SOCIAL FINANCE

Social Impact Bonds

A new way to invest in better healthcare

PREVENTION IS NOT ONLY BETTER HEALTHCARE BUT BETTER ECONOMICS. CAN SOCIAL IMPACT BONDS FUND A SHIFT TO PREVENTION?

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IF THE NHS IS TO BECOME A SUSTAINABLE HEALTH SERVICE, A PROPORTION OF ITS FUNDING SHOULD BE SPENT WITHIN A LONGER TERM MODEL.

Professor Paul Corrigan assesses the suitability of the Social Impact Bond model for the NHS in this report.

September 2011

PURPOSE

This report is about the potential applicability of Social Impact Bonds (SIBs) in the health field. The SIB is a financial mechanism where investor returns are aligned with social outcomes. The SIB is based on a contract with government in which the government commits to pay for an improvement in social outcomes for a defined population. Investors fund a range of preventative interventions with the goal of improving the contracted outcomes. If and as the outcomes improve, investors receive payments from government.

To widespread interest, the first SIB was launched in September 2010. Its aim is to reduce reoffending among short sentence male prisoners leaving Peterborough prison.

Social Finance believes that the reach of the Social Impact Bond model is wider than Criminal Justice. We asked Professor Paul Corrigan, a leading health adviser, to assess the suitability of the SIB model for the NHS. This report presents his thoughts. We hope that his report provokes a thoughtful debate on how, or alternatively if, financial mechanisms such as Social Impact Bonds, might fund new interventions, improve people's well-being and ultimately lead to a real change in the health system.

1 Introduction

This pamphlet explores the way in which longer term finance can be brought into the NHS to pay for some services for NHS patients. This is an important issue, not only because of the limits that are placed on the total amount of resources available from taxation for the NHS, but because the nature of the funding that is given to the NHS encourages a very short term annual approach to investment in services.

The NHS, as do health services in most jurisdictions, needs a form of resource which encourages the investment in services that provide both patients and society with a medium term return on that investment. At the moment if a service provides a return to the NHS over a four or five year period, but not at all in the first year, then annualised funding makes this a very difficult service to invest in.

I will argue that there are a range of highly important services that should be provided for more NHS patients that will only become mainstream if we develop a form of funding which moves beyond that provided by the Treasury on a year by year basis. Such services may well be uneconomic if based upon a single year's expenditure and return, but if they were allowed to be judged on a longer period than the one year, they would become a significant addition to the health of the nation.

The NHS matters enormously to the great majority of the British people. They support its basic principles very strongly. Its principles guarantee access for all without payment at the point of delivery, but its method of funding also contains an important principle. That is that the money spent on the NHS should come out of national taxation.

Public financing of the NHS is not an abstract issue. Whilst people will not know the details of national taxation, they do know that 'we all pay for the NHS'. In April 2002 when the Labour Government raised National Insurance to 'pay for the NHS' it gained support by raising taxes rather than lowering them.

This is an unusually febrile time in the history of the NHS. In 2010 the Coalition Government started a process of NHS reform that was initially labelled by them as revolutionary. Later this became styled as evolutionary, and in June 2011 they further reviewed their plans. These reforms have provoked an acrimonious debate within the NHS and across the country.

Given these circumstances, suggesting a new way of introducing long term finance into the NHS at such a time is dangerous. It is therefore essential to explain how the Social Impact Bond (SIB) fits in with the basic principles of the NHS and the current reforms.

SIBs can provide the NHS with the opportunity to show a real return on investment over a multi-year period. I will explore both the mechanics of how this might work and provide examples of how different parts of the NHS might use such bonds to provide services which would, if scaled up, have an important impact on the healthcare of the country.

How does a SIB work? A SIB is a financial mechanism where investor returns are aligned with social outcomes. It is based on a contract with the public sector in which it commits to pay for improved social outcomes. The public sector organisation agrees to pay the contractor for outcomes that will be delivered over a multi-year period, rather than a single year. On the basis of this contract, investment is raised from socially-motivated investors who are both interested in a return on their investment and the outcomes specified in the contract. This investment is used to pay for a range of interventions to improve social outcomes. The interventions are usually those that will take more than a year to come to fruition and that therefore could not be met through annual funding. If specified social outcomes improve, investors will receive payments from the public service organisations that gain from those outcomes. They will repay the initial investment plus a financial return. Since the investor is taking the financial risk, the financial return is dependent on the degree to which outcomes improve.

Just to underline clearly at the start. The application of SIBs fits in totally with the basic principles of the NHS. They would provide services which deliver equal access for all without any payment at the point of delivery. The finance that will provide the return on the bond will only come from resources that have been raised from national taxation, not from private insurance or from the wallets of those receiving the services. What is new for the NHS is the use of a financial vehicle where the investment will be recouped over a multi-year period from existing patterns of revenue. This is normal in all other walks of life. However because it is new the idea will be attacked. Anything new in the NHS needs to defend itself against the onslaught from the old.

2 The difficulty of longer term NHS investment

For most of the last 30 years – half the life time of the NHS - commentators, politicians and senior NHS leaders have pointed out that the NHS is not a National Health Service but a National Sickness Service. Again and again very significant people have made the case that prevention is not only better healthcare but better economics.

The most significant report to develop this analysis was the 2002 Wanless report: *Securing Our Future Health: Taking a Long-Term View*. This famously outlined three different scenarios for the future of the health service: solid progress; slow uptake and fully engaged.

