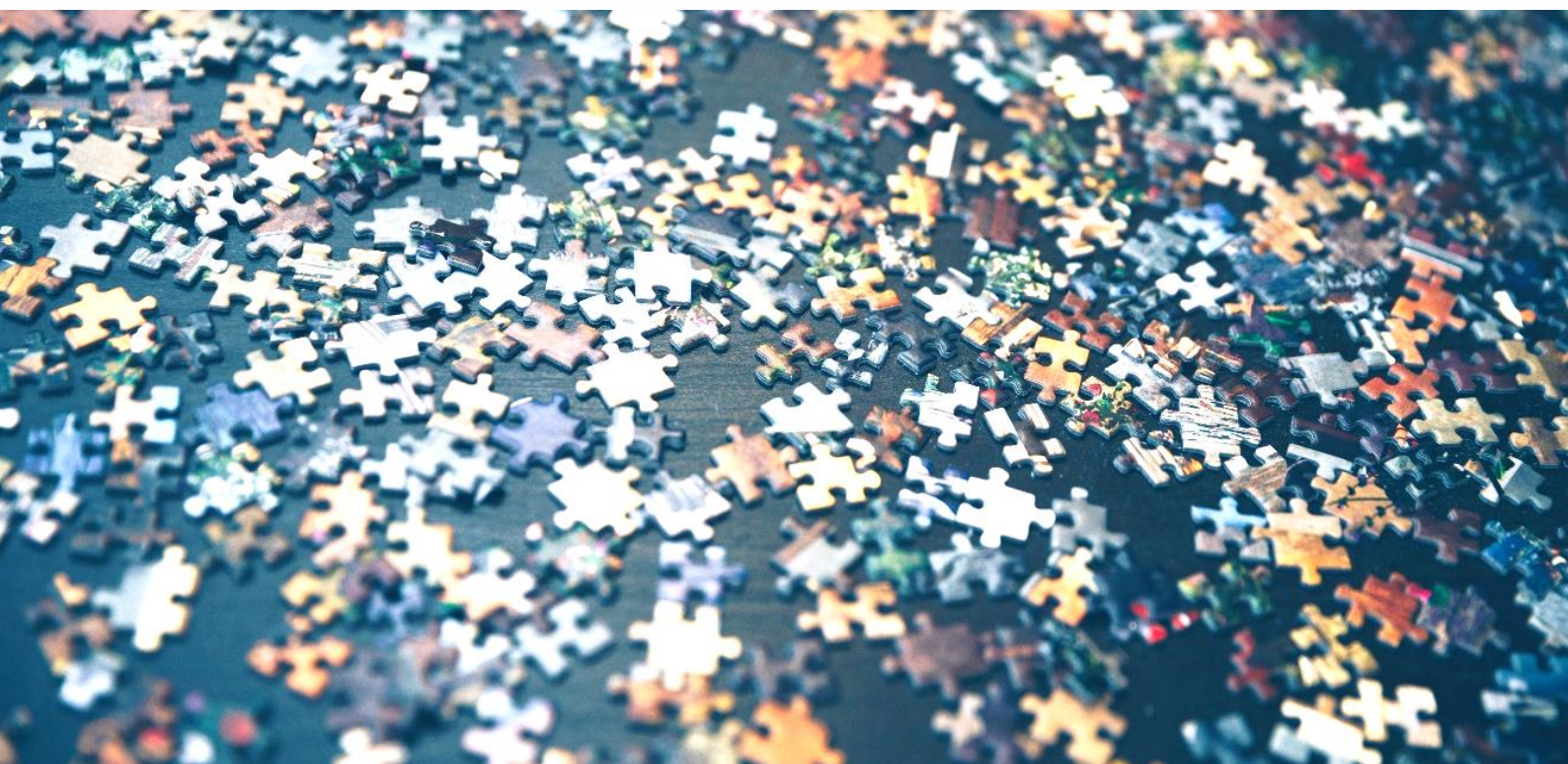




Financing Health Promoting Services

— An Information Guide



Financing Health Promoting Services

An Information Guide

This document is the first stage of an online information tool on financing health promoting services. The guide originated from an initiative by the Coalition of Partners of the WHO European Region. EuroHealthNet is grateful for the opportunity to lead the effort to develop this guide on behalf of the CoP.

This document will serve as a basis for the online tool highlighting how to overcome existing gaps in investment in health promoting services by providing concrete, 'out-of-the-box' examples of how investment can be mobilised. The online tool is expected to be available before the end of 2019.

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Foreword

The 2019 Finnish EU Presidency chose to focus on the economy of wellbeingⁱ. The aim is to engage in open discussion and reflect on the interdependency of the economy and welfare policy. Finland wants to bring a broader understanding into EU decision-making that wellbeing policy and economic policy should go hand in hand. At the Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) meeting in Brussels on 8 July Minister of Social Affairs and Health Aino-Kaisa Pekonen declared:

While the wellbeing of people has intrinsic value as such, we need to better recognise that it also is a precondition for economic growth and for social and economic stability. Conversely, sustainable economic growth brings better opportunities for improving everyone's wellbeingⁱⁱ.

Public spending on wellbeing, namely social, health, and education accounts for a large part of national budgets. As a result, Finland has been reflecting on how to ensure the wellbeing of our citizens at present and in the future. It is a novel approach as we frequently see in the search for fiscal consolidation, countries cut expenditures as the most common course of action. However, under the Finnish approach, a change in mind-set means that rather than understanding provisions for wellbeing as costs, reforms to social protection, health care, and education systems, are seen as benefits to be shared by the economy and the society as a whole.

In launching the approach, the former Minister of Social Affairs and Health Pirkko Mattila explained:

“The Economy of Wellbeing takes into account aspects related to social wellbeing, gender, health, employment and education and emphasises their importance for economic growth and stability, as well as for improving trust in public policy and ensuring the legitimacy of policy-making. At the same time, we are evaluating how different policy measures impact people's wellbeing. We call this policymaking approach the Economy of Wellbeing”ⁱⁱⁱ.

The guide on financing health promoting services offers a series of case studies with which policymakers can work towards conditions that encourage an economy of wellbeing. The aim of the guide, to stimulate system change and overcome existing gaps in investment, are central to uniting wellbeing policy and economic policy. They will help in the effort to establish an economy of wellbeing that improves the lives of all citizens.

Taru Koivisto, Director

Ministry of Social Affairs and Health

Department for Wellbeing and Services, Finland

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EuroHealthNet, Brussels, 17 09 2019.

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The idea for the guide originated from the Coalition of Partners for Strengthening Public Health Services in European Region (CoP), an initiative of WHO Regional Office for Europe. We are grateful to be a part of the CoP, and for the opportunity to lead the effort to develop this guide on behalf of the CoP. We would like to stress our gratitude for the support from Martin Krayer von Krauss and Anna Cichowska Myrup, and their colleagues at the WHO. Our work in researching, preparing, and finalising the guide would not have been possible without the financial support from the WHO and from the European Union Programme for Employment and Social Innovation (EaSI 2014-2020).

The guide has benefitted from our continued collaboration with the Steering Board for Social Infrastructure in Brussels (Age Platform Europe, European Association of Service Providers for Persons with Disabilities, European Social Network, Feantsa, Life Long Learning platform, Housing Europe). The steering board is a testbed to think through ideas and topics. It has allowed us to explore different challenges of working intersectorally.

We are indebted to the work of our panel of reviewers. The panel of reviewers furnished us with detailed feedback that helped to challenge our thinking and how best to present the guide to make it as applicable as possible.

Panel of reviewers

The following individuals reviewed and commented the guide:

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Executive Summary: Financing Health promoting services

This guide is for planners, policy and investment decision makers in all fields and at all levels who are relevant for creating and implementing effective health promoting services.

Health promoting services are a vital and valuable societal service. They are any activity organised by a public service or other institution which goes beyond a focus on individual behaviour towards a wide range of social, economic, environmental, and commercial determinants of health. Connections between different fields must be made urgently if the benefits for health, wellbeing, sustainable development, equity and safety are to be usable, useful and used.

Our intention is to assist health and social care planners, policymakers at national, regional and local levels in developing and financing of health promoting services that benefit health and wellbeing for all. We aim to inspire through a body of evidence that includes examples drawn from across the world. The guide has two central objectives:

- (1) to highlight the need for systemic change, shifting from treatment-oriented health services and strengthening of health promotion and disease prevention services, as well as multi-sectoral approaches to improve health and wellbeing for a healthier society;
- (2) to highlight how to overcome existing gaps in investment in health promoting services and urge health planners and decision makers to better liaise with the finance sector by providing concrete, 'out-of-the-box' examples of how investment can be mobilised.

In this guide we present different ways to design and implement health promoting services, with attention paid to different processes and procedures of financing. It delineates solutions for financing and delivering health promoting services through a range of cross-sectoral case studies. In addition, the guide presents a set of **public health-focused investment criteria** for potential investors or financial managers. The criteria aim to bridge the gap between public health and financial investment.

With this guide, as well as further collaborations and work in the field of social investment, we aim to **build the capacity of the public health and wider social policy community to access new funds** and to **help health professionals understand the language of the finance and investment world**. This guide is closely aligned to the efforts of the WHO General Programme of Work, the WHO European Roadmap to implement sustainable development, the WHO European Health Equity Status Report, as well as the United Nations 2030 Sustainable Development Goals. In addition, it is also in line with the European Pillar of Social Rights, InvestEU programme and one of its key elements - the Social Investment and Skills window.

This guide is **timely** as it demonstrates how to make shifts and transitions from spending on cures and treatments to investing in preventive approaches for better health and wellbeing, avoiding potential accumulation of health problems and rising healthcare costs.

It is **innovative** as it explores new sources of finance and new ways of problem solving beyond traditional models, metrics, partners, responsibilities and budgets.

It is **practical** and empowering as it includes concrete and inspiring 'out-of-the-box' examples of how the right resources and capacities can be mobilised to help finance, build and sustain these shifts.

The guide explores how we can we increase health promoting funds through smarter taxation, boost investments and innovative thinking, and recognise health as an asset that requires investment in order to allow all aspects of the economy and society to thrive.

Innovative multi-sector solutions are required to make the most suitable and equitable use of public funds and to maximise the added value of private investments. It is crucial to invest in the types of social infrastructure and health promoting services which best respond to the needs and expectations of people, especially for those who are most disadvantaged. Long-term solutions and alternative financial instruments must be considered and developed to fill existing gaps in investment.

Europe is facing a well-documented investment crisis in social infrastructure for health, education, and social services, which directly affects the health and wellbeing of all citizens. Since the 2008 financial crisis, public investment in social infrastructure has reduced dramatically, remaining 20% lower than a decade ago. It is estimated that the investment gap in social infrastructure in the EU is more than €150 billion per year^{iv}.

The ability to contribute to equitable and sustainable public health is crucial for society's economic development and social sustainability – for individuals, communities, countries, and populations. Yet provision standards for social services have declined, all while rising inequalities, the ageing of society and related chronic disease burdens, along with climate change and migration challenges have increased the demand for services. Preventative measures, delivered through health promoting services, require durable and dedicated funding. Current investment strategies and public funding are not suitable, are unsustainable, and produce unfair social, economic, and environmental costs.

Underpinned by our knowledge that working on the social determinants of health will be beneficial for all in our society, this guide offers a source of inspiration. Obtaining additional funding is required for services that reduce social isolation, address psychosocial problems at work, decrease consumption of health damaging products, and prevent ill health before it starts.

To meet these needs, policymakers and planners across departments require the tools to identify new funding opportunities and the techniques to put them into practice. Investing in well-planned, equitable, and evidence-based health promoting services has multiple benefits. This includes strengthening local communities, ensuring quality health and social services, encouraging environmental sustainability, and fostering economic activity.

This guide is intended as a first-step and practical resource to help to decision makers plan, design, and deliver effective and equitable health promoting services. **The need is urgent, the knowledge is here, and the chance to act is now.**

1

Why we need this Information Guide

Health, which is a state of complete physical, mental and social wellbeing, is a fundamental human right. Governments bear the responsibility to provide adequate health and social measures to allow citizens and residents to pursue the highest attainable standard of health.^v Unfortunately, there are large differences within and between countries in how long people live and how many of those years are in good health. For instance, Europeans who experience social and economic disadvantage are more likely to be in worse health and die prematurely in comparison to those in more favourable socioeconomic circumstances.^{vi}

In the EU in 2016, two thirds of early deaths of people under 75 were avoidable^{vii}. That is 1.2 million out of 1.7 million deaths. Of those, 741,000 deaths could have been avoided **through effective public health and primary prevention interventions**, and 422,000 deaths through timely and effective health care interventions. The picture is not uniform across Europe. The highest shares of avoidable deaths were registered in Romania with 80.1 percent, followed by Lithuania, Hungary, Latvia and Croatia, whose percentages were in the high 70s. France had the fewest avoidable deaths (60.6 percent), followed by the Netherlands, Poland, Bulgaria and Italy. This was due to public health interventions to prevent heart and lung disease and stroke, which accounted for most avoidable deaths.

The continued pervasiveness of health inequalities across and within European countries means that new approaches are needed. Restrictions on public health budgets require creative and novel ways of financing and delivering services that promote and protect health and wellbeing.

However, health promoting budgets face continual financial uncertainty. Throughout Europe approximately only 3% of health system expenditure is assigned to public health, health promotion and disease prevention. By comparison around two thirds is spent on curative and rehabilitative care, with the remainder for medical goods and governance.

Meanwhile long-term care costs continue to grow. All health and social systems seek new ways to meet needs sustainably and often cite prevention as being a better investment than cures. Such **restrictions on public health budgets demand creative and novel ways of financing and delivering services to promote and protect health and wellbeing.**

Knowing that health promotion budgets are among the most vulnerable areas of health system spending – often cut when resources are constrained – a range of actions are available. This information guide presents a series of options that planners and policymakers can utilise to tackle some of these resource challenges, improve health and wellbeing, and address the persistence and prevalence of health inequalities which are among the most important challenges for governments to tackle.^{viii}

Europe is facing a large gap between the needs of people and the actual budgets that are mobilised for social infrastructure (i.e. social services, education, health services and housing) which are key social determinants of health. **Public investments are 20% lower than a decade ago**, meaning that services such as education, health and social protection have reduced standards. Demand is growing from

ageing and demographically changing populations with related chronic disease needs; from consumer and provider pressures in rapidly developing technological media; and from factors around sustainable development including major climate change and migration challenges. **It is estimated that this investment gap in social infrastructure alone is 150 billion euros per year for the next ten years**^{ix}.

1.2 How can we practically address these needs?

There is considerable evidence that investing in cross-sectoral programmes, policies, and interventions results in numerous benefits that lead to equitable social and economic outcomes^x. Investment in health equity is essential to enable evidence-informed sustainable and fair policy for the benefit of all^{xi}. The United Nations Sustainable Development Goals (SDGs) provide **important mechanisms and common objectives** for actions to improve health equity through inter-sectoral approaches. The SDGs offer a road map of how to improve the health of citizens through inter-sectoral collaboration and better connections between priorities. (See Box 1)

However, notwithstanding signs of progress, investments that are essential to realising the SDGs continue to be underfunded. And while the interest in sustainable financing is growing, this has not been coupled with sustainability transition in the financial system at the required rate or scale^{xii}.

