS case (Case 3) point in the same direction: what persisted beyond the end of project funding was not the financial architecture but the relationships infrastructure that are carried forward.

3.3 Trust, relational infrastructure, and the community pocket

Trust is not a cultural precondition that some ecosystems have and others do not. It is a design feature: the product of repeated engagement around shared problems, structured to build genuine working relationships before actors are asked to share accountability. In Wales, the trust moment that allowed social prescribers to act as a bridging function was produced by open communication, evidence-sharing, and visible risk-sharing: not assumed in advance. That said, we also need to provide accessibility and inclusion as core transition infrastructure for people with complex needs, disabilities, rare diseases, low digital literacy or a high coordination burden.

What holds initiatives together through difficulty is rarely the financing instrument. It is relational trust (or social capital), a commitment to transparency when things go wrong, a clear and modest goal that gives people something concrete to point to, and an institutional anchor that provides stability without requiring everyone to agree on everything. The Dutch positive health ecosystem sustained years of institutional friction through genuine partner chemistry (a shared belief that the collective outcome was larger than the sum of individual contributions) before reaching the tipping point where municipalities began approaching the initiative rather than being approached.

There is also a wrong-pocket problem that sits entirely outside institutional budgets, falling on communities themselves. Communities absorb costs that appear in no budget line: the time spent navigating fragmented services, the informal care provided by neighbours, the civic energy invested in initiatives that prove their worth and then disappear. These costs compound: each successive failed initiative makes the next harder to launch, more expensive to staff relationally, and more dependent on external legitimacy to compensate for depleted local trust. Current financing architectures systematically extract value from community trust without accounting for the cost of that extraction. Social Return on Investment methodology offers one route to making this visible: by assigning proxy financial values to outcomes that matter to communities (reduced isolation, improved confidence, stronger neighbourhood reciprocity). SROI can surface the community pocket as a quantifiable contribution to the value chain rather than an invisible subsidy to it. The ROOMMATE case demonstrated a societal return of €1.51 per €1 invested precisely because it captured distributed value across patients, carers, and the wider community that a conventional cost-effectiveness analysis would have missed entirely. Making the community pocket measurable is not only a methodological challenge. It is a political one: once the hidden contribution of communities is quantified and visible, the systematic extraction of that value without reinvestment becomes harder to ignore.

Underlying all of this is a precondition that financing models rarely acknowledge explicitly: protected, paid and accessibility supported time for both institutional staff and citizen/patient partners. Trust develops through repeated interaction over time. Not through standalone interventions. Building cross-sector

[8] Anni Kyösti and Jenni Airaksinen (2020), *Future of Well-being Services at a Crossroads: Towards Outcomes Contracting?* Itla Children's Foundation, 1 October.
https://tem.fi/documents/1410877/21184793/Children+SIB_study_Finland.pdf/a1410d7b-77d3-4ba4-829c-406547d78fe9/Children+SIB_study_Finland.pdf?t=1605615236207

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relationships, designing sustainable models, and aligning stakeholders across institutional languages all require stepping back from operational pressures to engage in longer-term system work. In most settings this time is absent. Its absence is itself a structural barrier to crossing the middle. Meaningful participation must be financed as a line item, not assumed as a voluntary contribution. Payment for patient and citizen time, accessibility support, preparation materials in plain language, skilled facilitation, and organisational support for community and patient groups are not optional extras. Without them, participation defaults to those with the time, resources, and institutional proximity to engage for free: systematically excluding the communities carrying the greatest burden. The cost of meaningful participation is modest compared to the cost of initiatives that fail because communities were not genuinely involved in designing them. Accessibility and inclusion are not implementation details to be addressed after a model has been designed. They are core readiness conditions for scale. An initiative that does not work for people with complex needs, disabilities, rare diseases, low digital literacy, or a high coordination burden is not scalable. It has simply not yet encountered the full range of people it claims to serve. Accessibility must therefore be assessed as part of transition readiness, alongside governance, ownership, and financing. If a model cannot demonstrate that it works for the people most likely to be left behind, it has not yet crossed the missing middle.