- **Solid progress** – people become more engaged in relation to their health: life expectancy rises considerably, health status improves and people have confidence in the primary care system and use it more appropriately. The health service is responsive with high rates of technology uptake and a more efficient use of resources;
- **Slow uptake** – there is no change in the level of public engagement: life expectancy rises by the lowest amount in all three scenarios and the health status of the population is constant or deteriorates. The health service is relatively unresponsive with low rates of technology uptake and low productivity;
- **Fully engaged** – levels of public engagement in relation to their health are high: life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the health system and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. The use of resources is more efficient.

The fully engaged scenario assumes extensive investment in longer term aspects of care, most especially health prevention. The Wanless report argued for this scenario on economic grounds as a much better investment for the future. Increasingly sophisticated economic modelling has demonstrated that investment in health prevention now will save billions of spend on healthcare in the future.

Despite the report and all the evidence gathered over the years, the NHS in 2011 still primarily provides services for those people who are sick. It fails to substantially increase the proportion of its expenditure on prevention. There are three main reasons for this happening.

First, the NHS is a publicly funded service and as such conforms with Treasury rules as to where and how it spends public money. The Treasury feels that it needs to keep a clear line of sight of public money that it provides to organisations. And it does that through annual accounting. The Department of Health (DH) and the local NHS commissioning organisation must demonstrate annually how the money being spent adds up to the money given.

To keep control of public expenditure this makes a lot of sense. Local NHS Commissioners have as their CEO an 'accountable officer' who has to account upwards for that money. Over the last few years the NHS has become much better at working within these accountancy rules.

However, annualised budgets as a dominant form of public finance limit achievements. They provide both a reason and an excuse for thinking in terms of a very short term spend. A culture has developed that says 'the Treasury rules' will not allow us to do that, so there is little point in working out a proper medium term return on investment.

This has led to the second problem which is that NHS culture says that there is no point in working through a thorough economically sound case for a service intervention since the economics of the NHS will not allow you to do it.

In developing this pamphlet I have had numerous conversations with NHS staff who think they have a developed economic case for a form of NHS service. As we will see, the SIB needs organisations seeking to make a case to investors about their new NHS service. In making that case for real money, they will have to compete with others. Capital will only invest where it can minimise the risk of loss. It will minimise the risk of loss if it can believe it will get a real return on its investment. Real return needs to have real pounds involved in it, not some mythical hopeful money.

For many years the NHS has claimed that new services will save money but in nearly all of the conversations I have had with potential suppliers of services to NHS organisations the conversations started with the belief that their service will save the NHS millions. However they

became much less solid when you test how much of those savings can be realised and how much real money can be paid back.

Over recent years the NHS has invested in a very large number of new services, but clear financial returns from those services have only very rarely been realised. For example, the excellent telephone diagnostic service NHS Direct was intended to save the NHS a great deal of money because patients would not bother A&E or their GPs. But both A&E attendance and GP attendance increased alongside NHS Direct use. In another example, NHS walk-in centres were meant to stop patients going to A&E and GP centres but they simply became another service. These services were allowed to start up without a clear strategy about how they would recoup their investment.

> AGAIN AND AGAIN PEOPLE HAVE MADE THE CASE THAT PREVENTION IS NOT ONLY BETTER HEALTHCARE BUT BETTER ECONOMICS.

Thirdly the structure of the NHS has only recently been able to tell you what different parts of its services cost. It is difficult to make a case for either reform or savings if you don't know what the basic parts of your service cost.

In 2002/3 when the DH was looking to create a form of pricing for hospital work, it started with what was the easiest of activities to cost – orthopaedic activity for hip and knee replacements. The 'price' of a hip replacement was calculated by simply adding up the costs of all of the hip replacements that had taken place the year before in all the NHS hospitals and dividing that sum by the number of replacements carried out. Finding out how to charge for a hip replacement by averaging out what every hip replacement cost last year was a crude pricing method. It also assumed that hospitals knew what one of these units of service actually cost.

It is only in recent years that the NHS has any idea about what the simplest activities cost. And as we shall see, some of the activities that the SIB could be used for are much more complex patient pathways than a one off service.

Most NHS healthcare is not commissioned as a set of services. Primary care, mental health services and acute care are commissioned through a block grant. NHS commissioners spend money and then wait for the next year's allocation to spend even more. This has been the nature of NHS economics. The idea of getting some money back from an investment has been an odd one for commissioners. Value for money is good service for the money that you spend and not a real return in real money for any investment made.

> AT PRESENT, NHS COMMISSIONERS SPEND MONEY AND THEN WAIT FOR NEXT YEAR'S ALLOCATION TO SPEND EVEN MORE. THE IDEA OF GETTING SOME MONEY BACK FROM AN INVESTMENT IS AN ODD ONE FOR COMMISSIONERS.

It is mainly in the acute hospital sector that commissioners have been buying costed services and it is here that a much better understanding of what cost price and investment might mean is emerging.

There is a further cultural problem that arises from the end of year reconciliation that happens across the country. The parts of the NHS in regular deficit get given money to ensure they can continue to operate. Whilst there are repercussions for the management as individuals, organisations that in any real economic sense should be bankrupt, continue for years.

