SOCIAL IMPACT BONDS IN HEALTH

INTRODUCTION

Social Impact Bonds are a potentially very powerful instrument for creating change and improvement. This short paper describes the basic structure of social impact bonds, why they might be useful for the public sector, and some of the issues that need to be considered for implementation.

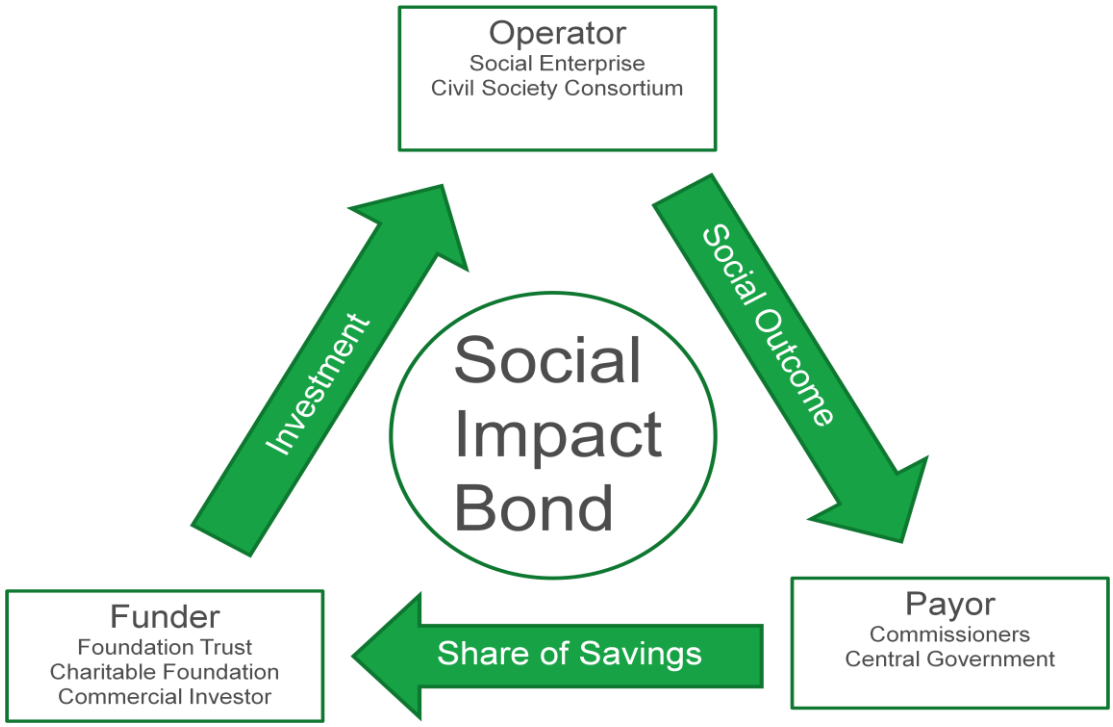
WHAT IS A SOCIAL IMPACT BOND?

A Social Impact Bond is a financial instrument that raises capital, and links financial returns to the achievement of a particular socially desirable outcome. Usually, outcomes are chosen so that improvements in the outcome produce savings as well as social good, and so fund the financial returns. For example, existing pilots target a reduction in reoffending behaviour by ex prisoners. The savings from reduced future costs of incarceration fund the payments to the original investors. In health, costs of inpatient treatment are the most likely source of savings, either by reduction in length of stay or admission rates. As moving care to the community setting often results in healthcare that is more appropriate for the patient, as well as cheaper, the dual goals of the SIB can frequently be met in health, especially for patients with long term conditions.

An SIB involves three parties

A Funder, who puts up the initial capital to fund the intervention.
An Operator, who performs the intervention
A Payor, usually central government, who makes payments to the investor based on the impact achieved.

As can be seen from the diagram below, these roles may be filled by a variety of different bodies, and indeed sometimes the investor and operator roles may be filled by the same body. These various configurations will give the SIB different characteristics. In the health sector it may be useful to consider two configurations in particular.



INTERNAL OR NHS SIB

In this configuration, all parties are NHS bodies. For example, a Foundation Trust (FT) may be both the funder and the operator, and the commissioners would be the payor. In this example the FT might create a new service that reduced future admissions, (for example a virtual ward), and would share in the benefits to commissioners of reduced admissions. I shall highlight some of the advantages and disadvantages of this configuration below.

EXTERNAL OR BIG SOCIETY SIB

This is the more "traditional" SIB, with the operator a Civil Society organisation or social enterprise. Here an example might be a local charity which works closely with those affected by dementia in an area, funded by a charitable trust or commercial bank, and with repayment again from commissioners.

WHY ARE THEY A POWERFUL IDEA?