3.4 Making value visible

In several cases across the three initiatives, the inability to make distributed value visible was itself a barrier to crossing the middle: not a post-hoc accountability concern but an active constraint on the willingness of partners to invest. The 2PCS case illustrates this directly: the value generated by a long innovation journey (engaging with stakeholders in the wider ecosystem to build credibility and market access) cannot be captured in any annual budget cycle or single-organisation financial model. Making that distributed value visible to the actors being asked to keep investing was part of what sustained ecosystem engagement through the years when commercial viability was still uncertain.

The actors who hold the most distributed and least-counted value are patients, citizens, and communities themselves, whose unpaid care, navigation burden, and civic energy are systematically excluded from traditional health economics. Social Return on Investment methodology offers a practical route to capturing this hidden contribution. By co-producing value definitions with patients and citizens from the outset, rather than imposing proxy indicators after the fact, SROI can surface what communities actually experience as valuable and make the cost of its extraction, when initiatives fail and trust depletes, visible to the commissioners and investors who currently bear none of it.

The AAL Programme's longitudinal evidence adds a specific dimension: every AAL solution that exceeded 10,000 users shared a multi-payer revenue structure. Direct-to-consumer models consistently failed to scale beyond niche segments. Making value visible to the specific mix of payers whose combined investment makes a model viable is not a communications exercise. It is a financing design question.

Choosing and embedding a measurement framework early (one capable of capturing value that accrues to multiple actors across time) is not a monitoring requirement. It is a strategic investment in the conditions for crossing.

The turning point is reached when responsibility and accountability internalise: when the governance, the budget lines, and the ownership of what has been built move from the programme to the ecosystem. None of the three initiatives has fully resolved this for all of their activities. But the conditions under which it happens are now better understood than they were when these initiatives began.

4. Business Models and Financing: What the Evidence Points Toward

Business models as a condition for crossing, not a consequence of it

One of the most consistent findings from the AAL Programme's legacy study is that projects which began working on their business model from the outset were substantially better placed to cross the missing middle. I4H's SCI work reaches the same conclusion from a different direction: the business model is not a revenue mechanism bolted onto a validated intervention. It is the logic that determines what an initiative does, for whom, in exchange for what. And specifically, how value is created and distributed across the multiple actors whose combined investment makes the crossing possible. Getting that logic right requires engaging with the wrong-pocket problem, governance, and ownership while the project is still running, not after the funding ends.

In contrast to a standard business model canvas built around a single organisation, what makes the business modelling by the three initiatives distinct are their explicit multi-stakeholder architecture. For example, the I4H multi-stakeholder framework builds from a common value proposition (what the collaboration creates beyond what any single actor could produce alone) through an operational model and an investment model that makes explicit how value is distributed across actors, held together by collaborative spaces that keep alignment alive under pressure. Critically, the common value proposition must be co-defined with citizens and patients from inception. Not validated by them after professionals and institutions have already shaped it. In the SCI multi-stakeholder canvas, citizens and patients are a named node with their own value flows: recognition of their contribution, paid time, capacity building, and meaningful influence over how reinvestment decisions are made. Not just observers of a model designed around institutional actors, but partners whose participation is a condition of the model's legitimacy.

The SCI framework also imposes a critical sequencing discipline: establish the common value proposition first, build the operational model hand-in-hand with the investment model, and only then identify the financing instrument that fits the specific form of the wrong-pocket problem. Initiatives that begin with the financing instrument and attempt to fit the model around it consistently find that the instrument does not fit the reality they encounter.