Achieving the development goals, which include; eradicating poverty, reducing inequality, and combatting climate change, requires a long-term inter-sectoral perspective. This necessitates governments, the private sector, and civil society working together. At a time when policymakers are often guided by short-term political cycles what we require is tools that bring together investors, citizens, and tools of government. Protecting health is a key means to do this and as this guide will show inter-sectoral collaboration is key to the different financial tools we will introduce. Whether this is an impact bond, a tax, or mandating insurance funds to invest in health promotion this can not be achieved from within disciplinary silos. **Implementing and fostering inter-sectoral collaboration is a first practical step.**

The United Nation's Sustainable Development Goals (SDGs)

The 2030 Agenda and its SDGs are a global blueprint for partnerships, peace and prosperity for people and the planet, now and in the future. Through the adoption of Agenda 2030, 193 Member States pledged to ensure sustained and inclusive economic growth, social inclusion, and environmental protection, fostering peaceful, just, and inclusive societies through a new global partnership. The 17 SDGs are comprised of 169 targets and 232 indicators. They recognize that eradicating poverty and inequality, creating inclusive economic growth, and preserving the planet are inextricably linked not only to each other but also to population health, and that the relationships between each of these elements are dynamic and reciprocal. These wide-ranging and ambitious Goals interconnect and integrate all 3 dimensions of sustainable development (economic, social and environmental) around the themes of people, planet, prosperity, peace and partnership.

Box 1

It is clear that current investment policies and practices are often unsustainable and result in high human, social, economic and environmental costs. Instead of seeing health as a cost, we need to find

pathways and resources which will persuade relevant policymakers, planners, and politicians – and the public – to understand **health as an investment asset and a common good** that needs to be preserved. **This would be a second practical step.**

This guide is provided to stimulate and support those aims and objectives: **to identify, develop and support financing of health promotion and health promoting services** that benefit health and wellbeing for all (see Box 2). We have an urgent requirement to harness the potential of innovation for financing health promoting services. However, we must be aware of potential risks. These must be managed carefully by policy makers and regulators.

Financing public services is an inherently ethical decision. In this guide we highlight an ethical investment tool (Finansol Label – signalling ethical finance – box 3) and the need to develop ethical guidelines between investors and services (Health and wellbeing quality criteria and investment framework for investors – annex 3). However, we must stress that this guide is in no way supportive of the implementation of charges or increases in charges for users of any public service. Nor is it a call for the easy to reach or easy to fund programmes to be sold off for quick financial profit. Rather, with this guide we are making a call **to place an ethical framework at the centre of decisions** made to improve health promoting services and the health of all people. What do we mean by this? We mean that an ethical perspective involves taking into account societal, environmental, universality, and transparency factors as well as financial returns. Financial returns must not take supremacy. At the centre of health promoting services are people. For all these services, the number one priority must be to improve the health and wellbeing of all people, no matter their background, circumstance, or their ability to pay.

Defining health promotion and health promoting services

Health promotion is the process of enabling people to increase control over and improve their health. It represents a comprehensive social and political process, which includes actions for improving the skills and ability of individuals to increase control over the determinants of health, and actions towards changing social, environmental and economic conditions to address their impact on public and individual health.

Health promoting services can be defined as any activity organised by a public service or other organisation/institution which goes beyond a focus on individual behaviour towards a wide range of social, economic and environmental interventions.

Box 2

This guide aims to **inform about evidence and offer examples** for inspiration. It has two main purposes:

- (1) to highlight the need for **systemic change and strengthening** of health promotion and disease prevention services, as well as multi-sectoral approaches to improve health and wellbeing for a healthier society; and
- (2) to highlight how to **overcome existing gaps in investment** in health promoting services and inform planners and decision makers to liaise better with finance sectors, by providing concrete ‘out-of-the-box’ examples of how investment can be effectively mobilised.

1.3 How traditional approaches can fail to meet changing need

Health promoting services are **typically reliant on central health system budgets** for preventative and curative approaches, although some responsibilities may be devolved to regional or municipal authorities so part of mixed system budgets. As outlined in the introduction, health spending prioritises curative and rehabilitative care, medical goods and supplies including pharmaceuticals, and hospital infrastructure maintenance.

In 2017, spending on health care in the European Union was 9.6% of gross domestic product (GDP), ranging from over 11% in France and Germany to less than 6% in Romania^{xiii}. In 2016, **around 77% of health spending in EU countries was financed through government and compulsory insurance**^{xiv}. In Denmark, Sweden and the United Kingdom, central, regional or local government financed around 80% or more of all health spending. In Germany, France, the Netherlands, the Slovak Republic and Croatia, compulsory health insurance financed more than three-quarters of all health expenditure.

Curative services, primarily through hospital expenditures, vary considerably between EU member states. Similar proportions apply, with high income countries spending most. Overall, EU countries spent EUR 1, 059 per person on hospitals in 2016. Spending is highest in Denmark at EUR 1 653 per person and is more than EUR 1, 500 per capita in Luxembourg and Sweden^{xv}. In contrast, hospital expenditure in Romania account for less than EUR 350 per person and is similar for Latvia, Bulgaria, and Poland^{xvi}. **The focus on curative services within health budgets crowds out financial resources for prevention**^{xvii} because health promotion financing is typically drawn from the same sources. The EU structural and investment funds, Health Promotion Foundations, and single disease philanthropic sources are at present the main additional funding sources for health promotion activities.

All health promotion and health promoting services must be carefully planned and monitored in order to ensure increased benefits for health and wellbeing for all. If not well-managed, these additional investment options could lead to potential **unintended negative consequences**, such as widening health inequalities or reduced services, particularly for people who are more vulnerable or in difficult conditions.

Traditional approaches are not meeting the needs and challenges of increasing inequalities, burden of chronic diseases and mental ill health. **The costs of health inequalities – the total welfare loss across 25 European countries – are estimated at 9.4% of GDP, which amounts to € 980 billion**^{xviii}.

- Inequalities-related losses to health account for 15% of the costs of social security systems, and for 20% of the costs of health care systems in the European Union as a whole.
- Cardiovascular disease (CVD) and cancers cost the countries of the European Union EUR 169 billion and €124 billion respectively each year^{xix}.
- Mental ill health costs the economy £110 billion per year in the United Kingdom and represents 10.8% of the health service budget^{xx}

Rapidly changing demographics, new ways of working and new technologies in public, private and civil society sectors, plus finite budgets to meet global goals and targets, mean this transformation- first set out globally in the Ottawa Charter for Health Promotion in 1987^{xxi} but still not realised in most countries – is now urgent.

1.4 Rebalancing Health System budgets: Invest in Prevention

Chronic diseases are the leading cause of mortality and morbidity in Europe^{xxii}. While we know that they are largely preventable. But that requires new and re-allocated resources as system budgets are unbalanced and insufficiently effective (see Figure 1). For example:

The proportion of GDP spent on health by the Croatian government has grown steadily since the early 2000s to reach 7.5% of its GDP on health by 2015. However, it spends only 0.2-0.3% of annual GDP on programmes, planning, and regulation of public health. In Poland, public expenditure covers around 70% of all health care expenses but only 3% (€19.24 per capita) was spent on public health and promotion. In the UK, the National Health Service (NHS) in England spends around 4% on prevention.

These are reflected in the 2018 World Health Organisation (WHO) analysis that concludes that prevention accounts for only 11% of primary health care spending in low- and middle-income countries.^{xxiii}

Resources for prevention should be understood as an investment, not a cost. The savings made to overall health budgets are substantial, particularly at a time of ageing populations and increases to social care needs, standards and costs.

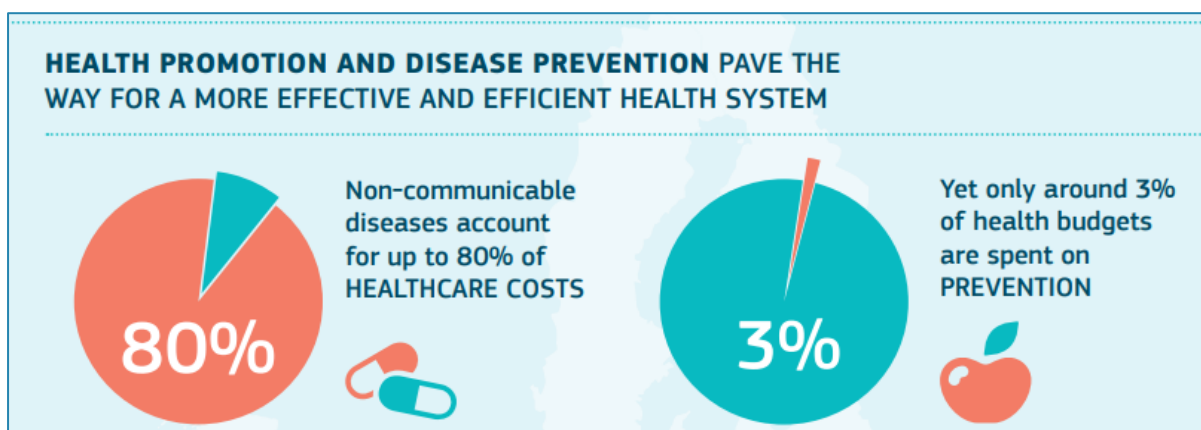


Figure 1. Costs for chronic disease and budget expenditure on prevention (State of Health in the EU, Companion Report, 2017, European Commission)

Given increases in burdens of chronic diseases the balance of health funding needs to be shifted towards prevention. This requires a fundamental change in thinking by policy makers and practitioners to value investment in prevention as **a core part of the health system which also levers in co-benefits** across sectors.

Achieving this re-envisioning can demonstrably result in **significant dividends**. A recent systematic review found that for every €1 spent on health promotion and disease prevention, €14 was returned to the economy^{xxiv}. The authors of the review note that health promotion interventions they found testified an overall twofold return on investment with a more impressive median cost benefit ratio of 14.4 (See chapter 8 for a description of return on investment calculations).

They concluded that although attempting to quantify returns within a short timescale can be challenging; even larger returns on investment were seen over a 10–20 years' time horizon. So again, **sustained and sustainable investment approaches are most successful for health and economic returns**.

Health system adaptation needs to adequately care for people with chronic diseases as well as prevent where possible. People often experience co-morbidity and may need care from different providers

simultaneously. **Integrated systems should be designed** to organise treatment and prevention so that (health and non-health) services are better coordinated across the whole range of care.

Addressing the challenges posed by chronic diseases also requires a change from centralised (typically large central acute systems) – to decentralised services (increased primary care facilities in communities). Hospitals remain important, of course, but improved primary care facilities can reduce burdens placed on specialised hospital centres. **Community-based services are often better-positioned** to take a more proactive role than large hospital centres in providing preventive and health promoting services^{xxv}.

2

Adapting complex systems towards promoting health equitably

2.1 Systematic approaches

The challenges that health planners and policymakers face are complex. Some cannot be solved solely by health departments, by ministries or even by whole governments alone. Complexity needs to be carefully unpicked; unforeseen consequences avoided; all stakeholders engaged meaningfully.

The United Nations SDGs offer a set of templates for enhancing cross-sectoral efforts to improve health, wellbeing, and the environment. Taking a **complex systems approach** is a further method for understanding and dealing with inherent complexities. The principal notion of systems thinking is that it explains how matters are connected to each other within some notion of a whole entity^{xxvi}.

A complex system is identified by its heterogeneity, dynamism, and emergent properties^{xxvii}.

- **Heterogeneity** is resultant from actors and structures operating at different levels.
- **Dynamic**, interactive, and adaptive nature is due to the ability of the system to respond to or resist external changes, including in any of its interacting parts.
- **Emergent** properties emanate via interactions between processes that alone do not exhibit such properties^{xxviii}.

Systems thinking includes visualisations to understand system dynamics, for example through systems mapping. (see *Figure 2 below for a systems map example of the sugar drinks levy from the United Kingdom*).

The adoption of a complex system approach can promote a better understanding of the wider political, institutional, and cultural context in which health outcomes, risk factors, and behaviours are embedded^{xxix}. This will assist the identification of potential influence points for equitable health interventions within the system. **The benefit is that it can empower thinking away from isolated intervention approaches and re-configure where power lies within governance** through breaking silos and working with broader groups of stakeholders. Pursuing a systems approach encourages action at the most crucial points in the system as well as systemic interventions that improve public health^{xxx} (see *box 14 for a modelling tool that uses systems approaches for health system future strategy and priorities*).

Therefore, **a first step is to think about promoting health through a complexity framework**. For example, a complex systems model conceptualises health inequalities as an outcome of a multitude of interdependent elements within a connected whole.^{xxxi} Sometimes the effects are subtle, sometimes not so subtle, causing ripples throughout the system^{xxxii}.

Public health problems that result from a complex system cannot be fixed with simple, singular interventions. The problem with most singular interventions for complex multi-causal problems, like chronic disease, is that they involve high levels of individual agency, have low reach and impact, and tend to widen health inequalities^{xxxiii}.

The interacting elements within the system, however, can be reformed to generate a **better set of outcomes**^{xxxiv}. Accordingly, changes to multiple factors are needed. While some might only have minimal effects on individuals, overall they drive large changes when aggregated at population level^{xxxv}.

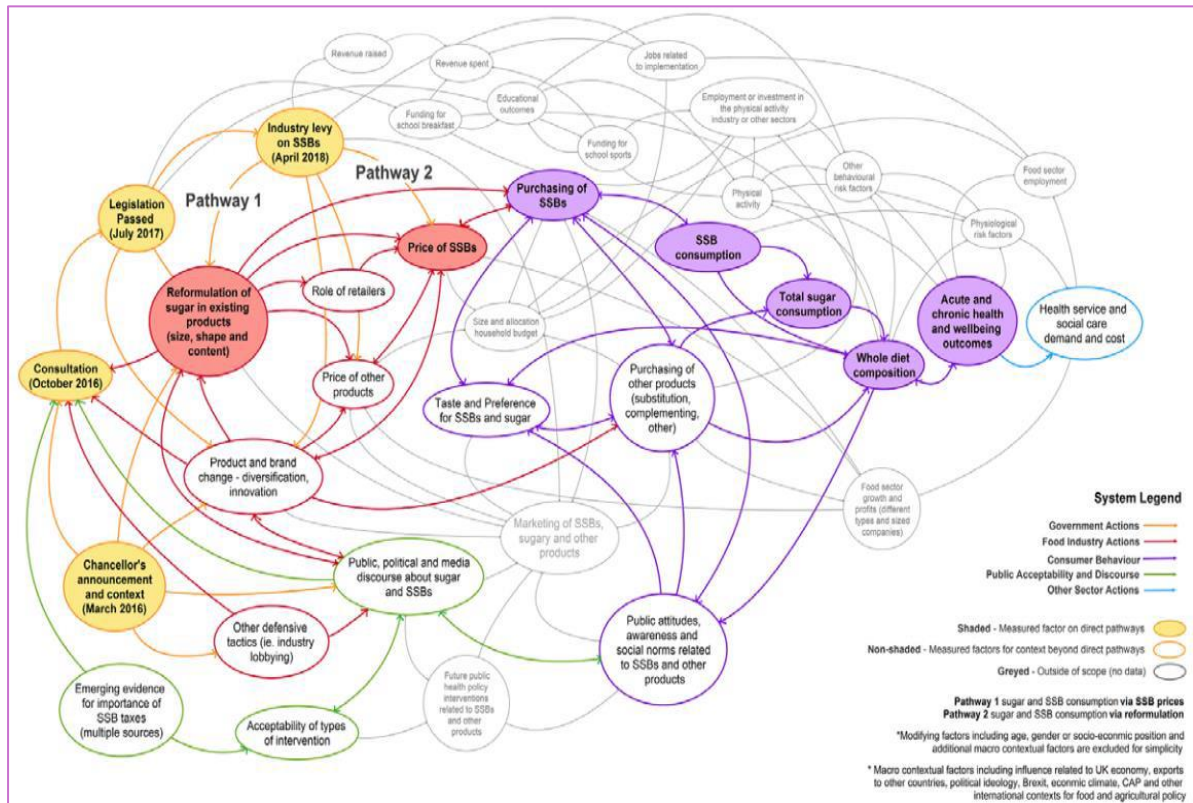


Figure 2. A systems map – for the evaluation of the health impacts of the UK Treasury Soft Drinks Industry Levy (SDIL) <https://doi.org/10.1186/ISRCTN18042742>

Adopting a complex systems approach means that we will navigate away from simple and linear causal models, towards thinking how processes and outcomes within a system facilitate change^{xxxvi}. Rather than questioning if an intervention works to fix a problem, we must recognise if and **how it contributes to reformulating the system in a positive way**^{xxxvii}.