The one part of the NHS where this does not apply is the Foundation Trust sector. Since 2004 a growing number of trusts have had to operate within an economic model that does not bail them out if they lose money. They are expected to operate as real businesses with an understanding of where the annual budget will come from and where it will go. Foundation Trusts adopt a counter cultural approach to old style NHS economics with a growing appreciation of the relationship between investment and return.

3 Developing a new economic reality

NHS culture and its own economics mean that this not a straightforward arena within which to develop an economic tool that demands a real return on real investment. Yet it is this that is at the core of the Social Impact Bond. Having set the difficult cultural scene of the NHS, the rest of this pamphlet argues for ways of introducing this form of economics into the NHS.

The impact of the coming economic squeeze on NHS resources will assist this. The last ten years has seen a doubling of the resources going into the NHS. This spectacular growth in resources has come about on the back of decades of growth that has been above the level of growth of GDP. This means that annually the NHS has become used to working with a greater slice of a bigger cake. This has been the norm for most health services in developed societies. This will now change.

For the next decade the British economy will do well to grow by 1% a year and the NHS will do well to hold its share of that growth. We know the budget for the NHS over the next five years will increase by 0.1% a year. It is unlikely that the growth will be much greater in the second half of this decade. Every year the demand for healthcare increases. This has been true for decades and will continue to be the case over the next few years. The life expectancy of our population rises by two months every year that passes. This will have a number of significant impacts on a range of services, with particular impact on the demand for healthcare.

In a 2009 British Medical Journal article it was reported that over the next decade the number of over 85 year olds will increase by a third. In this study more than nine out of ten (94%) participants had seen their GP and almost eight out of ten (77%) had seen a practice nurse in the previous year. This level of demand for healthcare from the older population is greater than for any other groups of the population.

As the number of 85 year olds grows, so will the very specific demand for healthcare for people with long term conditions. It is not easy to judge the impact of these new and increasing demands for healthcare on the NHS, but the costs will probably increase between 3-5% every year.

Long term conditions such as diabetes, breathing disorders and arthritis are not episodic health events such as tonsillitis which a visit to the doctor can treat. Nearly always, they are conditions that will be with the person for the rest of their life. The aim of healthcare is to stop the condition from diminishing the person's life for as long as possible.

As we get a lot older that becomes more difficult. The impact of the condition on our body and our minds will intensify and we will need more health interventions to stop the condition from worsening.

It would be wrong to simply see these conditions are diseases of aging, but it would be right to characterise old age as being a much more likely time of life to have one or more of these conditions.

The medium term economics of the NHS must reflect a compound increase of resources between now and 2020 of about 1.5% and a compound increase in demand of about 40-50%.

If we were to try and provide care for those individuals who represent the increased health demands due to long term conditions in the way in which we have treated people with these conditions up until now, the NHS in any form as we know it, will go bankrupt. It will then have to stop delivering many of the services it currently delivers.

> EVERY YEAR THE DEMAND FOR HEALTHCARE INCREASES.
> THE LIFE EXPECTANCY OF OUR POPULATION RISES BY TWO MONTHS WITH EVERY YEAR THAT PASSES.

The first NHS response to the increase in demand is to lobby for more resources. But the current financial outlook for the general economy and specifically for the taxation based public services means that that the possibility of an increase in resources of the order of 50% over the next ten years will not happen.

Commissioners (people that buy NHS healthcare) are increasingly aware of this growing economic reality. But the vast majority of the population are unaware of the crisis that will increasingly impact upon the NHS as they need it more in their older years.

The choice is stark. The NHS either gets a lot more money from public taxation, crumbles as it tries to meet the new demand in the way in which it has met the old demand, or it uncovers new ways of creating significantly better healthcare outcomes from the same resources.

4 Culture Change

This pamphlet provides an analysis of the NHS economic culture within which the Social Impact Bond might be developed. First the NHS has a culture of annual income and expenditure which undermines the possibility of the longer term economics of a return on investment.

Second, the majority of the NHS has developed for decades within an economics that assumes there will always be more money for increased demand and if an organisation gets into financial trouble it will be bailed out.

Both of these factors mean that the economics that define many other services, one that demands a clear return on all investment, is not the orthodox economics of the NHS.

Investors, such as trusts and foundations, have a legal duty to secure a return on investment, and whilst they are in a position to take risks, they would not be able to carry out that duty without a clear understanding of where the return might come from.