The Tesoma Wellness Alliance in Tampere (an outcome-based public-private partnership offers the clearest available illustration of what this sequencing produces when it works. The alliance (a ten-year outcome-based contract between the City of Tampere, the wellbeing services county, and a private provider, all operating with open books and shared Key Performance Indicators) was built by establishing the common value proposition first, designing the operational model around it, and only then constructing the investment model that distributes risk and reward structurally across all partners. The result is a model in which value distribution is built into the contract logic rather than assumed to emerge from goodwill.

Available financing approaches

The cases in this White Book illustrate rather than exhaust the available financing approaches. What they demonstrate is that no single instrument is sufficient for the missing middle, and that instrument selection without prior diagnosis of the specific form of the wrong-pocket problem tends to produce misalignment between the tool and the terrain. Five financing approaches are drawn on across the three initiatives, each with conditions under which it functions and conditions under which it breaks.

Smart Capacitating Investment (SCI) is not only a framework for financing prevention initiatives. Applied to the missing middle itself, it is a transition financing logic: a way of capitalising the period between proven project and sustainable system using shared values, shared risks, innovative finance, and a reinvestment model. Using SCI instruments explicitly to fund the crossing (not just the intervention) is one of the most actionable implications of the combined evidence from the three initiatives.

Internal resource pooling and reallocation (redirecting existing public budgets, in-kind contributions, and staff time) is typically the lowest-friction starting point. West Wales demonstrates both its power and its limits: it resolves the institutional wrong-pocket problem within a shared funding pot, but does not generate the transitional governance infrastructure that more complex crossings require.

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Public-private blended finance is particularly suited to the readiness-building phase between a successful project and scaling: the period most chronically underfinanced. The risk is misaligned expectations: blended models dissolve when private contributors anticipate cleaner returns than the model can generate.

Outcome-based contracts and Social Impact Bonds link payment to results rather than activities. The Finnish SIB demonstrates both what this makes possible (structural resolution of the wrong-pocket problem across multiple actors) and what it requires: political readiness, existing governance capabilities, and a dedicated transition facilitator. Administrative complexity has limited replication despite demonstrated impact.

Social Outcome Funds address a specific limitation of individual SIBs by providing shared infrastructure that smaller initiatives can access. When initiatives succeed, savings can be recycled into new projects: a reinvestment logic that grant-based approaches cannot replicate.

Three requirements hold across all of the above instrument types: (i) Match the instrument to the specific form of the wrong-pocket problem: budget fragmentation calls for pooling; incentive misalignment calls for outcome-based contracts; time horizon mismatch calls for patient capital. (ii) Build the operational model before the investment model: interventions that begin by designing the financing instrument and then attempt to fit governance and delivery around it consistently find that the instrument does not fit the reality they encounter. (iii) Design for sustained participation from the outset: the conditions that motivate initial engagement erode over time, and models that do not account for this tend to dissolve at the point when they matter most.

Across all five cases, citizen and patient participation in financing design remained limited. Present at the level of service co-design in the stronger examples, but absent from the governance of financial instruments, the definition of outcome metrics, and the allocation of reinvested savings. The OECD principles for stakeholder participation in public governance provide a useful benchmark: moving from informing and consulting citizens toward genuinely engaging and empowering them in financing decisions. Co-defining what counts as valuable, holding a named stake in outcome payments, and participating in reinvestment governance is not only a democratic requirement but a design condition for financing models whose legitimacy depends on sustained community participation.

5. Conclusions and Next Steps

Three conclusions

1. The missing middle is a function gap, not a funding gap The three initiatives together have demonstrated what fills it: named ownership at the solution level, transition financing, relational infrastructure built in advance, and governance conditions that precede rather than follow the innovation. More money, directed at projects with the same architecture, will reproduce the same pattern. What is needed is a different architecture: one that treats the transition phase as a distinct investment requirement, not a residual problem for project teams to solve after the funding ends.