One challenge is that some of the positive effects of health promoting endeavours will only be observed over long periods of time. In addition, effects can sometimes only be measured on specific pathways to health outcomes, but not related to health improvement directly. This means that all short-, medium-, and long-term processes and outcomes must be tracked and evaluated to reduce the chances that effective programmes and interventions are deemed ineffective^{xxxviii}. **Planning and bidding for longer term, more sustainable funding will help in this objective** and help to disrupt the restrictive impact of three- to five-year funding cycles.

2.2 How tackling health equity offers a key to complexity

Addressing health equity should be at the core of all health promoting efforts. Often, tackling inequities offers a key to unpick the complexity of systematic problems. Health and wellbeing promotion and improvement are clear cross cutting societal needs and goods along social gradients, whereas curative or rehabilitative care may be addressed via more linear responsibilities. Health equity can be used to understand and break down barriers and silos – for example between health and social protection, or health and education, increase use of new technologies and data sources, or link targets for health and sustainable development.

We know that health inequalities are not limited to poor health for the worst-off people, or the most socially disadvantaged^{xxxix}. There is a prominent **social gradient** in health and disease that runs throughout society. The social gradient can be found in all countries, whether low-, middle-, or high-income^{xl}.

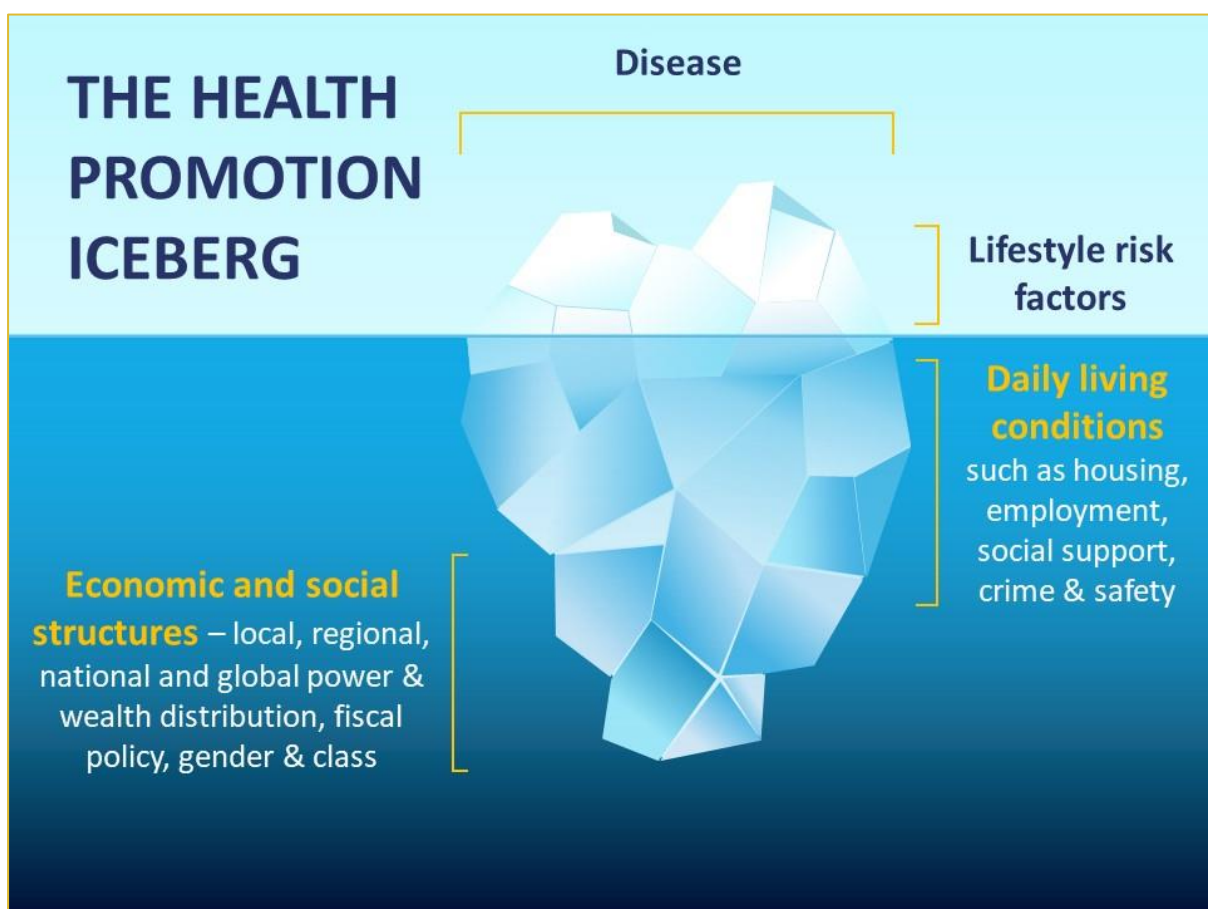


Figure 3. Fran Baum (2019) from Baum F.E. More than the tip of the iceberg: health policies and research that go below the surface. *Journal of Epidemiology & Community Health* 2009; 63: 957

Tackling the health dimensions of these gradients is not solely a question of access to curative services. For example, the newly established right to health for citizens set out in the European Pillar of Social Rights states “*Everyone has the right to timely access to affordable, **preventive** and curative health care of good quality.*”^{xi} So that puts equity and prevention equally alongside cure in health systems. It also establishes them as parts of wider social rights and raises issues about universality, affordability and

quality, which is reflected in other rights such as wellbeing for children and older people, or at work. It also raises questions about how such rights can be delivered. Few countries have met those objectives. An answer lies in developing health promoting health services.

- We know well that the existence of some health inequalities is to be expected partly due to genetic factors^{xlii}. However, the continual and systematic association between health status and socio-economic status suggests that these differences are largely a result of exposure to unhealthy living and working conditions as well as unsatisfactory access to basic social services^{xliii}. This means that **health differences are inequitable – avoidable and unjust – and are the product of an unjust society which complex systems are failing to address.**
- We know well that the determinants of health often lie largely beyond narrowly defined health systems, and comprise economic, social, environmental, political, cultural and commercial factors^{xliiv}. But of course, addressing them has to be a core role for effective health systems as individuals or patients presenting with complex needs will often do so within acute, primary or community health service settings. They will therefore need some measure of specialist health system attention – and cost – but the solution may only be partly addressed directly. Very often wider solutions are needed – maybe housing, social care or protection, environmental factors, improved education or health literacy. (See Figure 3)

So it is to the potential advantage of whole of society, whole of system, whole of government and whole of investment processes that health equity, health promotion and sustainable wellbeing are addressed via complex systems approaches. That is why this guide aims to **inspire integrated actions and spur new ways to deliver health promoting services** to address and respond to the multiple causes of health inequalities.

- It offers **case studies** to inspire and inform possible connections, ideas, and initiatives that can be adopted, modified, or developed to fit locally specific contexts, issues, and policy frameworks.
- It demonstrates the ways in which **health-related sectors** such as housing and education can impact on health and shows how to work on an interdisciplinary and multi-actor basis.
- It aims to support and work with **private and public investors**. It also argues for integrated and cross-sectoral models of public health and health promotion.

To achieve these new ways of working and to encourage investments, **new alliances**, connections, and bridges are needed within and across other fields of expertise. This has been reflected in numerous position statements published by partners in this guide^{xliv}.

3

How new thinking can close investment gaps for health promoting services

It is possible to increase available funds for these aims through smarter fiscal measures and investments plus innovative thinking. **A distinction that we make in this guide is that funds and funding include grants and subsidies, while financial instruments and financing include loans, capital, and social impact bonds.** Therefore, we are thinking and planning far more ‘*out of the box*’ than has traditionally been the case – and arguably part of the problem.

We know that:

- Existing budgets fall far short of current and forecasted needs.
- Public resources are finite;
- Making the case for re-allocation of limited existing funds can cause division within health systems;
- If a united case is not made to financial decision makers, it is less likely to succeed.

Therefore, new thinking – and identification of new sources and solutions – is needed. It is needed systematically to achieve the scale of change which is effective, not only for promising but isolated projects (which might in some cases inadvertently increase inequalities).

While some additional public funding might be possible and should be sought, it is also part of potential solutions to maximise the added value of private investments. To achieve that, it is crucial to invest in the types of social infrastructures and health promoting services which best respond to and bring together the needs and expectations of planners and people.

It is important to remember that the core values and outcomes of health promoting systems (including quality, efficacy, equity and affordability) are assets for potential investors as much as for governments and citizens. Sustainable solutions and alternative financial instruments can be explored and developed to fill this huge investment gap, but that is based on better identification of what is available to achieve better outcomes for all rather than service or system reduction.

It is also important that sustainable technological developments and innovations may offer new ways of working and thinking which make new options more viable: as long as they are evidence based and demonstrably have potential to be useful, usable and used.

In order to mobilise all available resources and safeguard European social standards for better health and wellbeing, it is important to build capacities of health planners and decision makers at local, regional and national level. They need to be able to acquire knowledge and skills for^{xlvi}:

- **better** understanding of relevant financial instruments
- **bundling** of sectoral or multi-sectoral projects

- **blending** of public funds and private finance schemes
- **boosting** long-term investments
- Increasing the pipeline of **bankable** projects.

As a secure and sufficient public funding **basis** is generally a necessity to unlock further private investment – especially given a usual reliance on public funding to repay or guarantee private sources directly or indirectly – understanding of the requirements and complementarities of such resources is important.

The **benefit** of gaining these capacities is a practical and demonstrable enhanced ability to calculate and show the societal *and* monetary benefits of health promoting services, as well as to know **when, why, and how to access best investments** to finance objectives.

AN EXAMPLE FROM FRANCE

Solutions that address these investment gaps and address the underlying causes of health inequalities can be found in different areas of action with positive social impacts. For example, the *Finansol Association* was created in France in 1995 to spark collaboration between financial institutions and solidarity-based enterprises addressing a social and environmental challenge. The *Finansol* Label was introduced two years later:

1. to offer a guarantee of confidence to the savers and investors from an external third-party;
2. to distinguish a solidarity-based investment from other savings products;
3. to benefit from the association's collective support. (*See Box 3 and Annex 1 for the full case study*).

One possible outcome is for health promoting services across cities, regions, municipalities or countries to team up to create their own label. This could assure private investors that money is being safely invested.

French Finansol Label – signalling ethical finance

Solidarity-based finance is a concept that satisfies the solidarity desires of the individual savers and the financing needs of the solidarity-based enterprises, non-profits, and other beneficiary organizations with a social and/or environmental impact. Ethical banks, solidarity-based investment funds and others act as intermediaries between these savers, by proposing traditional investment vehicles (savings and life insurance accounts, investment funds, etc.) to which solidarity mechanisms have been incorporated.

In 1997, the Finansol label was introduced in order to identify the various solidarity-based financing vehicles available in France through intermediaries, such as those offered by banks, investment funds, insurance companies, mutual funds and employee savings accounts, to name a few. Largely based on transparency and solidarity criteria, as well as various management aspects, the label provides security for solidarity-oriented investors that the assets they place through intermediaries will indeed serve to finance projects with strong social and environmental impact.

In 2018, the Finansol label was awarded to more than 160 recipients, such as VITAMINE T Group which is a holding company whose subsidiaries promote inclusive policies and work reintegration activities for men and women who have been removed from the labour market for a long period of time (long-term unemployed, recently out of prison, youth with little to no work experiences, etc). With 12 businesses and 2 800 employees (1 800 of whom are involved in work reintegration activities) and an annual turnover of 50 M€, VITAMINE T is the leader in its field in France. Industries in which the Group operates include: organic farming, creation and maintenance of public spaces, environmentally friendly transportation, and recycling of household electronic waste.

Entreprendre pour Humaniser la Dépendance (EHD) EHD is a network of shelters that provide a safe haven and care for those in need, by renovating buildings intended to house older persons with very low-income levels who are no longer self-sufficient (often with physical, mental or social handicaps). This solidarity-based enterprise subsidizes rental prices, provides temporary housing options for those in transitional contexts, and arranges permanent housing options in institutions with strong healthcare facilities for those in need of constant attention.

During the years, several pieces of legislations have emerged to create a better environment for solidarity-based saving in France. For instance, in 2001 and in 2008, public authorities passed regulations requiring companies to propose at least one solidarity fund among their employee saving schemes, creating the funds called “90-10 funds” because they are characterized by the obligation to invest between 5 and 10 % of the fund’s assets in social companies.

As a consequence of this environment – as well as the dynamism and innovative capacity of the solidarity-based finance actors – solidarity-based funds have continued growing. By the end of 2017, they represented more than 2,4 million solidarity-based savings products subscribed by private individual investors and institutional investors with 11,5 B€ solidarity-based total assets in France only.

Box 3

4

Benefits to thinking beyond health sector budgets

Europe faces an enormous – and growing – investment gap in social services, including social housing, education and health. It is essential for health promotion providers to begin **exploring the opportunities offered by complementary and innovative funding mechanisms**. Social investment also offers an opportunity to both private and institutional investors, who are likely to be more involved in social investment and services in Europe in the coming decades^{xlvii} due to public investment constraints, government divestments, and policies to encourage private sector participation^{xlviii}.

While this increased collaboration is welcome, we must acknowledge that these investments carry certain **risks for both investors and recipients of investments**. For investors this includes political and regulatory exposure; governments can amend the standards of service expected from privatised facilities, the length of their leases or concessions, or the level of risk-weighted returns on capital outlays^{xlix}. For recipients this includes badly drawn contracts, negative impact on staffing, limitations in provisions, and cherry picking of services, which could exacerbate health inequalities.

This is why health promoting service providers must be **proactive in seeking innovative financing opportunities and knowledgeable of financial language, measures, and instruments**. The idea of a ‘two-fold asset class’ could be used to encourage investors to diversify their portfolios while pursuing a dual investment objective: to earn steady, noncyclical returns and to make a positive impact by helping to build stronger communities for improved health and wellbeing.

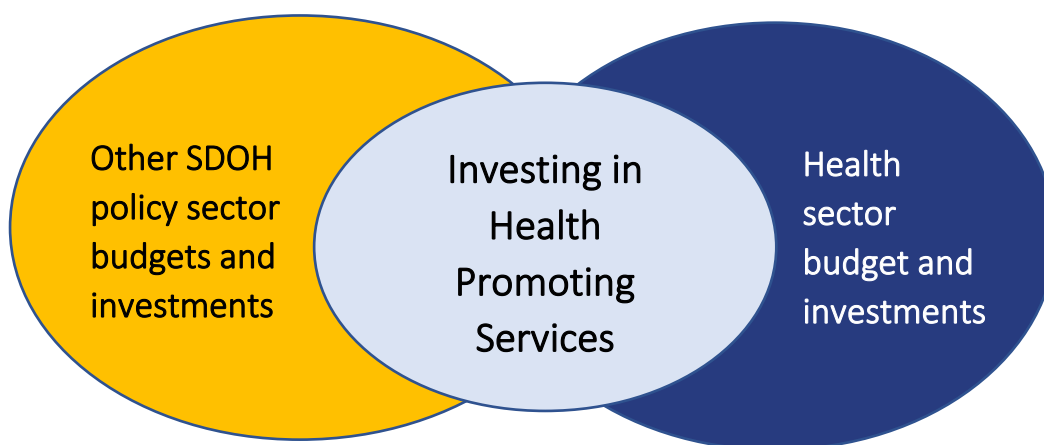


Figure 4. Diagram to indicate confluence between health promoting services and other sector budgets (SDOH – social determinants of health)

There are benefits to thinking beyond health sector budgets alone to realise systemic change and make substantive progress. This requires smarter thinking about the ways in which cross-sectoral

relationships and services can be leveraged to reduce expenditure and improve the quality of service provision. Working with other sectors, including housing, education, and long-term care, can result in a better continuity of care for the community and bring about **co-benefits** such as improvement in the underlying social determinants of health, ultimately leading to the prevention of illness and reduction of health inequalities!