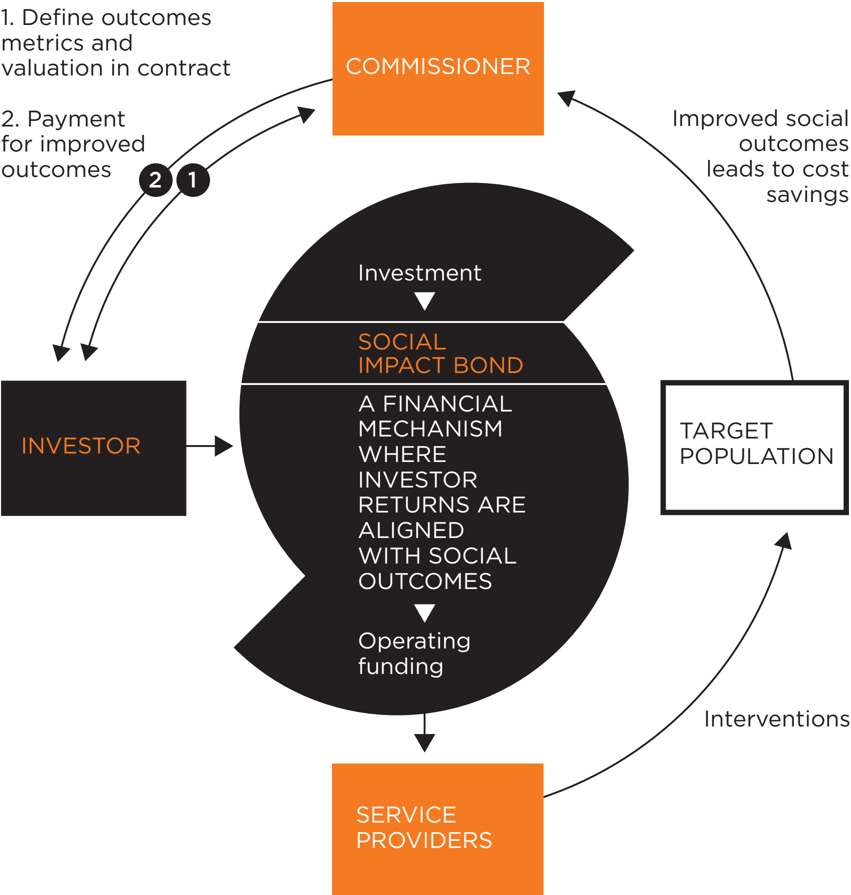
What the NHS needs and what the SIB can provide is a set of innovations which will challenge the existing value for money equation in the NHS. By organising a financial model over a number of years and not on an annual basis, it secures an economics of the medium term rather than on an annualised basis.

The SIB needs to identify where the resource to be saved resides at the moment and then demonstrate how it will realise that resource. It demands rigorous analysis from those interested in developing health services. This is not in any sense free money. It has to earn other money as a return. It requires clarity about what the return on investment will be.

5 What is a Social Impact Bond?

SIBs are an innovative way to bring in non-governmental money to fund preventative services. Social Finance and others are developing the SIB model across a number of sectors.

1	A Social Impact Bond (SIB) is a financing mechanism where investor returns are aligned with social outcomes.
2	It is based on a contract with the public sector in which it commits to pay for improved social outcomes. Investment is raised from socially-motivated investors.
3	If social outcomes improve, investors will receive payments from the public sector.
4	These payments repay the initial investment plus a financial return.
5	The financial return is dependent on the degree to which outcomes improve.


1. Define outcomes metrics and valuation in contract
2. Payment for improved outcomes
COMMISSIONER
Improved social outcomes leads to cost savings
Investment
SOCIAL IMPACT BOND
A FINANCIAL MECHANISM WHERE INVESTOR RETURNS ARE ALIGNED WITH SOCIAL OUTCOMES
Operating funding
INVESTOR
TARGET POPULATION
Interventions
SERVICE PROVIDERS

6 How would a SIB work within the NHS?

First there needs to be an intervention that clearly improves social outcomes. For many services being developed for the NHS, this is the easy part. Nearly all service providers believe that they have a social outcome to provide. Most new services do provide an outcome that improves people's health. So if the outcome was purely social, most services would meet this. Almost certainly some aspects of the improvement of social outcomes will have been developed by other aspects of existing NHS, so the initial contract with any NHS organisation will have to make clear which improved outcomes the SIB is responsible for.

Second, if social outcomes improve, investors will receive payments from government. It is essential that the savings produced by the SIB are clearly identified, and have been obviously realised through the interventions funded from the SIB.

Thirdly, these payments repay the initial investment plus a financial return. This means that this particular NHS service must be set up in such a way as to recoup savings in real pounds and then make a return to the SIB investors. This requires an accounting system that can track investment and savings, as well as a recognition that investment deserves to obtain a return on its capital.

Fourthly, the financial return is dependent on the degree to which outcomes improve. Again this is a straightforward part of any economic return on investment model. The return that you achieve will have to depend on the outcomes that the service delivers. This is the calculation that the investors are making and in the world of investment it is a normal calculation.

If at the start of the process of thinking about a new service, the size of the return on the investment is a part of this process, then, as we shall see, there are very different interventions that might develop services that are segmented in certain ways.

Peterborough SIB

The first SIB was launched in September 2010 by Social Finance to reduce re-offending levels. The rehabilitation of offenders is a cornerstone of the government's criminal justice policy. Successful rehabilitation will deliver benefits to society and reduce public spending on the prison system. Fewer offenders will commit less crime requiring fewer prisons, costing less money. With 60% of short sentence prisoners re-offending within a year of release there is a real opportunity to revolutionise the rehabilitation of prisoners.

The challenge is that reducing re-offending is a long-term commitment requiring time and investment. There is a natural time lag between offering new and improved rehabilitation services, reducing re-offending and closing prisons. With no new public funding available for rehabilitation services, particularly in the current spending environment, how can the transformation be funded?

Social Finance developed Social Impact Bonds to bridge the funding divide and raise external social investment to fund preventative programmes. This finance funds voluntary sector and community organisations to deliver programmes which stop prisoners returning to prison after release. The first SIB provides intensive rehabilitation support for short-sentence male prisoners leaving Peterborough prison.

If this initiative reduces re-offending by 7.5% or more, investors will receive from Government a share of the long term savings. If the SIB delivers a drop in re-offending beyond the threshold, investors will receive an increasing return the greater the success at achieving the social outcome, up to a maximum of 13%.