2. The turning point is reached when responsibility internalises None of the three initiatives has fully resolved this. But the conditions under which it happens (governance anchoring, named ownership, a transition facilitator with mandate and relationships, value measurement embedded from the outset) are better understood than they were when these three initiatives began. The pattern is consistent enough across the five cases and three initiative families to support this conclusion with confidence.

3. Projects are not the problem The learning that projects generate is rarely structured to survive the transition. What is needed is not better projects but deliberate investment in the transition phase: the governance, the ownership, and the financing that allow what a project has learned to compound rather than disappear. AAL's twenty-year evidence base (and Use Case 3 in particular) makes this concrete: the question is not whether a project worked, but whether the ecosystem relationships built during the project is capable of carrying what was learned forward without the initiative funding that created it.

Two observations for practitioners navigating the missing middle now

The first is about timing. The governance, ownership, and business model conditions described in Sections 3 and 4 cannot be built retrospectively. Every case where the missing middle was successfully crossed involved deliberate investment in these conditions during the project phase. If you are in the final year of a funded project and these conditions are not yet in place, the window is narrow but not closed. The most urgent priority is naming who owns the solution and beginning the governance conversation now. It is almost never too early. It is frequently too late.

The second is about scale. Several cases reached a successful crossing only to find that the conditions responsible for it (the relational chemistry, the lightweight governance, the personal relationships) could not survive the growth that success attracted. Before attempting to scale, ask whether the model that crossed the missing middle was designed to be replicated by others, or whether it depended on conditions that cannot be transferred. The AAL Competence Network made this choice deliberately: by keeping the model lightweight and franchisable from the outset, it preserved the possibility of replication without requiring anyone to rebuild what already existed.

Four next steps

1. Develop a joint learning framework. Build a learning framework, co-produced with CPAG. Author it under the GRIPP SF reporting standard and host it across the I4H Social Franchising Package and other platforms. Success means practitioners entering the next funding round can find and use what the three initiatives learned: without starting from scratch.

2. Test SCI transition financing at new ecosystem sites. Run a real test of whether the paper's central argument can be put into practice. Apply the SCI approach at ecosystem sites where projects are approaching the end of their funded phase (at the point of handover) and document what governance structures, ownership arrangements, and stakeholder commitments are in place and if they are sufficient. Report findings in a form the next funding round can act on.

3. Develop and pilot a short-term outcome measurement instrument. Build a tool that lets upstream health initiatives show funders early signs of long-term impact: co-designed with patients and citizens from the outset. The instrument should generate short-term proxy indicators alongside citizen-defined measures of value, and connect with the SINTEF co-governance platform in development. Success means a commissioner can see credible early signals of value within a standard funding cycle.

4. Bring the combined evidence to three named European policy moments. Use already-scheduled events and partnerships to put the missing middle on the agenda with a specific ask: that it be named as a distinct investment priority in the next European health programming round. Priority platforms might include the THCS Partnership WP9, the WHO European Programme of Work, and the S3 Health Resilience Partnership for structural funding conversations.

The I4H project ends soon and the AAL Programme is completed. The THCS Partnership continues. The knowledge, the relationships, and the institutional conditions they have helped to build do not have to. That the legacy endures needs to include the relationships built with patients and citizens and pausing those relationships well (with accountability for handover, recognition of contribution and a route to be heard by successor initiatives). Overall, this depends on whether the actors with the relevant leverage are willing to treat the evidence in this White Book as a basis for action, rather than a contribution to a longer conversation that never quite arrives at a conclusion.

Finally… **a principle of responsible exit should apply to every initiative that reaches the missing middle**. If a project cannot be sustained, the communities that contributed their time, trust, and hope to it should not simply be left behind. Ending, adapting, or handing over a project requires explicit accountability: transparency about what is stopping and why, a genuine transition plan for the people who depended on it, recognition of what communities contributed, and a clear route by which their experience can inform what comes next. Responsible exit is not failure management. It is a condition of legitimacy and a foundation for the trust that the next initiative will need to build.

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