It is important to also encourage **investing in infrastructures**, as part of a broader shift across sectors that recognises the need for integrated, community-based health and social care and services.

- **“Hard” social infrastructure** may include building health centres, good quality social housing, sustainable transport infrastructure, playgrounds or green spaces.
- **“Soft” social infrastructure** investments include staff skill development, community programmes, welfare advice services, prevention and early interventions, and person-centred approaches.
- **Investments in both – simultaneously – are critical** for supporting sustainable and effective health promoting services.

(See chapter 11: benefits of joint budgeting and investments in health-related sectors; and chapter 12: bundling projects).

AN EXAMPLE FROM GERMANY

Investing in soft infrastructure has benefits for promoting health and wider benefits felt throughout society. In Germany a recent project that sought to help employability through vocational rehabilitation is not only a successful example of soft infrastructure project, it also relied on collaboration between business and rehabilitation centres to share the costs and services of the rehabilitated people. The impetus was due to a survey carried out by the German Confederation of Trade Unions (DGB 2014) that showed that almost half of the employees could not imagine carrying out in their current occupation until retirement. At the individual level, this means considerable personal and financial restrictions due to a premature job leave. At the national level, the economy loses considerable resources of labour which creates additional burden on social security system. A preventive measure is a job-rotation within and between companies to counteract this process before health problems develop. While this was only a three-year funded programme and the coordinators are seeking permanent funding, it is the type of project that speaks to the ideas we suggest around soft infrastructure, inter-sectoral collaboration, and positioning health throughout the economy. *(See box 4 and Annex 1 for the full case study)*

Job-rotation as a tool to maintain employability – TErrA project in Germany

The preventive job rotation process, developed during the TErrA project (2016-2019), is a consulting model for employees who are willing to change jobs and companies that support job rotation for personnel development. Companies and employees go through a 4-step consultation process of (1) sensitisation and orientation, (2) finding perspectives, (3) realisation and (4) aftercare. Throughout the process, the personal health status, personal qualifications, specific requirements of possible new jobs and motivation are considered.

TErrA project in Germany has shown, among other things, that since internal job changes in SMEs are often limited due to low jobs variance, inter-company job changes in a Regional Company Network could enable a good fit between work requirements and employees' qualifications. Classic examples are a nurse who qualifies as a medical coding specialist, or a roofer, who switches to sales in the construction sector. Employees must be made aware of their current employment risks and opportunities at an early stage in their career planning in order to prepare for a future job change. The process requires a corporate culture where employers and employees bear joint responsibility for employability.

The major learning of the project was that currently there are no possibilities for the financial support of a preventive job rotation. For companies and employees, a job change is usually associated with further training. The costs of such preventive training are currently not covered neither by the pension, accident, health nor unemployment insurance. An entitlement to benefits only exists when the first health related impairments have already occurred. As a result, both employees and companies lack the possibility of shaping a preventative employment career path.

The hope that the German Prevention Act will provide new impulses to fund preventive job rotation has not yet come true. Intending to close the gap, social insurance institutions are designing initial models attempting to move towards preventive employment paths. Nevertheless, there are other laws that could support further development and implementation of the job rotation project. For instance, "Flexirentengesetz" adopted in 2016, which makes the transition from working life to retirement more flexible, at the same time increasing the attractiveness of working beyond the regular retirement age, allows for a voluntary work-related health check for insured persons aged 45 and over ("Ü45 check"). Another current development is the "Qualifizierungschancengesetz" (Qualification Opportunities Act) aimed to considerably increase investment in further employee qualifications to keep them fit for the rapidly changing labour market.

The development and coordination of networks to support inter-company job changes should be promoted by the state as structural features of a life course-oriented social and labour market policies. In this spirit, the Federal Association of Vocational Rehabilitation Centres is currently developing a consulting service for companies and employees based on the TErrA idea.

Box 4

4.1 Spending effectively and benefits of evolving towards value-based health systems

It is crucial to work with all stakeholders, including health planners, implementers and investors, to generate and share understanding and practical knowledge about how investments in strategic priorities in health and other social sectors can help achieve optimal health and wellbeing outcomes. **New ways of collaborating** – and a new conceptualisation of what constitutes health promoting systems and services – are needed to tackle health inequalities and resolve investment gaps.

In 2012 neighbourhood teams were introduced to the Overvecht community, a deprived neighbourhood of Utrecht, the Netherlands. The teams have been catalytic in the development of medical and social cooperation. They comprise an integral group of social workers, debt-assistance counsellors, housing counsellors, youth-care workers and those working in other social disciplines. In their work, professionals apply the model encompassing four domains (i.e. 4D model): **physical, psychological, social functioning and social support**. (see Annex 1 for the case study).

The uneven relationship between current healthcare spending and health outcomes in many countries is not linear (see figure 5 below)ⁱⁱ. If that was the case, additional expenditure would result in an equivalent improvement in the measured health status of a population. But the greater the expenditure, the lower the marginal improvement in health status as a result of its increase.ⁱⁱⁱ

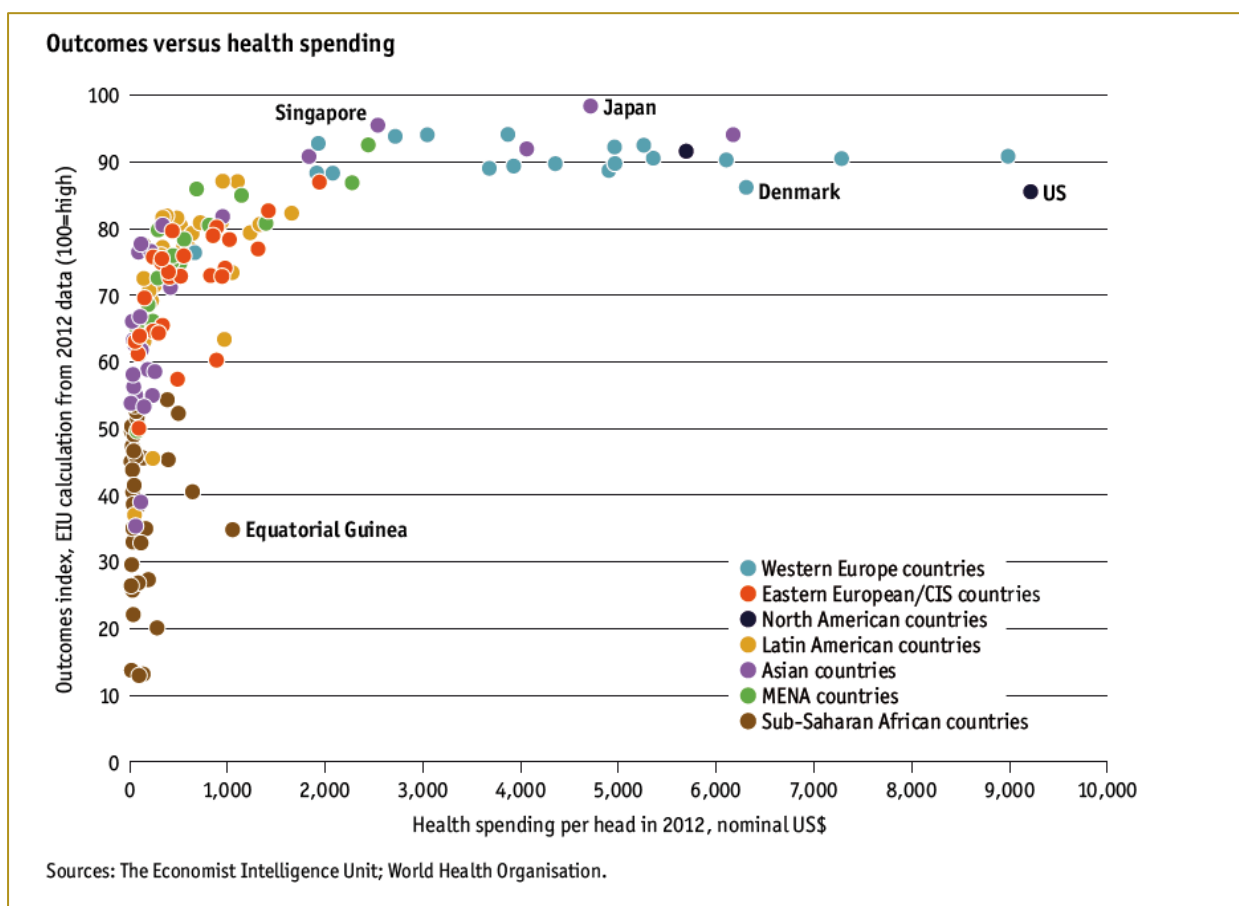


Figure 5. Outcomes versus health spending

Countries also differ in their abilities to manage a similar level of resources into health outcomes. Country by country evaluation indicates that equivalent per capita healthcare expenditure often results in different health outcomes even after considering the differences in lifestyle and socio-economic realities among countries^{liii}. It is **not only how much money is spent, but also how it is spent, that determines a country's health status**^{liv}.

The level of **resources invested in infrastructure, equipment, ICT and human capital seems to fluctuate more with economic cycles than current spending on health services**. OECD explains that this is because such investment decisions are more discrete and so can be more easily postponed or brought forward. The slowdown in health spending experienced following economic crisis affected all spending categories, but to varying degrees. Reducing wages in public services, postponing staff replacement and delaying infrastructure investment were among the most frequent measures taken in EU countries to balance health budgets.

So, as an example of a beneficial rebalancing, the return on investment from **community health workers** – who play an important role in the identification of risk factors for disease, health promotion, and early diagnosis – is \$2 for every \$1 in the USA.^{lv} This shows social as well as health and economic benefits through such shifts to focus more on preventative measures, when enhanced employment and community cohesion are vital across governments and societies. This can be a focus for use of EU Social, Structural or Vocational Training Funds, which are often aimed at increasing jobs in key sectors.

This shows the **benefits of evolving towards value-based health systems**. The value is health outcomes for all in society, with health as an investment that must be protected and shared. This is achievable through treating health as an asset, instead of an unintended result of other policy aims or even the sole responsibility of individuals^{lvi}. Such a change needs involvement of stakeholders including employers, insurers and citizens. The EU advisory body, the Expert Panel on Investing in Health (EXPH), has reported on Value Based Healthcare^{lvii}. Its key conclusion is: *“A reallocation of resources – the freeing of resources and accordingly the reinvestment – from low to high value care is perceived by the EXPH as the utmost necessity for sustainable and resilient European healthcare systems.”* For this to happen, equitable prevention services must be funded on a comprehensive basis.

5

Strategizing for the design and implementation of health promoting services

There is a substantial evidence base suggesting that many health promoting services and interventions delivered within the health system, as well as in partnership with social and other sectors, are **highly cost effective**^{lviii}. Primary prevention works and prevention is better than cure. It is important to strategise for health promoting services. This entails understanding how, when, and for whom prevention services work and seek to work.

The WHO global strategy on integrated people-centred health services^{lix} calls for reforms to reorient health services, shifting away from fragmented supply-oriented models, towards health services that put people and communities at their centre, and surrounds them with responsive services that are coordinated both within and beyond the health sector, irrespectively of country setting and development status. To do this the strategy proposed five interdependent strategic goals:

1. EMPOWERING AND ENGAGING PEOPLE;
2. STRENGTHENING GOVERNANCE AND ACCOUNTABILITY;
3. REORIENTING THE MODEL OF CARE;
4. COORDINATING SERVICES;
5. CREATING AN ENABLING ENVIRONMENT.

Action on each of these strategic goals is intended to have an influence at different levels. However, the strategic goals must be **responsive to local contexts, existing barriers and facilitators as well as the values held by people**. They must also take into consideration the current health service delivery system, and the financial and political resources available to support change. The five key strategic areas that are outlined in the WHO's plan are useful for thinking through how to strategise for action and plan health promoting service delivery.

The expert group on Health Systems Performance Assessment (HSPA)^{lx} of the European Commission evaluated the transition to integrated care. The review was able to single out several inter-related "building blocks" or "system levers" for the effective design and implementation of integrated care frameworks. These included: political support and commitment, governance, stakeholder engagement, organisational change, leadership, and collaboration and trust.

It is clear that to make the shift from centralised systems of care to localised integrated care is challenging as it involves a fundamental re-configuring of health systems. The shift from curative to preventative requires a similar shift in perception, direction, and action. The need to strategize clearly can take vital lessons from the HSPA review and the identification of the key building blocks. These are the blocks that must be utilised to enable health promoting services to be prepared for the next fifty years.

AN EXAMPLE FROM THE USA

In box 5 below we introduce the *ReThink Health Dynamics Model*^{lxi}. This is a model developed in the USA that utilises **systems thinking and agent-based modelling** to enable health planners to envision changes to the health system, see the effects unfold, and learn from the results. A model such as this holds promise for designing health promoting services as tool for service delivery and for creating a dialogue with different sectors, service providers, and citizens.

ReThink Health Dynamics Model

The ReThink Health Dynamics Model is a regional health system in a computer. By simulating how a health system responds to changes, it lets leaders see which investments will do the most to save lives, reduce costs, improve quality, enhance equity, and boost productivity. The model can help to discover a new path to system transformation. It lets you ask “what if” questions and get the results instantly to see how various strategies are likely to unfold. With a diverse menu of initiatives and financing options, everyone can test their own ideas and track results across scores of measures. Designed by an award-winning team of MIT-trained system modellers, the RTH Dynamics Model brings together decades of evidence and is regularly updated to reflect the latest research and input from users.

The ReThink Health Dynamics Model^{lxiii}, representing a US region (city, county, or larger), simulates changes in population health, health care delivery, health equity, workforce productivity, and health care costs by quarter year increments from 2000 to 2040. This is done within a single, testable framework tied to many sources of empirical data and open to sensitivity analysis. It is a compartmental stock-and-flow structure with causal feedback, built according to the principles of system dynamics.

The model divides the population into ten subgroups by age (youth, working age, seniors), socioeconomic status (advantaged or disadvantaged, based on household income above or below 200 percent of the federal poverty level), and insurance status (yes or no) for youth and those of working age. The model simulates changing health states as they are shaped by unhealthy behaviours, crime, environmental hazards, poverty, lack of insurance, aging, and the quality of care. Together, those drivers affect physical illness (mild and severe), mental illness (treated and untreated), acute clinical episodes (urgent and nonurgent), and deaths^{lxii}.

The model considers financial incentives from different payment schemes (such as fee-for-service versus global payment) along with the program cost and return on investment for each simulated initiative. If an intervention does save health care expenditures, model users might choose to reinvest a fraction of those savings in an effort to sustain or expand the initiatives over time.

The model contains more than twenty options for simulating the likely effects of efforts to alter health risks, health care delivery, provider payment, or program financing. Each strategy can be simulated individually or in combinations. The model rests on data from more than a dozen national sources, along with numerous studies in the literature on health services, health economics, and population health. It can be calibrated to represent a particular region using available local data and small-area estimates.

Box 5

5.1 Structural involvement of all stakeholders

The current short-term fiscal perspective adds medium-to-long term fiscal costs by failing to sufficiently invest in the most effective elements of public health spending, with a high return on health equality plus social and economic return.^{lxiv} Boosting additional private investment in health promotion services will require authorities and investors to better understand each other's investment needs and logic.

Despite its huge potential, the current difficulties private investors have in investing in health promoting services can partly be explained by the fact they have not yet developed **the right instruments** to make such investments work. Too often poorly developed or ill-suited investment mechanisms from other sectors or much larger infrastructure projects such as hospitals are prioritised.

Investing in health promotion and prevention and defining measurable targets requires a more targeted understanding of the logics behind such services. Ill-suited or ageing concepts for new and innovative policies will struggle to lead to developing effective investment instruments or identifying the right projects. Authorities and investors should **structurally involve** providers such as health services or experts as well as the users and potential beneficiaries to develop the best instruments at the best time to find the best solution, as has been shown in "health in all policies" methodologies^{lxv}.