7 How would the NHS raise money through a SIB and how would it improve the existing model of NHS care?

For a Social Impact Bond to work it needs to be able to realise benefits to repay the capital and a return on the investment. There are two very different parts of the NHS which may, in the current economic climate, be interested in this proposal.

First, local commissioners of healthcare. Since the early 2000s, Primary Care Trusts (PCTs) have been responsible for the commissioning of most healthcare services in their locality. Over 85% of the NHS budgets now go through PCTs. The Government NHS reform programme plans to change the care commissioning process, abolish PCTs and establish clinical commissioning groups in their place.

For the next few years, the economics of the NHS will place greater economic pressure to achieve significantly better healthcare outcomes for about the same resource. For every year that they fail to engage in this different economics, parts of the NHS in their locality will suffer and many of them will fail to break even. I am not suggesting that the entirety of local NHS commissioning over the next two years will switch from one form of economics to another, but I am suggesting that a number of local commissioners will be looking for a real economic model of investment and return.

There are two reasons why GPs have been chosen to lead clinical commissioning groups. First they are doctors. As GPs they make the day to day referral decisions that spend most of the NHS's resources, but up until now they have made clinical decisions with no responsibility for the financial implications of those decisions. If GPs were in charge of commissioning it is assumed that there would a closer congruence between what is financially and medically necessary.

The second reason GPs have been chosen to lead commissioning is because they run small businesses. Since 1948 the GP sector of the NHS has been organised through a number of small businesses as GP partner practices. Over this period GPs have learnt to become small business people with an eye to the economics of investment and return. Currently they make decisions about taking on an extra nurse if they

feel they could obtain a return in their income for that new member of staff. GP-led commissioning is based on the premise that it is possible to transfer GPs economic skills from running the £m GP practices to £100ms of NHS commissioning.

The second area of the development of longer term economics in the NHS is within NHS Foundation Trusts (NHS FTs). The first NHS FTs were set up in 2004 as NHS healthcare providers not owned by the Secretary of State. This is in contrast to other hospitals and NHS acute trusts that have been owned by the Secretary of State since 1948. The autonomy of NHS FTs means that their Boards are responsible for their success or failure. They are expected to break even and even to make an annual surplus. They are expected to operate on the lines of a normal business. Unlike other non FTs they cannot expect to be bailed out by the rest of the NHS if they were to make a loss.

Over the last seven years as the FT sector has grown they have learnt to make more and more decisions within the reality of real economics. As of the summer of 2011, they have a surplus of over £2 billion between them.

I believe there is a strong case to argue that the FTs could understand an investment model of investing in a service that would provide a return over five years.

However, as we shall see in the next section, one of the main ways in which a return on investment could be made by any SIB would be by reducing the number of people who spent time (and or the length of time they spend) in a hospital. Why should an acute hospital FT invest in a service that will only make a return on investment if they have less core business in terms of hospital usage? Whilst this may be the way in which the average hospital thinks, there are some leading hospitals that are developing a different business model and would be interested in investing in a service that would reduce hospitalisation. They recognise that in the medium and long term the NHS will need fewer patients in hospital for shorter times. They want to be a part of that business even if it changes their existing business model.

PEOPLE WITH
LONG TERM
CONDITIONS ARE
DISPROPORTIONATELY
HIGHER USERS OF
HEALTH SERVICES
REPRESENTING:
50% OF GP
APPOINTMENTS,
68% OF OUTPATIENT
AND A&E
ATTENDANCES
AND 70% OF
INPATIENT BED
DAYS.

8 How would a SIB realise any benefit?

I am not suggesting that SIBs should be developed to replace existing mainstream funding in the NHS. Given the importance of the basic funding principle of the NHS, that it is paid for out of national taxation, the existing flows of finance will continue in the orthodox way that they do at the moment. Given the budget for the NHS is over £110 billion, the development of a sizeable market for SIBs could take place within even 1% of this market. If the SIB market grew from zero to that in five years it would be spectacular growth, but it would a small percentage in NHS terms.

The vision for SIBs is that they can have a significant impact on NHS health services, but they will not transform all of them. I don't believe that over the next few years, the economics of basic healthcare prevention will lead to the creation of a thousand SIBs. This may be best explained by an example. An investment in a service that would reduce obesity in young people would, if scaled up, undoubtedly have an impact upon the health of the public. Over a long period of time it would reduce a range of very costly public service and health interventions, but drawing an economic line of causation between the intervention and the money saved over 20 years will be a difficult one. Therefore demonstrating how the savings for that investment can be realised and actually saved, would be difficult.

So this pamphlet does not suggest that SIBs can be used for general population public health interventions. I am suggesting that in the first instance SIBs are used as a form of investment for people with long term conditions (LTCs). All of these suggested interventions concern people who are already sick. Asthma, diabetes, coronary heart problems, breathing problems, muscular skeletal problems and depression are the major long term conditions that could benefit from SIBs.

People with long term conditions are disproportionately higher users of health services – representing 50% of GP appointments, 68% of outpatient and A&E attendances and 70% of inpatient bed days. Current trends suggest significant growth in the number of very high intensity, high cost users – these are often people with multiple co-morbidities of long term conditions. Over the next few years the number with three or more conditions will increase by around 60%. (In a quarter of people with multiple LTCs, one of the conditions will be depression.)