The central purpose of SIBs is to more effectively realise social goals: creating more good for less money. They achieve this by:

- Creating more effective incentives
- Promoting innovation
- Accessing new capabilities

INCENTIVES

Incentives are a powerful force, and correctly designed incentives can prompt real and rapid improvement. However until recently incentives have often been based not on health outcomes, but on activity. Whereas commissioners are keen to shift care out of hospital, and thus hold down costs, acute providers are incentivised to generate as much activity as possible. While clinicians are motivated by a desire to do the best for a patient, we know from experience that schemes that involve large amounts of revenue leaving a hospital department are very difficult for managers to accept. We have seen dedicated clinicians push for more appropriate treatment at home, but find management keen to retain the higher tariff inpatient treatment. The internal, or NHS, SIB provides a way of allowing the Acute Trust to share in the benefit, offsetting their lost revenue.

INNOVATION

The NHS is an innovative organisation, with a proud history of invention and discovery. The issue for the NHS is not the invention of new ideas, but the taking of those ideas to widespread application. SIBs provide an evidence based path to scale for innovative new services.

Firstly, SIBs shift risk to those with the appetite for it. Large public service institutions are not usually comfortable with risk. As well as the obvious financial risk, commissioners who invest in a new service take a reputational risk which does not happen when they continue to fund an existing and conventional service, even an ineffective one. As Keynes said "Worldly wisdom teaches that it is better for reputation to fail conventionally than to succeed unconventionally".

SIBs move much of the risk away from commissioners, and towards those who are more comfortable taking it. In the case of the internal NHS SIB, the FT's local knowledge may give them a high degree of confidence in what they are doing. In the case of the external SIB, external funding sources may have a higher risk appetite. Commissioners should thus be more comfortable with innovative ideas.

Secondly, SIBs impose an evidence based path to scale. Since payment is based on social impact and on savings, SIBs are designed to produce robust evidence. While massive quantities of clinical evidence are produced every

day, there is much less evidence of the cost and productivity impact of new ideas. Promotion of new services can therefore be haphazard, with many promising initiatives persisting for years at a small scale. On the other hand, when an idea seizes the attention of central government roll out can be so rapid that it outpaces institutional capacity and large scale results are disappointing.

SIBs provide a structured pathway to scale, generating high quality evidence of efficacy and savings, and encouraging sensibly paced growth without centrally mandated directives. Instead scheme operators can use the steadily growing body of evidence to raise increasing sums for steady expansion.

CAPABILITY

In seeking to adapt to the needs of patients, the NHS may need skills and capabilities that it presently lacks. Particularly, it needs to engage with patients in their own homes and in their daily lives. Further it needs to engage with carers and the wider community to deliver support appropriately.

Civil Society groups are positioned to fill this gap. However Civil Society groups do not necessarily understand how to deliver services in the way the NHS requires, nor do they often operate at scale. The external, or Big Society, SIB can provide the funding and support necessary to develop the service to a scale and structure that the NHS finds useful. Further the outcome based contract provides an objective language for success that both sides understand, rather than imposing on small Civil Society groups the complex overhead of performance management that the Public sector typically uses.

IMPLEMENTING SIBS

FAIR MEASUREMENT

The most technically complex issue with SIBs is to measure the impact fairly. Any improvement in the required outcome must be shown to be due to the new service, and not any other factor. Under certain circumstances a randomised controlled trial may be necessary, but the most practical method is to use propensity score matching. The HES database can be used to create a very large group of patients with similar conditions and backgrounds (similar propensity). The course of their treatment, particularly the number and length of hospital stays, can be compared to the patients in the SIB, in order to give a clear idea of cost savings. Statistical techniques to do this are well established, and organisations such as the Nuffield trust can perform this analysis for a wide range of conditions.

The statistical level of confidence in the savings will depend on the number of patients in the trial, and the size of the impact. Some minimum level of impact will be necessary to establish statistical significance, and thus a full payout will only happen above a certain minimal level. Exactly what this level is depends on a trade off between number of participants and desired confidence, as well as the nature of the patient group under study.

ROBUST SAVINGS

In order for savings to be real, they must be cashed. So even if we reduce length of stay, no saving emerges until wards are closed. Since this is a difficult, even tortuous, process, the prospect of savings may be less attractive than might at first appear.

The simple solution to this is to focus on admissions. From the point of view of commissioners, reductions in admissions are instantly cashable. Foundation Trusts now have the financial freedom to absorb changes in demand, and develop new services in response.

However there is also an issue with backfill. If admissions are reduced, will the hospital find new admissions in other areas to fill the gap, resulting in no real savings? This question depends on the overall commissioning framework, which is not yet clear. If acute trusts continue to be penalised for an excessive number of admissions, then backfill may not be an issue. Further, if hospitals are redirecting their effort towards areas where commissioners wish to see increased activity, this is also a desirable outcome.

CONCLUSION

SIBs represent a potentially very useful solution for the NHS, correctly aligning incentives, promoting innovation, and accessing new skills and capabilities for the NHS. SIBs can be effective in areas of particular concern for the NHS, such as allowing patients with Long Term Conditions to remain as independent as possible.