Political Scientist Kingdon proposes the existence of three non-linear streams in policy-making – problems, policies and politics – which interplay to open windows of opportunity for policy decisions and must coincide in order for policy change to occur. Adopting Kingdon's theory certainly helps to strategise how to encourage change in the world of investors. Following this principle, it would be optimal to adopt a health in all finances approach. This would put health at the forefront of thinking and would involve a health representative in meetings and discussions across governmental departments.

The purpose is not just about how to prioritize^{lxvi} investments; it is also about how to attract investment. So engaging stakeholders in the process of **generating investable propositions for investors** is crucial and needs to cover:

- Gap **analysis** and proof of need
- Pilots, **test results** and scalability
- **A Business Plan** with value proposition ("*unique selling point*"), situational analysis, investment focus (physical capital or intervention service/project), funding requirements, lifecycle cost projections, capacity and competencies to deliver, key performance indicators.

It is unlikely that most existing health promoting services would have all the knowledge and skills needed to do this. So structural investment in those capacities is wise, including engagement of those who do, for example in consortia, partnerships or across sectors and borders.

6

How to prioritise investments: investing and disinvesting for smart budgets

Health promotion and broader services that promote health need to have realistic starting points. This means **better use of existing assets**. For example, the OECD report on ‘Wasteful Spending in Health’ presented alarming data on wasted resources with estimations ranging from a conservative 10% up to 34% of expenditures^{lxvii}. A reallocation of resources - the freeing of resources and accordingly the reinvestment – is an urgent priority for sustainable and resilient European healthcare systems^{lxviii}. For crossover interventions involving multiple sectors or borders, it means identifying where these assets are and how they are being used within strategic and intervention specific value chains (most valuable areas of activity) and networks.

There are different ways to facilitate an adequate process to disinvest to reinvest. To be effective these need to be **transparent, systematic and explicit** in order to assess the potential for disinvestment in certain interventions and technologies. This might be needed because

- there are indications that they are failing to achieve the objective(s) for which they were originally financed;
- states and regions face public health challenges but are still hampered by static public budgets.

EXAMPLES FROM THE UNITED KINGDOM

In **Wales**, a national Programme Budgeting and Marginal Analysis (PBMA) exercise was completed by Public Health Wales and considered public health interventions at a national level, taking into account NHS services and those provided by public and private partners^{lxix}. PBMA can be employed as a means of using expert opinion as a part of evidence-based decision making. The PBMA is a process that helps decision-makers maximise the impact of healthcare resources on the health needs of a local population or meet other specified goals such as equity considerations. Programme budgeting is an appraisal of past resource allocation in specified programmes, with a view to tracking future resource allocation in those same programmes. An expert panel was established with representatives from: Public Health Wales, Welsh Government, NHS Health Boards, third sector, local government and primary care. The results identified a budget of £15.1 million, spanning 10 Welsh Government priority areas, and 6 life course stages. Due to lack of evidence the panel recommended total disinvestment in 7 out of 25 initiatives releasing £1.5 million of resources, and partial disinvestment in a further 3 interventions releasing £7.3 million of resources to be reinvested.

Despite substantial evidence that prevention works, the level of investment remains low. More effort must be devoted to the **generation of return on investment and risk analysis**. Messaging should place emphasis on both the health *and* non-health benefits, particularly when reaching out to sectors where

the health system would like to collaborate^{lxx}. This is an area where economics can make important contributions to health promotion^{lxxi}. Evidence is needed on the economic benefits of interventions and the economic evidence for different regional or country contexts, as well as the development of return on investment models for different sectors over different time scales^{lxxii}.

The Prioritisation Framework is a priority setting tool for public health investment decisions in **England**. It provides a **platform to aid local authorities to make decisions regarding budget allocations** in a structured and transparent manner. This new Framework was developed by Public Health England (PHE) and launched in March 2018. (See *Box 6 for further information and Annex 1 for the full case study*).

Prioritisation Framework (PF) for public health investments

The PF comprises eight essential steps that can take place over several workshops. Those taking part in the workshops would ideally be stakeholders from each of the health programmes under consideration.

Step 1 defines the criteria against which programmes will be evaluated. Operational criteria are selected during this stage of the process, representing key factors of what is to be achieved within each local authority and weights are then applied to each of the criteria in **Step 2**. The weights that are assigned to each represent the importance of each criteria relative to all others.

Step 3 gathers evidence from each programme area that is relevant to the criteria. The evidence gathered relates to what could potentially be achieved by each programme area against each criterion.

Step 4 rates each of the programmes on a scale of 1 to 5. The higher the score indicates which programme areas have the best potential to achieve positive outcomes.

During **Step 5** the weights that were assigned to the criteria and the scores given to the programme areas are combined to calculate an overall score. This final score represents the overall outcome of what could potentially be achieved by each of the programme areas.

Step 6 is used to gather evidence regarding the current expenditure and outcomes of the programme areas. **Step 7** assigns scores, with the scoring based on the evidence of the current performance of the programmes against 3 measures: investment, outcomes, and feasibility. Each programme is given a score from 1 to 5 against each of these measures. Overall, the score gives a clear representation of how the programmes are currently doing in a numerical form.

Finally, in **Step 8**, the PF produces recommendations on whether to maintain, increase or decrease the current budget allocations. The stakeholders then have the option of following what has been advised or to decide their own actions in the light of other contextual factors.

Box 6

7

Co-benefits of using fiscal measures for promoting health while generating income for public good

When priorities are established in an integrated framework, it offers new logical opportunities for identifying the kinds of measures which might be used for financing and funding. We shall move on to investment models shortly. But first it is important to consider if fiscal measures are also desirable in national, regional and local contexts. These might appeal to public (and possibly also private) economic decision makers in new and unexpected ways as they offer potential increases in public resources while providing societal benefits including health and wellbeing.

Fiscal measures are being applied and studied in many countries which affect health and behaviours directly or indirectly. It is wise to differentiate between various fiscal issues and measures that could be available for public investment decision makers in a “toolbox”:

- specific levies on goods;
- hypothecation of such levies;
- consumption taxes;
- environmental taxes and charges (on land use, transport, housing, pollution etc);
- tax incentives for individuals, businesses and organisations etc to stimulate and promote wellbeing approaches (not just behaviours);
- regional and strategic investment incentives;
- allocation of part of the income tax to an organisation of citizen’s choice (See Box 7).

These are complex intersectoral decisions in themselves, which usually attract much public debate, so need rigorous impact assessments. These go beyond the immediate scope of this specific Guide, but to help stimulate initiatives and awareness of how these measures might fit into systematic packages of investments and disinvestments, we include here some examples which might be valid elsewhere.

It is important to state that these focus on more direct impacts. However other fiscal measures in social, economic, environmental or educational spheres can have effective co-benefits for health and equity. As one example, making fiscal incentives available along social gradients, for investing in education through life which include significant health and digital literacy components, could offer major medium to long term co-benefits in a range of health behaviours. There are many other such possibilities which are available for exploration – potentially also within private- public partnerships to aid take up of fiscal benefits. Improving employment abilities, productivity and safety offer significant public and private gains, which can be stimulated – or sanctioned and regulated – fiscally. This may be vital in the context of emerging modern ways of working such as “gig economy” platforms.

Allocating part of income tax for health promotion

The Lithuanian Fund for NGOs

Lithuanian citizens can allocate up to 2% (in 2019) of the Income Tax to non-profit organisation of their choice when they deliver the Annual Income Declaration. Via this procedure, the state gives part of collected taxes to the organisation.

Maternal and child health promotion in Portugal

Besides the Nossa Senhora do Bom Sucesso Foundation's revenues from services, it is financed through citizens donations. Citizens in Portugal can allocate a part of their VAT and Income Tax to an organisation they choose when delivering the Annual Income Declaration. (see Annex 1 for the case study)

Box 7

Meanwhile, the most frequently observed instances in the current context of taxation for effective health promotion stem from **changing the behavioural environment**, nudging and include efforts to reduce tobacco use, obesity, hypertension, and alcohol consumption. For example, measures adopted to reduce harmful alcohol consumption have included:

- raising alcohol prices through higher taxes,
- bans on advertising to reduce social acceptance of excess drinking,
- restrictions on the sale of alcohol by licensed retail outlets or during limited hours,
- applying minimum purchase and consumption age restrictions^{lxxiii}.

Approaches to prevent obesity^{lxxiv} include taxing unhealthy food and efforts to encourage food re-formulation^{lxxv}. Such taxes are part of a suite of efforts that also include better planning of the urban environment, improved public information and disclosure on health impacts (e.g., better labelling of food additives and ingredients), and a restriction on advertising targeting children and adolescents. There is evidence that low-income consumers and young people get the greatest health benefits from taxes^{lxxvi}.

An increasing number of countries and jurisdictions around the world have introduced regulatory measures to curb consumption of sugar drinks through taxes. Australia, Chile, Colombia, France, Hungary, the Philippines, Mexico, Norway and five US cities have introduced a tax on sugar. In 2018 alone, taxes for the Republic of Ireland, the UK, South Africa, and the US city of Seattle, Washington were introduced^{lxxvii}. Despite the prevalence of so called 'sin-taxes' the WHO has argued that they are **not the sole answer to any health problem**. This is particularly evident WHEN are budget shortfalls or societal issues AROUND as smoking or unhealthy nutrition, as fiscal measures can only part of a suite of efforts to eradicate tobacco consumption, obesity, or any other non-communicable disease. The tax was introduced in Hungary, as we see below (*Box 8*), at a time when the emerging public health crisis and nutritional issues were subject to intensive public discourse. The tax was **part of a comprehensive set of measures targeting nutritional behaviour**. Similarly, from a public finance perspective, the tax neither resulted in a revenue windfall nor a public health financing revolution. **The Hungarian public health product tax was one component of a larger diversified financing strategy to raise revenues for health**^{lxxviii}.

AN EXAMPLE FROM HUNGARY

The Hungarian public health product tax

In 2011, to improve Hungarian health statistics as well as to make some funding available for the health service staff, the Hungarian Minister for Health suggested to introduce a tax on unhealthy food and beverages. The food industry fiercely opposed the tax, even complained to the European Commission saying that the planned measures would harm the industry. But the Minister of Health was ready to respond, a working group created to examine the national data on population health, delivered strong evidence to support the introduction of a new tax.

The new tax was introduced in September 2011 and included sugar-sweetened beverages, energy drinks, confectionery, salted snacks, condiments, stock cubes, flavoured alcohol and fruit jams. The targeted food product prices rose by an average of 29%. At the same time, sales of taxable products fell by an average of 27%. Overall, the impact assessments concluded that consumers changed their eating habits and tax revenues contributed to the increase of wages for 95,000 health workers.

Apart from the support for the tax from the health NGOs and the medical staff, teachers in Hungary pushed for the energy drinks to be covered by the tax. They have expressed their concerns about the direct correlation between the consumption of energy drinks among pupils and poor behaviour at school.

Initially, the national media was unsupportive of the tax and sided with the industry claiming that the measure was discriminatory. As a response, the public health sector launched several campaigns, organised several conferences and actively engaged with the media to explain the positive impact on health that the tax could bring^{lxxix}.

The first impact assessment conducted in 2012 showed that around 40% of unhealthy food products manufacturers changed their product formulas either reducing (28%) or eliminating (12%) unhealthy ingredients. At the same time, since the introduction of the tax, legislation had to be reviewed five times to close the loopholes permitting manufacturers to replace taxed ingredients with other tax-exempt unhealthy ingredients.

A 2015^{lxxx} WHO analysis concluded that a fiscal instrument can play an effective role in improving the nutrition behaviour of the population. However, the Hungarian tax is not a silver bullet for addressing poor nutrition or a budget shortfall. Healthier products due to product reformulation are a positive consequence of tax avoidance. A key outcome of the tax was increased nutrition literacy, and improving nutrition behaviour beyond the direct impact of price increase. Intersectoral action enabled accurate problem definition, development of an appropriate policy solution, and effective implementation. Continuous refinement of legislation after initial enactment was essential for exposing and shutting loopholes, ensuring tax's effectiveness.

There are four intended benefits of a sugar tax^{lxxxii}, they: (1) reduce consumption through a price increase and produce subsequent public health benefits; (2) generate revenue, that could be reinvested solely into prevention measures; (3) emphasise that regular consumption of sugary drinks is not part of a healthy diet; and (4) incentivise manufacturers to reformulate products to reduce sugar content.

AN EXAMPLE FROM MEXICO

Early research from the sugar tax in Mexico has had two noteworthy findings: (1) the tax on sugar sweetened beverages was associated with reductions in purchases of taxed beverages^{lxxxiii}; (2) Purchases of untaxed beverage increased 2.1 percent in the first two years following the introduction of the tax^{lxxxiii}. In Mexico, two years after the introduction of a tax on sugary drinks, households with the fewest resources reduced their purchases of sugary drinks by 11.7%, compared to 7.6% for the general population.

AN EXAMPLE FROM DENMARK

However, Denmark introduced a tax on saturated fat that was implemented on 1 October 2011. The tax was subsequently abolished on 1 January 2013, the reasons that have been cited included weaknesses in design, lack of a coordinated voice from public health organizations and a lack of public documentation of the aggregated effects on health. The tax also suffered from imprecise effects on the economy which gave opponents of the tax – for example the food industry and trade organizations – free play to create negative publicity and to initiate EU jurisdictional actions against it.

Learn more about how the Irish example was planned and implemented in the Box 9 below (*also see Annex 1 for the case study*).

AN EXAMPLE FROM SWITZERLAND

Switzerland established a **Tobacco Control Fund** in 2004 to finance smoking prevention and cessation measures and to protect non-smokers against passive smoking. The fund receives 2.6 Swiss centimes from every packet of cigarettes sold. The tax revenue is guaranteed by law and makes some 13.5 million Swiss francs (almost €12 million) a year available for tobacco control measures. However, a significant drawback of the Swiss fund and associated political agreement is that the same amount of money is also allocated to subsidise tobacco farmers. Such a drawback could be overcome in other countries or contexts by including specific requirements that all funds resulting from the new tax be allocated only to health-improving sectors.

AN EXAMPLE FROM CANADA

A different type of governmental funding via tobacco taxes is the **Politique gouvernementale de prévention en santé** in Quebec, Canada. The government of Quebec has developed an inter-ministerial action plan that aims to increase structured upstream action on social determinants of health to improve health, to decrease the incidence of avoidable health problems, and to reduce health inequalities within the province.

This is a **pan-governmental policy and multi-year action plan** that binds the commitment of 15 ministries and governmental organizations from various sectors. The policy and action plan foster collaboration, complementarity, synchronization and coherence of ministry interventions. It consists of concrete ministerial measures designed and operationalized to affect the individual and environmental dimensions that make a population healthy: lifestyle, schooling, land use, housing, income, working conditions, living environments, and organisation of the health and social services systems. The taxes

from tobacco sales are key to funding the prevention plan and none of the revenue from tobacco taxes is directed to the tobacco industry.

AN EXAMPLE FROM IRELAND

The Sugar Sweetened Drinks Tax (SSDT)

In terms of research outcomes, the [2017 Healthy Ireland survey](#) showed that 16% of adult population drank sugar sweetened drinks (SSDs) daily. Almost half of 13 year olds consume SSDs at least once per day, while males, young people and those from lower socio-economic groups are the [most frequent consumers](#).

The Institute of Public Health, Ireland was requested by the Department of Health to undertake a Health Impact Assessment (HIA) of the proposed tax. As part of this assessment, a stakeholder engagement event was organised with representatives from a range of sectors, including the health and the food and beverage industries. In addition, a review of current literature and a modelling exercise were also carried out. The HIA concluded that:

- SSDs are a source of energy intake with little or no nutrient value;
- Price increases tend to decrease demand, but the degree to which this happens is variable;
- There is a positive relationship linking consumption of SSDs to overall energy intake;
- A 10% tax on sugar sweetened beverages could reduce the number of obese adults in Ireland by 10,000. This reduction would be greater in young people and regular consumers.