There are three reasons for suggesting the development of SIBs in long term conditions patient provision. First its importance. The earlier statistics especially of the percentage of healthcare usage by people with long term conditions demonstrate that this is a vital part of the way in which the NHS develops care.

Second, nearly everyone who suffers a long term condition does so for a long part of their life. This changes the dynamic between the patient and their healthcare more than it does with an episodic, one off event. If a patient knows they are going to suffer from a condition for the rest of their lives it is worthwhile them investing some time and effort into understanding how that disease interacts with their lives and their bodies. For many patients with long term conditions, the NHS fails to fully invest in the full utilisation of the power of the patient to bring about improvement in his/her condition. One of the main aspects of SIBs is to realise the value for the patient and the NHS that can be created by much more patient involvement in the care of his/her long term condition.

Thirdly, the economics of current provision is wasteful. The statistics of usage above are telling. There is a high percentage of each category of care. Spending the first day in an intensive care bed and then two or three days in a high dependency bed before being transferred to a normal acute care bed, is a move from the most expensive form of healthcare to the very expensive. It is for these economic reasons that much of the health policy over the last five years has been trying to keep people out of hospital.

Why do people with long term conditions use inpatient hospital beds to such a high extent? Many of their visits to inpatient beds come under the headings of 'complications' or emergency admissions. If you are a patient with breathing problems and you have an acute exacerbation, you or your carer ring 999 and an ambulance takes you to hospital where you are usually put straight in an intensive care bed. You will then be admitted into the hospital for treatment. You spend several days there until your breathing has stabilised and you can go home.

If you are a person with diabetes and your blood sugars get out of control, you may collapse and be taken to hospital where the similar interventions happen. If you are depressed and your depression deepens until you become very ill, you will probably be taken to hospital for much better drug intervention.

The patients may have forgotten their drugs; forgotten to take a test; ate badly; exercised wrongly or in some way helped to cause their exacerbation. Or the doctor or nurse may have not recognised a change that had taken place in the person's life, body or mind that needed a different approach. Usually it is a failure of the interaction between the medical intervention and the patient that leads to the emergency hospital admissions.

It is here that the crux of the future economics of the NHS resides. An emergency admission is amongst the most expensive care that the NHS provides. Yet much of that care and the resulting expenditure come from a failure to look after someone who is chronically and not acutely ill. Too many expensive emergency episodes are caused by failures of day to day chronic care.

If we can invest in better organised patient care for people with chronic conditions and reduce a small number of emergency admissions, then the return on the investment for the chronic care is realised from the savings from emergency admissions.

The SIB works because it substitutes, over time, day to day chronic care for the expensive hospital care. However, the organisations that are providing the return upon the original investment must ensure that they realise the savings from emergency hospital admissions that do not take place.

In my first section about the economics of the NHS I made the point that up until now there were very few examples of a return on investment being realised. It is essential that the prospective SIB tackles the realisation of the savings from lower hospital admissions so that the return on investment can be realised. If that is the case then investors will invest the original capital.

Over 60% of the most expensive part of the health service (inpatient beds) is spent on people with long term conditions. If a new service, invested in the patients, their carers and more immediate nurse or primary care led care, can save that money, then it is possible to demonstrate a return on investment. It may take more than one year to deliver that return on investment. Therefore a SIB that expects the return to build over a multi-year period provides the initial longer term investment and has the prospect of a return on its investment.

9 Why has this not happened before?

Firstly the NHS needs to agree with an economics which sees a return on investment as a necessary part of having the investment in the first place. Most new services have claimed that they can obtain a return on investment but have not been able to do so.

Second, the evidence of the return on investment – real pounds in real time – needs to be clear and in the cases of the previous examples would only be realised through the money that would have gone into the emergency spells in hospital. That money needs to be a part of this equation.

Up until now many of the new services for people with long term conditions have failed to secure a return. What we need to make a SIB work is not just a health service which is aimed at people with long term conditions but one that is aimed at those with long term conditions who are more likely to have used emergency admissions without that intervention.

The successful SIBs are those that are likely to segment the group of patients that they are working with rather than simply say all patients will get this service. This is not to say that those patients should not get a service, but it is to say that the financial vehicle of the SIB is the right way of financing those particular services.

10 Three health services where a SIB might work

1

GREATER SELF MANAGEMENT OF DIABETES CARE
JOHN GRUMMITT DIABETES UK

John Grummitt is the vice chair of Diabetes UK and has an interest in radically improving services for people with diabetes.

Over the last two years he has been working with GPs, patients and other professionals in Bexley to provide a much better care pathway for patients with diabetes. He is proposing a new seamless service for all people diagnosed with diabetes in Bexley.

Today there are approximately 9,500 people with diabetes in Bexley, up from 5,000 in 1996. Approximately 1,000 have Type 1 diabetes while the remainder have Type 2. With Type 1 diabetes, the pancreas fails to produce insulin, in response to an auto immune attack. In contrast, Type 2 is a more gradual decline of insulin production or a resistance to it. The number of both types of diabetes is expected to rise at a rate of at least 5% a year to 15,000 by 2025.