A public consultation process was also engaged by the Department of Finance in order to determine views in relation to the design, scope and practical implementation issues of the tax. This process received 30 submissions, which are published on the Department of Finance website.

Finally, the Health Research Board commissioned an opinion poll with adults in Ireland on the topic of SSDs. This research revealed that 44% of purchasers would buy SSDs less frequently if the price increased by 10%, while 34% would not change their purchasing behaviour. 40% also stated that they would switch to diet drinks if they were cheaper than SSDs. Women were more likely to respond to this price change than men.

Per the Irish budget for 2018, it was estimated that this tax would generate €30 million by the end of 2018 and €40 million within one full year. In 2018, following its inception in May, the tax produced €16.5 million in revenue. Figures released in July 2019 show that the tax has produced €15.8 million in revenue in 2019 so far. The funds generated through this tax are allocated to general funds as hypothecation (the dedication of a specific tax for a particular expenditure purpose) is not a feature of the Irish tax system.

Box 9

8

Understanding how investment processes and returns can work for promoting health

The metrics for achieving significant returns on investment cover varying methodologies, which are not simple but which merit better understanding. These are the key relevant aspects.

There is the conventional financial profitability measure of the **Internal Rate of Return** (IRR) which is used by, for example, companies or financial institutions, for areas with trustworthy prices. Similarly, the **Economic Rate of Return** (ERR) is used by public institutions such as the European Investment Bank.

Governments or businesses carry out the evaluation of the efficiency of investments, projects, and programmes by calculating within a “**Cost-Benefit Analysis**” (CBA) framework. A cost-benefit analysis is a process to analyse decisions. An analyst sums the benefits of a situation or action and then subtracts the costs associated with taking that action. Analysts can build models to assign a monetary value (Euro, Dollar, etc.) on intangible items, such as the benefits and costs associated with building an infrastructure project like a new hospital, road, or railway line.

Specifically, for the social impact area, there has been development of the index of **Social Rate of Return** (Sroi). Unfortunately, the methodology for this particular metric is by no means settled. It contains a variety of elements, valued differently depending on the analyst: stakeholder engagement, articulation of change processes, monetisation when possible, transparency etc. Despite the name, Sroi is confusingly not really a rate-of-return at all, in that it is closer to a benefit/cost ratio.

In Box 10 we have outlined the different return on investment methods with a brief description of each.

Return on Investment

Internal rate of return (IRR) is an interest rate that gives a net present value of zero when applied to a projected cash flow of an asset, liability, or financial decision. This interest rate, where the present values of the cash inflows and outflows are equal, is the internal rate of return for a project under consideration, and the decision to adopt the project would depend on its size compared with the cost of capital^{lxxxiv}. **In plain language this means it is the rate at which an investment project promises to generate a return during its useful life^{lxxxv}. In other words, it is used to estimate the profitability of potential investments^{lxxxvi}.**

Economic rate of return^{lxxxvii} (ERR) is an interest rate at which the cost and benefits of a project, discounted over its life, are equal. ERR differs from the financial rate of return in that it takes into account the effects of different fiscal measures (tax breaks, subsidies) to compute the actual cost of the project. In addition, ERRs can include income or value-added that is expected to be generated through environmental and social improvements, such as the effect of clean water on health outcomes, or improved female educational attainment on incomes.

Cost benefit analysis (CBA)^{lxxxviii} is a systematic approach to estimating the strengths and weaknesses of alternatives used to determine options which provide the best approach to achieving benefits while preserving savings. In a more straightforward way, it is a method of reaching decisions by comparing the costs of activity to its benefits^{lxxxviii}. **CBA is an assessment that quantifies in monetary terms the value of all consequences of the activity^{lxxxix}.**

Social Return on investment (SROI) compares the net present value of benefits to the net present value of the resources invested, but it aims to do so by accounting for the whole range of value generated, beyond the narrow microeconomic dimension. **SROI considers not only benefits generated for the investor but also focuses on what social value has been created to the society, including other stakeholder groups. The definition of SROI is still widely debated^{xc}.**

RoI Calculator, developed by the Commonwealth Fund, aims to help community-based organisations and their partners across the health system to plan sustainable funding for social services to high-need, high-cost patients. The tool is intended for health systems, medical providers, social service providers to explore, structure and plan sustainable financial arrangements to support the delivery of services. The tool's basic algorithm calculates the financial returns of partnerships by subtracting the expense of offering social services from the financial benefits of avoided medical events. To use the tool, it will be necessary to estimate what the overall medical costs of the targeted population would be under standard care – that is, in the absence of social services. – <https://www.commonwealthfund.org/roi-calculator>

Box 10

9

How Health Insurance Funds offer potentials

Insurance funds, active in many countries' health systems, are key players in funding health services. Several European countries have enabled health insurance funds to finance preventive work of public health services. This has huge potential for combining well planned health promoting services and sustainable financing. It also offers a range of different sectors the opportunity to become involved in **aligning their work towards common targets**.

In addition, the potential savings for insurance funds are a positive cycle that can lead to further increases of finance available for preventative measures. Other institutional investors and funds, such as pension funds, are another potential source of increased funding that has the potential to work across sectors and create positive feedback through improving health and wellbeing, increasing their return on investment, and boosting the pensions for an active aging population.

AN EXAMPLE FROM GERMANY

In 2015, the German parliament passed the **Health Equity and Public Health Act ("the Prevention Act")** which aims to reduce socially determined health inequalities and to improve coordination between actors which can promote and enable good health. This political arrangement allows for German health insurances and care funds to invest approximately €500 million per year in health promotion and prevention. It is an ambitious policy development that holds potential for the development of similar models. We take a closer look at the Prevention Act in Box 11 below to explore the development and key challenges that lie ahead.

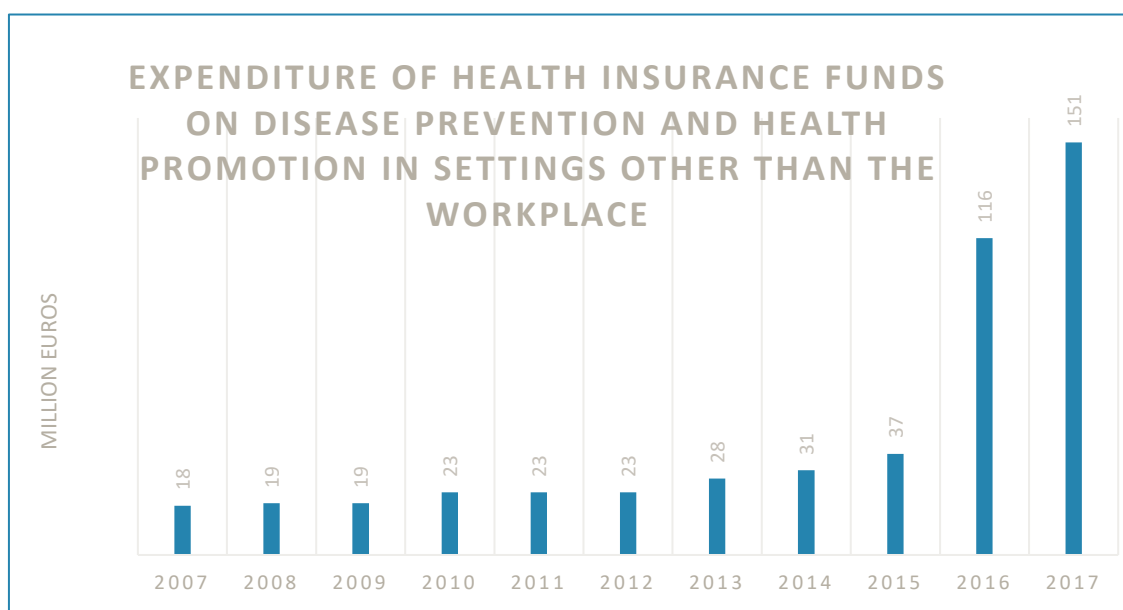


Figure 6. Expenditure of health funds on disease prevention outside the workplace

The German Prevention Act

The Prevention Act is an innovative mechanism to improve health equity as it includes actors from both within and outside the health sector. **Guided by the national prevention strategy**, German social insurance institutions work together with regional authorities and the Federal Employment Agency to agree on ways of cooperation in health promotion in schools, companies, day-care centres and more.

The Prevention Act (Präventionsgesetz – PräVG) was passed by the German parliament and entered into force on 25 July 2015. Essentially, **the new legislation strengthened the cooperation and coordination** between actors in the area of prevention and health promotion. In addition to the statutory health insurance, the pension insurance and the accident insurance, the social nursing insurance and the private health insurance companies are now also involved.

The Act clearly specified a mandate of statutory health insurance, established a common understanding of disease prevention and health promotion and facilitates setting common goals. The **National Prevention Conference (NPK)** was set up to develop and update a National Prevention Strategy. The social insurance institutions, together with the federal government, the federal states, the municipalities, the Federal Employment Agency and other the social partners set common goals and agree on a common approach.

On the basis of a national prevention strategy, the social insurance institutions agree with the Länder and with the participation of the Federal Employment Agency and the local umbrella organizations on the specific way of cooperation in health promotion in different settings like nurseries, schools and companies to name a few. Since 2016, **health insurance funds are obliged to support the establishment and strengthening of health-promotion structures** with 7 € per insured person, about € 500m in total. The pattern of expenditure can be observed in the graphs below (Figures 6 & 7).

In June 2019, the Federal Minister of Health received the first prevention report about the experiences applying the law. Every 4 years, the NPK Prevention Report will give an overview of the achieved goals set in the prevention strategy. Part of the evaluation was conducted against four commitments: to grow up healthy, to healthy living and working, healthy in old age, and reducing unequal health opportunities. In more detail:

- a) It was concluded that children and adolescents of school age, children in the kindergarten and their parents, as well as expectant and young families were frequently reached. Most often, the activities aimed to improve health literacy, promote healthy eating and exercise, and strengthen mental health and resilience.
- b) The long-term care insurance reached residents of inpatient care institutions. Additionally, activities of the private health insurance as well as of the federal government, the municipalities and the civil society reached persons in municipalities. The content of nursing care activities most often included promoting physical activity, mental and cognitive functions. The activities of the private health insurance also included health literacy, disease and accidents prevention.
- c) 40% of the health insurance commitments took place in the so-called “social hot spots” and 10% in enterprises with a high proportion of employees without completed vocational training.

The report has also shown that National Framework Agreements were concluded in all 16 federal states. The vast majority of negotiating partners are satisfied with the status of agreement implementation.

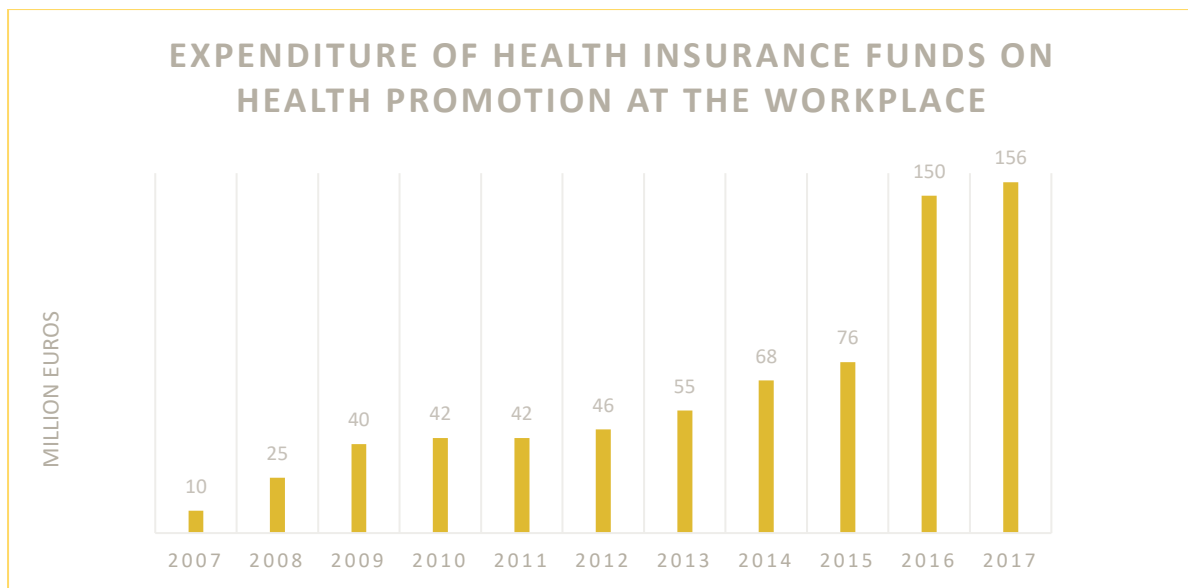


Figure 7. Expenditure of health insurance funds at the workplace

AN EXAMPLE FROM THE NETHERLANDS

The Prevention Act is not the only example of including health insurance companies in financing health promotion. In the Netherlands, the **Combined Lifestyle Intervention** (CLI) focuses on starting, and maintaining, a healthy lifestyle. The intervention includes advice and guidance for forming healthy eating habits, following a healthy exercise pattern, and coping mechanisms for such issues as stress and a lack of sleep which have an impact on health and wellbeing. The development and implementation of the CLI took more than ten years from the publication of a report on how prevention could fit into the healthcare system by the Dutch Healthcare Institute in 2006^{xci}, to the inclusion of such interventions in basic insurance packages in 2018. Learn more about CLI in Box 12 below (*also see Annex 1 for the full case study*).

Combined Lifestyle Intervention (CLI) in the Netherlands

Combined lifestyle interventions (CLI) are **designed to reduce risk factors for lifestyle-related diseases through increasing physical activity and improvement of dietary behaviour**. Starting January 2019, the CLI is covered by the basic package of health insurers. A CLI is a combination of treatments focused on healthier foods and eating habits, exercise more and, if necessary, individual psychological treatment to change behaviour. Only CLI's that are proven effective are covered.

The RIVM (*National Institute for Public Health and Environmental Hygiene*) evaluates lifestyle interventions on their effectiveness. Not everyone with weight related problems or in need of coaching on healthy living, is eligible for CLI. In order to qualify for treatment, a referral by the family doctor is needed. The family doctor determines this on the basis of Dutch Standard for Overweightness and Obesity. Referral can only take place in case of a moderately increased weight related health risk.

The tasks, roles and responsibilities of the main actors involved in organising the service:

- The Dutch Healthcare Institute: establish what interventions are reimbursed and determine whether programmes meet the requirements.
- The Dutch Healthcare Authority: establish a policy (including the rate at which intervention is reimbursed) and monitor implementation.
- The Dutch Association of Healthcare Insurers: determine whether programmes can be reimbursed under the basic insurance package.
- The National Institute for Public Health and Environment: assessment of the quality, effectiveness and feasibility of the programmes and monitoring the implementation of the CLI.

Their tasks, roles and responsibilities of the main actors involved in implementing the service:

- Health insurers: decide which programmes to purchase and conclude contracts with lifestyle coaches or healthcare professionals who want to offer the CLI.
- Intervention owners: distribute their programmes and provide training to healthcare professionals who will be offering their programme.
- General practitioners and medical specialists refer patients to one of the programmes.
- Lifestyle coaches or other primary-care professionals: carry out the programme.

Box 12

10

Public Investment Banks

Another opportunity for significant positive change lies with public investment banks. If banks such as the European Investment Bank (EIB) or the Council of Europe Development Bank (CEB) shift their approach from traditional ‘hard’ infrastructure investments to support ‘soft’ investments, this could have a positive impact on health and wellbeing. Public Investment banks, such as the EIB, the CEB, [the national promotional investment banks](#) and others make investments in the health sector. These investments, however, tend to finance expensive ‘hard’ infrastructures, such as hospitals, and innovation coming from medical research, technology and equipment, health informatics and medical training. While important, these investments usually have less (or even negative) impact on the reduction of health inequalities.

However, public investment banks are changing. Thanks to their experiences with the benefits of ‘green investments’ in the climate and infrastructure sectors, public investment banks are increasingly exploring the benefits of similar socially-conscious investments in the health and social sectors. For example, in Ireland, 14 new primary care centres are to be built following agreement of a €70 million 25-year loan from the European Investment Bank (*see Box 13 for more information*).

European Investment Bank financing of Primary Care Centres, Ireland

14 new Primary Care Centres are to be built across Ireland following agreement of a new €70 million 25-year loan from the European Investment Bank in 2018. This represents the EIB’s first support for healthcare investment in Ireland and the first dedicated backing for primary health care anywhere in Europe. The new public-private partnership (PPP)-based scheme will **support the shift from hospital-based healthcare to community-based care** closer to patients. The new Primary Care Centres are to be built in Sligo, Roscommon, Mayo, Galway, Limerick City, Waterford City, Tipperary, Wexford Town, Kildare and Dublin. They will provide basic health services, including GP surgeries, occupational therapy, social work and dietary advice. In some locations, additional services will also be provided, including mental health, dentistry, addiction services and a local ambulance base.

Financing from the EIB represents 49.5% of the total investment cost of the new facilities. The project will be **co-funded by commercial lenders**. This is the second healthcare project to be backed by EFSI.

Box 13

10.1 How the European Investment Bank works

The European Investment Bank is the European Union's public lending institutions, whose shareholders are the Member States of the European Union. The EIB should not be confused with the European Central Bank, whose main task is to maintain price stability in the euro.

In short, the EIB is the European Union's bank and therefore works closely and increasingly with the other EU institutions to implement EU policy. The EIB is also the world's largest multilateral borrower and lender and offers 3 main types of products and services:

- lending – about 90% of its total financial commitment
- blending – allowing clients to combine EIB financing with additional investment
- advising and technical assistance – maximising value for money.

The EIB makes loans directly to project promoters (public, private, not-for-profit)-primarily above €25 million. When smaller loans are involved, the EIB opens credit lines for financial intermediaries (often, national or regional banks) who then provide cheaper loans to enterprises (public, private, not-for-profit). This is done through the European Investment Fund (EIF).

The EIB prioritises four main areas:

- Innovation and skills
- Small businesses
- Infrastructure
- Climate and environment

The EIB is also active in healthcare, having – according to their statistics – helped to improve healthcare services for 27.3 million people in 2018. They work on three main principles which guide the selection of projects for financing:

- Projects which enable universal access to effective, safe and affordable preventative and curative health services;
- Projects which provide sustainable health services;
- Projects with the highest expected economic value for society, taking into consideration outcomes and impacts, such as health outcomes, employment creation and social gains.

The EIF is specialist provider of finance to benefit small and medium-sized enterprises (SME) across Europe. As part of the EIB Group their shareholders are the EIB, the European Union, represented by the European Commission, and a wide range of public and private banks and financial institutions. They support SMEs with either their own resources or those provided by the European Investment Bank, the European Commission, by EU Member States or other third parties.

The main aim of the EIF is to support Europe's small and medium-sized businesses by helping them to access finance. They have two specific objectives:

- fostering EU objectives, notably in the field of entrepreneurship, growth, innovation, research and development, employment and regional development;
- generating an appropriate return for our shareholders, through a commercial pricing policy and a balance of fee and risk-based income.

The EIB will be the main implementing partner for the European Commission's InvestEU programme that is part of the 2021-27 multiannual financial framework. The agreed proposal reached by the

Council, the European Parliament, and the European Commission approves the EIB Group as the main partner for 75% of the InvestEU programme. The EIB will provide technical support to project promoters under the InvestEU Advisory Hub (see Annex 5 for more information on InvestEU).

A new initiative led by a hospital in *Treviso, Italy*, demonstrates the openness of the EIB to exploring “soft” infrastructure and is another *example* of a sustainable public health infrastructure project. A **social impact investment model** for Treviso hospital is derived from savings from the EIB financing and re-investment of funds in social entrepreneurial initiatives involved in the public health field in the community.^{xcii} Similarly, the CEB is providing budget support to the *Autonomous Region of Madrid*, thereby contributing to social cohesion through improved social care services to vulnerable people in need. However, it must be noted that such opportunities are likely to be highly competitive and inaccessible to programmes with modest budgets and limited capacity to ‘speak’ the language of the finance and investment sector.

10.2 What the Council of Europe Development Bank does

The Council of Europe Development Bank (CEB) is now also dealing with more complex and integrated projects, blending ‘soft’ and ‘hard’ infrastructure components, and is increasing its emphasis on targeting specific vulnerable and isolated populations. As a multilateral development bank with a purely social vocation, the CEB **provides governments, local or regional authorities as well as public or private financial institutions with loans for social projects**. The borrowers are generally the beneficiaries of the loans they receive, but they can also act as project promoters on behalf of one or several final beneficiaries.

The CEB bases its activity on its own funds and reserves and receives no aid or subsidy from its member states. As a non-profit driven institution, the CEB applies only a limited margin to its loans and charges no fees, thus enabling its borrowers to significantly reduce the cost of the loans they take out to finance social projects.

The CEB represents a major instrument of the policy of solidarity in Europe. With the aim of strengthening social cohesion, the CEB contributes to the implementation of socially oriented investment projects through four sectoral lines of action: strengthening social integration, managing the environment, supporting public infrastructure with a social vocation, and supporting Micro-, Small and Medium Sized Enterprises.

These include projects targeting, among others:

- people from disadvantaged backgrounds,
- vulnerable groups and people with disabilities,
- unemployed people through job creation,
- homeless and refugees,
- elderly people.

AN EXAMPLE FROM BOSNIA & HERZEGOVINA

A recent project the CEB has co-financed is the development of primary health care facilities in Bosnia & Herzegovina^{lxxxvi}. This included rehabilitation, medical, and IT equipment for family medicine facilities (*ambulancias*), and training for doctors and nurses in Family Medicine specialisation. The project was part of the “Health System Enhancement Program” (HSEP),

elaborated by the Government of the Federation BiH and Republika Srpska with support from the World Bank, the CEB and local Governments. The CEB funding involved two loans approved in 2005 (US\$ 14 million) and in 2011 (€ 9.2 million). The project was co-financed by the World Bank and the low interest rates help the government to manage repayments from central funds.

11

Benefits of joint budgeting and investments in health-related sectors

Ministries of health and Ministries of finance play a pivotal role in increasing investment in health promoting services. However, communication between health and finance sectors for making a case for prevention and health promotion is not easy (*action is also not limited to these two ministries as we showed in chapter 4*). Simply **increasing the volume of evidence on positive health and wellbeing outcomes and economic returns is unlikely to make a dramatic impact** on overall investment levels. Scepticism on prevention remains over the long time period for returns, calculation of risk, and the ultimate form of the return on investments^{xciii}. A public guarantee as offered via the EU programmes for EFSI or *InvestEU* is likely to be more reassuring and offer a suitable route to mitigate these challenges and make investors feel more secure. The public guarantee acts as a form of security to investors. The idea is that investors feel more secure in investing with the knowledge that money has been guaranteed to repay them if necessary.

One way of increasing funding for actions that benefit health is by working outside the health sector and to **form cross sectoral alliances**. Health and other social sectors share common goals, benefits, and economic gains from taking a health equity perspective to their work. For example, cross sector benefits include school health programmes that cover school performance, mental health, and health literacy^{xciv} and are inclusive of families and the community. To provide shared funding, sectors can take a joint budgeting approach, including mutually determined targets and outcomes, as well as the breakdown of roles and responsibilities for the delivery of pre-agreed services.

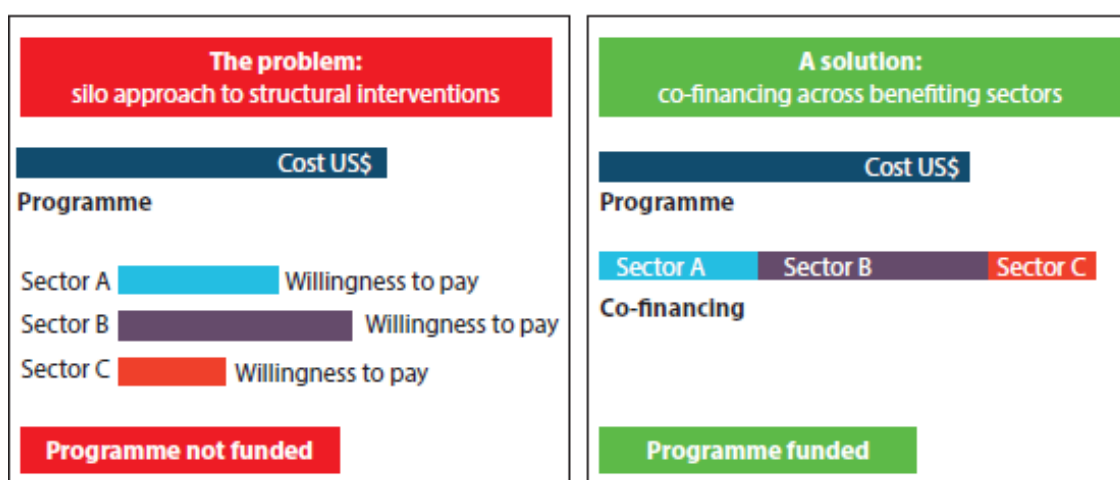


Figure 8: Silo-approach to financing versus the cross-sectoral co-financing approach (UNDP, 2019)

Co-financing, for example as developed by United Nations Development Programme and colleagues, is an approach whereby two or more sectors or budget holders, each with different development objectives, co-fund an intervention or broader investment area, which advances their respective objectives simultaneously^{xcv}. Co-financing does not require additional resources or increases in capital investment (see figure 8 below for a visualisation of the co-financing model). Rather, it helps optimise allocation of existing resources across sectors to maximize cross-sector outcomes.

The co-financing methodology necessitates different government departments, sectors, or budget holders to move outside their current silos and work together. This includes through effective cross-sectoral governance, planning and financing mechanisms through their interinstitutional and coordination mechanisms. The co-financing methodology is reliant upon two key expectations:

- (1) that the objective of budget holders is to maximise their sectoral outcomes;
- (2) that budget holders are solely constrained by their budget when making decisions about the interventions in which to invest^{xcvi}.

However, when the methodology is put into practice there are numerous potential barriers. This includes institutional feasibility and the incentives and disincentives of the different departments to actively engage and collaborate. **Transitioning away from input-based budgeting towards programme or output- and outcome-based budgeting is helping to address barriers involved with co-financing.** In addition, funding schemes can be developed where funding is contractually conditional on having an intersectoral partnership between health and one or more sectors. There are new ways emerging to help health planners become more effective in working with other sectors^{xcvii}.

Engaging local stakeholders and funders to create collective action in communities is a core component in tackling health inequalities, as it offers community members joint ownership of the process, thereby improving the level of control over their circumstances, a determinant of health.

AN EXAMPLE FROM MONTREAL, CANADA

In Montreal, citizens, community agencies, schools, health and social services and businesses have worked together since the 1990s to create concrete projects that improve neighbourhoods and their living conditions. The *Projet Impact Collectif* does not provide standard, one-size-fits-all solutions. Instead, they invite the 17 neighbourhoods to experiment, innovate, and find new ways to accelerate change through their intersectoral collaborative local roundtable. To carry out the activities, they pool funding from various donors, who thereby willingly share decision making with the communities.

12

Bundling Projects

Investment Banks, both public and private, are keen on increasing their investment in the social and health field. Yet, until now, they have been far more effective in targeting very large infrastructure projects -such as hospitals or schools- worth over €50 million. Such investors generally target these very large projects due to the complexity and high cost, including administrative costs, of investing in smaller projects. In fact, avoiding the risk of smaller scale projects has been a concern for public investment banks. This is [one of the main criticisms of the EU Investment Plan for Europe](#). Whilst there is not one single solution to this challenge, the **bundling of smaller health and social projects**^{xviii} (or even with other sectors) together could provide some answers for investors.

There are several ways as to how the bundling process^{xcix} could take place.

One or several local and regional authority/ies could group together the investment needs in a variety of different sectors over which they have responsibility (either to provide or fund, or both) and request a loan directly.

The [EIB loan to the Irish National Development Finance Agency to build 14 primary care centres across the Ireland](#) is a good example of how the Irish authorities grouped together what could have been different investment projects^c. Another example is the [EIB Framework loan to the town of Orebro in Sweden](#), who requested a €180 million via a 25-year-long loan to invest in 40 small to medium size schemes in education, childcare, and municipal housing.

Local and regional authorities are not the only bodies able to bundle projects together. With the right push for providers and enterprises requiring loans, **banks can also bundle different projects together** or see potential for such development access support from the European Investment Bank.

One example of this is Belgian bank Belfius' smart and sustainable cities programme where Belfius and the EIB invest together in over 100 different projects from a wide range of sectors: environmental, health, retirement care, and digital.

Another option is for the service providers themselves to group their investment needs together and create a special purpose vehicle able to request financing from an investor.

Whilst there are some potential examples, this avenue **remains largely unexplored; partly explained by the lack of support and capacity-building to such bundling by local and regional authorities**. Some authorities are currently exploring how they could fund such developments, through for instance the Technical Assistance budget of the European Social Fund.

13

Social Impact Financing

One of the key financing challenges facing the health and social sectors is a way to make the returns on investment in health promoting services clear and attractive for investors. To make this work, health and social sector actors must first define what constitutes so called ‘soft’ infrastructure, and subsequently demonstrate that **investments in “soft” infrastructure can result in not only social impact but also cash returns**. They should also prove that these investments offer stable, long-term returns as well as the chance to enhance the value of associated “hard infrastructure assets” (e.g. through increased use of health centres or improvements in the overall quality of life and property value in selected neighbourhoods).

Investments that directly improve social spaces, the lives of citizens, and improve the quality of social and health services being provided can increase the value of the social investment asset which will be of interest to investors. Two social impact financial instruments are **social impact bonds (SIBs)** and **social outcome contracting (SOC)**. These new instruments are increasingly being piloted as additional funding mechanisms to existing government support for improving public health and launching new health promoting initiatives.

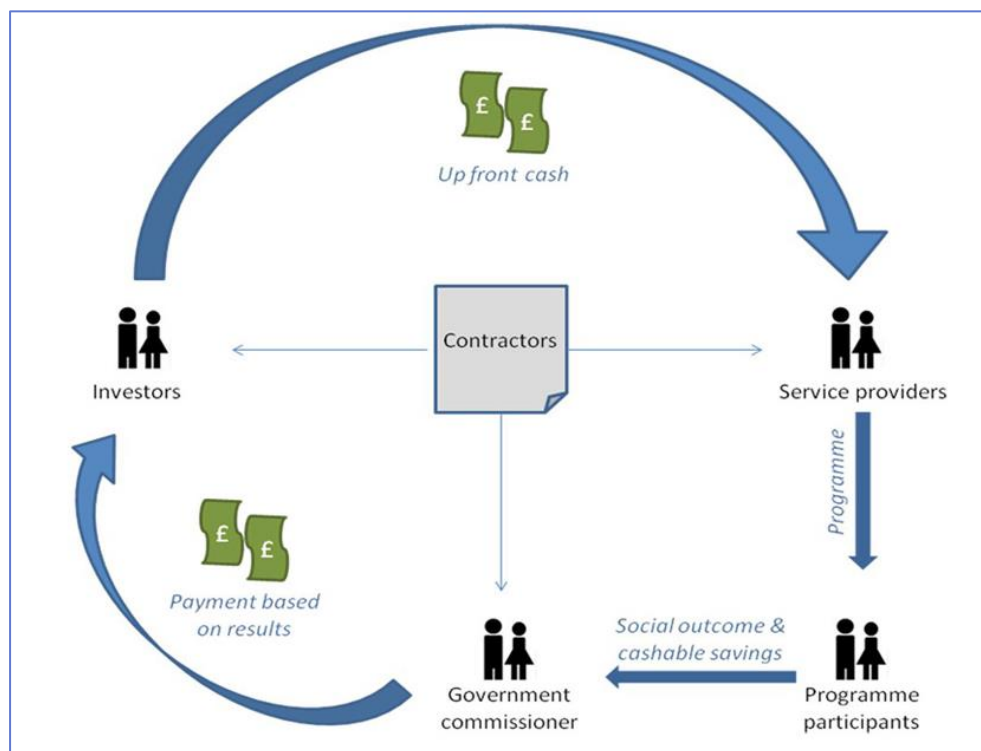


Figure 9: Social Impact Bond Diagram (Cabinet Office, UK 2018)

A social impact bond (SIB) is a contract with the public sector or governing authority, whereby it pays for better social outcomes in certain areas and passes on the part of the savings achieved to investors^{cii}. A social impact bond is not a “bond”, per se, since repayment and return on investment are contingent upon the achievement of desired social outcomes: if the objectives are not achieved, investors receive neither a return nor repayment of principal.