Half of those with Type 2 diabetes already have complications at the time of diagnosis. A significant majority of the complications arising from Type 2 diabetes are preventable with good self management together with effective support from healthcare professionals. It is estimated that 10% of the NHS budget is spent on diabetes. It follows that the vast proportion of the expenditure on these complications is also avoidable. 70% of people dying with diabetes have cardiovascular disease or end stage renal failure. High quality care in conjunction with effective prevention measures is therefore a necessity, not a nicety. Failure to act will continue to fuel patient volumes requiring additional treatment.

PROPOSED SOLUTION

We shall build on the 2008 Diabetes Pilot which sought to move care out of the acute setting into the community, improving patients' experiences and reducing spending on expensive acute services. As well as improving GPs' basic care, we have the opportunity to bring some elements of specialist patient care into the community.

We shall ensure that care is delivered by appropriately qualified professionals:

- **Basic care by GPs and nurses**
  e.g. care planning for annual reviews, lifestyle change, insulin initiation
- **Specialist community support by specialist consultants and nurses**
  e.g. pre-pregnancy planning, Type 1 diabetes annual reviews without complexities
- **More complex care will remain in an acute setting**
  e.g. further investigation of complications, children, gestational and those with diabetes who fall pregnant

To manage the allocation between settings there will be a triage service. In arranging patient care in this way, we expect at least 80% to be treated in the community. This will impact on the emergency hospital admissions for complications.

www.diabetes.org.uk

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THE EXPERT PATIENTS PROGRAMME

The provision of much better education and training for patients with long term conditions has had a number of champions over the years. The economic idea behind the programme is the belief that it should be possible to change the way patients use the health services (and other public services) if the person with the long term condition can look after themselves more and is more actively engaged in their own care. The next phase of the development of the NHS must involve patients adding considerably more value to their own care.

The Expert Patient Programme has carried out its own analysis of the return on investment if patients are better equipped to manage their condition. What is interesting is that this analysis shows very different returns from different programmes depending on which specific patient group the programme is aimed at. Some groups of patients provide much bigger returns on investment because the savings that accrue from this group are greater than the average. These patients are probably those who are initially less able to deal with the impact of the condition on their lives. It is here therefore that there is greatest potential for using external investment to generate better outcomes and savings.

The voluntary sector has long championed the need for patients to be more engaged with their care, and the Department of Health began to pilot Expert Patients Programmes in the NHS in 2002.

Expert Patient Programmes are usually six week courses, often focused around a long-term conditions or a particular issue (e.g. substance misuse). Delivered by trained tutors, many of whom have first-hand experience of the condition, they aim to improve participants' skills in

living with their condition and help them feel more in control. The Expert Patients Programme was spun out from the Department of Health as an independent community interest company in 2007 to become a national provider of self-management courses.

A recent study investigated the social impact of lay-led self-management programmes in the Wirral over a one year period. These courses focused on people recovering from drug and alcohol misuse. Generic expert patient programmes in Salford aimed at a wider population were also looked at in order to compare the social impact on different groups and the difference between targeted and untargeted approaches. There was a focus on the ancillary and lasting systematic impact. These conservative evaluations found that the programmes have a social return on investment (measuring broader social value) of £1.85 for every £1 invested, in addition to the health benefits.

TARGETING

EPP CIC has undertaken further work to understand the profile of service users who are more likely to have poor health and to adapt and develop its programmes to be more effective for these groups. We have observed that the frequency of avoidable hospital admissions, service use and care requirements are not always consistent with the clinical severity of the condition. Often the level of disability or disease burden is disproportionate to the degree of actual impairment.

Due to this, careful thought should be given, if budgets are limited, on how best to integrate Expert Patient Programmes within existing services and referral pathways so that they can be targeted at those who would benefit most from them. The best return on investment comes from those that in some ways are those that are finding it the hardest to cope.

Given that Social Impact Bonds need to offer investors a return on investment, they could be best used to fund Expert Patients Programmes if targeted at particularly vulnerable patients. Providing better self management for those that are managing well will almost certainly improve and reinforce their quality of life, but it will not necessarily provide an economic return.

www.expertpatients.co.uk

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SEVERE ASTHMA HUBS
NEIL CHURCHILL ASTHMA UK

Severe Asthma Peer Support Hubs

In 2008/09 there were approximately 67,000 hospital admissions for asthma. Almost 17,000 stayed in hospital for three days or more. More than 4,000 were readmitted in 28 days suggesting on-going problems with asthma management.

There are around 250,000 people in the UK who suffer severe asthma. As a result, many experience frequent asthma attacks leading to repeat hospitalisations and live with serious side-effects arising from long-term use of steroids, such as osteoporosis, growth problems, weight gain, diabetes and hair loss. This, in turn, can lead to depression and other mental health problems.

These are patients with some of the worst health outcomes whose care is amongst the most expensive for the NHS. There is a strong economic case for interventions targeted at risk populations who incur high drug costs and frequent emergency admissions.

In 2010, Asthma UK carried out an in-depth user-engagement project across the country and heard from hundreds of people with severe asthma. The project demonstrated the importance of emotional support in building the resilience needed to maintain health, deal with the debilitating effects of severe asthma and recover more speedily from episodes of ill-health. Isolation is a risk factor in repeat hospitalisation

* How to deliver high-quality, patient-centred, cost-effective care: Consensus solutions from the voluntary sector. http://www.kingsfund.org.uk/publications/articles/how_to_deliver.html

and long-term deterioration of mental health. The importance of emotional support in improving care and productivity was one of the main themes of a joint study by ten health charities produced with the King's Fund, published in 2010*.

Now, Asthma UK is keen to pilot the concept of Peer Support Hubs for people with severe asthma, with the goal of using peer support to improve emotional resilience, signpost specialist information, optimise health outcomes and improve quality of life (such as the ability to work), which together can reduce the cost for tertiary services. Personal and environmental influences are major factors affecting the quality and persistence of health outcomes in tertiary asthma care.

On the ground, the peer-support groups would be led by users, referred by the tertiary clinics and recruited and trained by Asthma UK to become community health champions. Each hub would be established as an independent self-supporting entity with members leading their own groups. It would meet regularly to exchange health information, and would have access to expert speakers, healthcare professionals and clinicians if required. The groups would help severe asthma patients to build relationships, access support, and combat isolation, enhance self-esteem and build emotional resilience. For example, the experience of being admitted to hospital can be made worse if you feel isolated. Patients with severe asthma are interested in building a peer network that alerts friends that an emergency admission has occurred and enables support to be provided. That can be delivered simply through text messaging and can allow peer support to be provided face-to-face, on phone or via email or text. All make a difference. Many patients say that such a facility would help enormously with speed of recovery and subsequent rehabilitation. Research shows that meeting the psycho-social needs of people with severe asthma will help them to improve the management of their condition, improve the quality of their life and reduce their dependency on specialist health services.

The Hubs would be enhanced through on-line peer support. People with severe asthma often say that they live in fear of a life-threatening attack which can be triggered by everyday items like perfume or pollen, or by common colds and viruses. As a result, many live a life of restricted mobility and rely on social networks to engage with family, friends and colleagues. Asthma UK will build on existing social networks for asthma and enhance their functionality so that they are able to deliver aspirations

of patients to support each other, swap information and learn more about managing asthma. We will introduce on-line nurses into these social networks to provide clinical support. As a result, this will enhance self-management, improve early identification of the deterioration of lung function and reduce the risk of hospitalisation.

Research shows that Asthma UK has been co-producing projects with severe asthma patients over the past year and will continue with this approach. In addition, we plan to work in partnership with two of the main tertiary centres for severe asthma (The Royal Brompton in London and Wythenshawe Hospital in Manchester) as well as the Severe Asthma National Network (a clinical special interest group), the British Thoracic Society Difficult Asthma Network, Clinical Leads and Respiratory Boards and the pharmaceutical industry. Adding a 'health economics' study to the project will be vital to evaluating economic impact and we will work with an academic partner to analyse and publish this aspect of the programme. If successful it has the potential to be developed at other tertiary and secondary care centres.

We anticipate that Peer Support Hubs could lead to substantial savings in spending on emergency hospital care, which can cost £625 to £1,836 (2008/2009 figures). If the economic analysis showed that the Hubs lead to savings that outweigh the investment, Social Impact Bonds could be a way to fund a roll out of the approach across the country.

www.asthma.org.uk

CONCLUSION

I provide these examples as three possible areas of NHS healthcare where SIBs could be introduced.

These are specific interventions where an individual new service is aimed at a segmented part of the population especially where that intervention can on its own be shown to improve health outcomes, provide savings and a return on investment.

What is important in developing specific examples that may be appropriate for the SIB is that they all focus on a very specific group. These are usually a sub group of an already segmented population. For example with the expert patient programme there is evidence that when the programme is addressed to sicker people, the amount of resources that can be saved is much greater. So simply saying there should be services for a whole population sub group lacks specificity for the SIB.

There are a small number of interventions which can be provided for a segment of the population which overall improves the outcomes for that population and makes savings from all of the interventions rather than just the one.

To reduce emergency admissions for a hospital and realise savings, a combination of risk stratification for that population, better coordination of health and social care, together with better use of IT and more self support are needed. Together they can change the health economy for that group and provide a general return on the original investment.

If over the next couple of years SIBs could be developed across this spectrum, then it could make a real intervention into the way in which the NHS works and improve the medium and long term healthcare for some of the sickest populations in England.

Professor Paul Corrigan
September 2011

ABOUT THE AUTHOR

Professor Paul Corrigan gained his first degree in social policy from the LSE in 1969, his PhD at Durham in 1974. He is currently an adjunct professor of public health at the Chinese University of Hong Kong.

For the first 12 years of his working life he taught at Warwick University and the Polytechnic of North London where he taught, researched and wrote about inner city social policy and community development. In 1985 he left academic life and became a senior manager in London local government. In 1997 he started to work as a public services management consultant. In 1998 he published *Shakespeare on Management*.

From July 2001 he worked as a special adviser to Alan Milburn first and then John Reid, the then Secretaries of State for Health. At the end of 2005 he became the senior health policy adviser to Prime Minister Tony Blair. Over six years he was instrumental in developing all the major themes of NHS reform not only in terms of policy levers but in developing capacity throughout the NHS to use those levers.

Between June 2007 and March 2009 he was the director of strategy and commissioning at the London Strategic Health Authority.

Since then Paul has been working as a management consultant and an executive coach helping leaders create and develop step changes within their organisation. As a columnist for the Health Service Journal and his own blog 'Health Matters', he has continued to argue the case for reform of the NHS.

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Social Finance Ltd
131–151 Great Titchfield Street
London, W1W 5BB
T +44 (0)20 7667 6370
info@socialfinance.org.uk
www.socialfinance.org.uk

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