SIBs derive their name from the fact that their investors are typically those who are interested in not just the financial return on their investment, but also in its social impact. SIBs are a new mechanism providing investment to address social challenges, including health promotion and disease prevention (see figure 9 above for a visualisation of the link between financial success and the delivery of measured social outcomes). In straightforward language, **SIBs can be understood as a loan made by an investor, where repayment is linked to the achievement of specific agreed-upon health (or social) outcomes.**

13.1 Social Impact Bonds

The first SIB was launched in the United Kingdom in 2010. Public authorities have become increasingly interested in their use, especially to finance innovative projects. There are currently more than 120 impact bonds in 24 countries worldwide, mobilising more than £300 million of investment into tackling complex social issues such as refugee employment support, loneliness among older people, rehousing and reskilling homeless youth, and diabetes prevention.

While more time is needed to make an overall evaluation of SIBs effectiveness, in the right circumstances and developed in the right way and for the right projects, social investment bonds could be a useful tool to boost investment into innovative health promoting projects and enable public authorities to share the risk of such investment with private investors.

AN EXAMPLE FROM FINLAND

As a response to the global displacement crisis which peaked in 2015, the **Finnish government** decided to establish a social impact bond focused on the employment of Finnish immigrants. Unemployment, particularly long-term unemployment, represents a huge risk of social exclusion for immigrants; thus, finding stable and quality employment is a very important part of the integration process. The **Finnish Innovation Fund Sitra** proposed the idea of a SIB that would offer immigrants work-life oriented training. The subsequent three-year (2017-2019) pilot Koto-SIB for the employment of immigrants kicked off in 2015. The objective is for immigrants to enter the labour market on average four months after the training has begun. The training is followed by further on-the-job training and includes language, culture and professional skills studies.

Outcomes are measured by the following two indicators: unemployment benefits and income tax. The expectation is that the proportion of unemployment benefits paid to the people involved in Koto-SIB is smaller and that they would contribute with greater income taxes in contrast to the control group not involved in the programme. The service providers are first paid based on direct operations costs, but the rest of the payments are based on outcomes. This **structure incentivises service providers** to do their best to find suitable and quality work for every participating individual.

While this is certainly a promising initiative, it is important to note that not every immigrant is able to participate in these services, due to age, disability, or other conditions that render them incapable of participating in the labour market. This **SIB must be complemented by additional services and programming to make sure no one is left behind.** This includes strong measures to ensure that reliable,

well paid jobs are included and that new arrivals have a voice on an oversight committee to ensure that their voices are heard throughout the process^{ciii}.

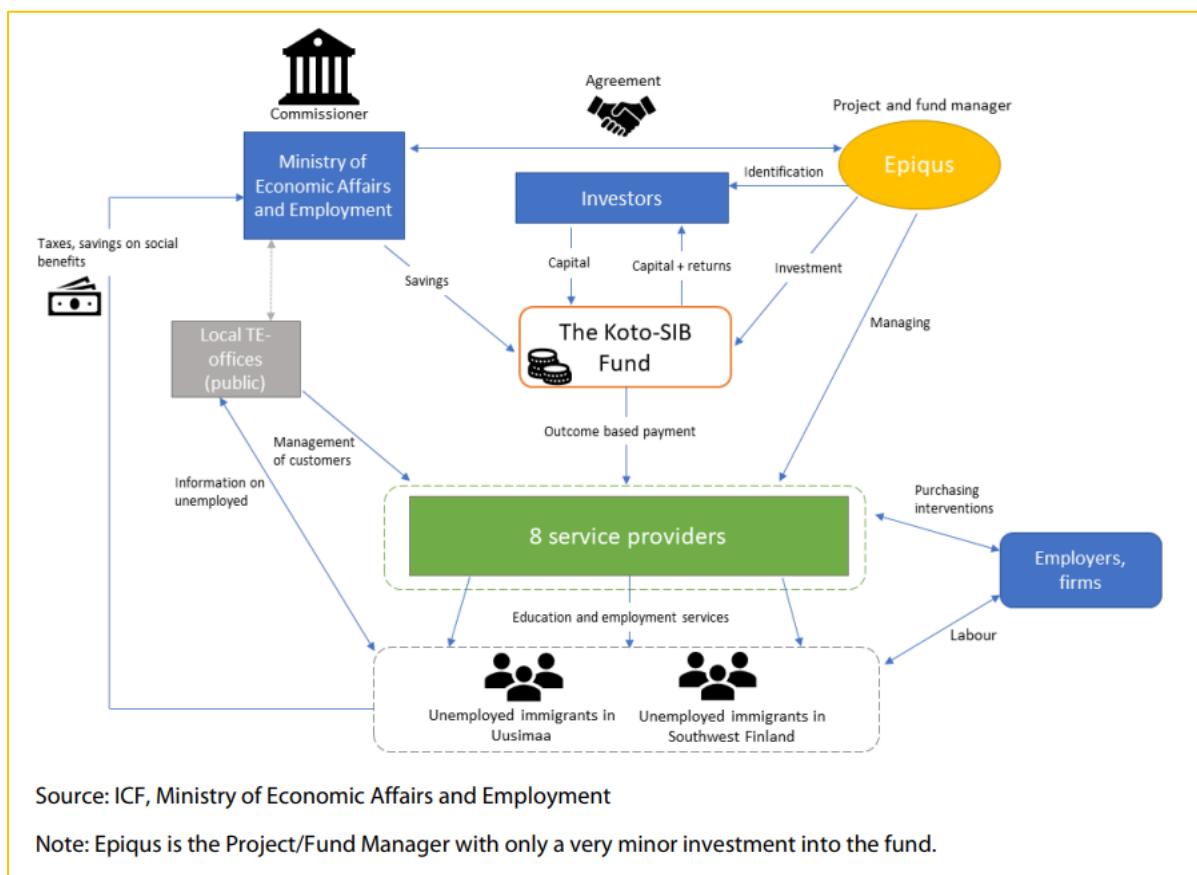


Figure 10. Pilot Koto-SIB for the employment of immigrants

AN EXAMPLE FROM CANADA

The Heart and Stroke Foundation of Canada launched another SIB, the **Activate Programme**, in 2018. This programme was developed in response to the high rate of heart diseases and stroke. It is a lifestyle-change programme to help people at risk of developing hypertension (one of the most important risk factors for heart diseases) to adopt healthier habits to get their blood pressure under control. This is Canada’s first health-related SIB.

The Health and Stroke Foundation selected this instrument as it allowed them to innovate and develop their own governance structures. They approached the *Centre for Impact Investing* seeking help to establish this bond. The main negotiation involved establishing the rate of return on investment for investors that took place between the Foundation and the federal government (in Canada, prevention is a responsibility of the federal government while the provinces are mandated to manage healthcare). (See Box 14 for information about Activate programme in Canada and Annex 1 for the full case study.)

This experience demonstrates that SIBs represent a great **opportunity to innovate but might be insufficient to provide a stable long-term programme funding**, despite positive outcomes. As a result, this several-years project can prove its cost-effectiveness and **increase the likelihood to receive mainstream government funding**.

Activate in Canada

The Activate program is a 6-months **community wellness program** that is designed to prevent the onset of hypertension (high blood pressure). It is funded by a social impact bond through a pay-for-success model over the course of 3 phases from 2018 to 2020.

- The outcomes of success for the Activate program are measured by the volume of enrolments and the average change in blood pressure between recruitment and a follow-up after at least 6-months of the program.
- The target for success was set by cardiologists at no increase in blood pressure readings, but an overall decrease is even more desirable. Without intervention, half of pre-hypertensive people in Canada over age 60 will go on to develop high blood pressure within four years.
- Cohort 1 of the Activate program enrolled 527 participants into the program and we observed an average change in blood pressure of -5 mmHg systolic.
- As of Week 19 in Cohort 2, there were ~1950 enrolled new participants, and the team expanded the program beyond the initial plan of the Greater Toronto Area to include several other regions in Ontario, Canada.

Activate was designed to prevent the onset of high blood pressure among older adults. Hypertension is the number one risk for stroke and leading risk factor for heart disease. Without intervention, half of all pre-hypertensive people over 60 in Canada will develop hypertension within 4 years. Heart disease & stroke are leading causes of death, taking the lives of more than 66,00 Canadians every year. This program is an **opportunity to assess the impact of preventative health measures on hypertension**. The target for success was set by cardiologists at no increase in blood pressure readings, but an overall decrease is even more desirable.

Funding for Activate comes from a pay-for-success (PFS) model or social impact bond (SIB). Working closely with the MaRS Centre for Impact Investing, Heart & Stroke has attracted philanthropically minded private investors to provide upfront capital. The federal government, through the Public Health Agency of Canada, repays the investors based on successful outcomes. This is only the second time in Canada that this funding model has been used, and the **first time for a large-scale chronic disease prevention initiative**. There are 2 key outcome measures:

1. Volume - How many people we enrol in the program (7,000)
2. Blood Pressure - Were we able to halt the increase in BP over the 6 month journey. Success = flattened BP trajectory. A decrease would be over performance.

The investors get paid after the recruitment phase of each Cohort based on volume, as well as a final payment based on blood pressure reading.

There are 4 key payments:

1. Volume Payment 1 - Summer 2018
2. Volume Payment 2 - Summer 2019
3. Volume Payment 3 - Summer 2020
4. BP Payment - end of the entire program, so early 2021 if not the very end of 2020

The rate of return depends on both volume and blood pressure at the end of the program. While the funds come from the federal government, the outcome payments do not come from funds for existing services (e.g., hospitals).

AN EXAMPLE FROM THE UNITED KINGDOM

Commissioners from the health system and local authority adult social care providers in Worcestershire, **England** have also introduced a social impact bond. The different stakeholders came together in 2014 and decided that the relationship between loneliness, health and service use provided a rationale for expanding services to address loneliness and social isolation in the community. The service commissioners were attracted by the SIB mechanism, under which **investors fund the service up front and commissioners only pay if outcomes are achieved**. The commissioners were interested to transfer some of the delivery risks in developing the programme and keen to stimulate innovation and adaptation.

The end result of this approach was the ‘*Reconnections*’ programme. It takes a tailored approach to the needs of participants, with a volunteer or case worker supporting an identified person in-need over six to nine months to re-engage with the interests and social relationships of their choice and overcome practical and emotional barriers. Since its launch in 2015, over 1,300 older people have been supported. On average, self-reported loneliness is significantly lower at 9 months and 18 months after entering the service. Early evaluations by the London School of Economics are also positive and the service has been **held up as an exemplar by national policy makers on how to tackle loneliness and social exclusion in later life**^{civ}. (See Box 15 below for more information on *Reconnections* and Annex 1 for the full case study)

Combatting loneliness and social isolation in England

In the case of *Reconnections*, the social impact being sought is a **reduction in loneliness**. Investors receive outcome payments for each aggregate reduction in self-reported loneliness using the UCLA self-reported loneliness question (a 12-point scale). The payment metrics are:

= £740 (c.€850) per point reduction after 9 months after service start

= £240 per (c. €275) (sustained) point reduction 18 months after service start.

These outcome ‘tariffs’ were set due to growing evidence on the relationship between loneliness and poor physical and mental health and consequent healthcare and social care usage. A London School of Economics interim evaluation found that reducing loneliness in people who feel lonely most of the time could potentially save up to £6,000 per person in costs to the system over 10 years.

The service costs approximately £330,000 (EU380,000) each year to support up to 430 older people a year (c. £750-800 per participant). At the start of the service, investors provided £650,000 in up-front capital - £565,000 as debt and £85,000 as equity. In the first two years of running the service was loss making – however, as impact has grown, and 18 months payments have increased, **the service is now making a small surplus**.

By April 2020, commissioners are expected to have made outcome payments of around £1 million. The first £175,000 was returned to investors in early 2019 and subsequent payments are expected 2019-2021. However, it is not yet certain that investors will fully recoup all of their initial £650,000 investment given that service costs were more than originally anticipated. This is a clear risk that investors must face when deciding to invest in social impact bonds.

Box 15

While social impact bonds are clearly an exciting new avenue to introduce innovations and improvements into the delivery and funding of health promoting services, they do not come without risks. **Care must be taken** that promising new funding instruments like SIBs do not result in ‘cherry picking’ or ‘creaming,’ which is targeting the ‘easiest’ participants or results to support to the detriment of the rest of the participants or programme. This type of perverse incentive can be avoided through careful design and service specification.

In addition, social impact bonds should **never replace mainstream public funding and responsibilities of national, regional and local governments**. SIBs however are well placed to pilot actions and interventions in order to demonstrate effectiveness, and secure more traditional funding for the long term and for scaling up. They can also be utilised to boost investment into health promotion and prevention measures by sharing the risk between public and private investors.

13.2 Social outcomes contracting

Social outcomes contracting represents another novel mechanism for investment in health promoting services. Social outcomes contracting (SOC), or outcomes funds, are contracts in which payments are made only when pre-agreed social (or health promoting) outcomes are achieved by the funded programme/organisation. This is in opposition to a ‘*payment-by-outputs*’ approach and it differs from the social impact bond. The most significant difference between impact bonds and outcome contracting is the inclusion of the investor in the development stage. SOCs help participating organisations to align their incentives to achieve social outcomes while also saving public expenditure due to its focus on prevention and generating return on investment.

AN EXAMPLE FROM SWEDEN

In Sweden, the project Social Outcomes Contract (SOC) for a **preventive and healthy workplace** has been developed in response to an increase in sick leave across the country. The costs for sick leave benefits have risen from 26.2 billion Swedish Krona SEK in 2013 to 39.8 billion Swedish Krona in 2016. This trend is particularly noticeable in the workplaces of public regions and municipalities, compared to private employers. It imposes a high burden on these public employers as they cover the expenses of short-term sickness (days 1-14). In addition, it increases indirect costs and negative effects including productivity loss and lower quality in public services.

A pre-study conducted in Swedish municipalities, in collaboration between *SALAR, RISE, the European Investment Bank and Kommuninvest*, found that 20% of employees account for 75% of the costs of short-term sick leave. The identified risk group of employees were found to be absent 3 or more occasions during a 12-month period. The pre-study further indicated that regions and municipalities do not put enough effort into early identification and intervention in terms of reducing sick leave and improving employee health. As the results of health promoting interventions tend only to be observable years after the initial investments are made, it was challenging to identify long-term financing, particularly due to annual budget cycles. A SOC was identified as a valuable tool in terms of **providing financing for early interventions and health promotion in workplaces** as well as for monitoring outcomes.

The main outcome measurement used for financial evaluation is the **direct costs for reduction in net short-term sick leave days** (1-14 days), adjusted for national trends in sick leave. The average reduction

during the intervention period will be compared to a baseline of historic data from the municipality. Other outcomes measured are long term sick leave (15+ days), purchasing of occupational health care services, size of risk group. Learn more about this model in Box 16 below (also see *Annex 1 for the full case study*).

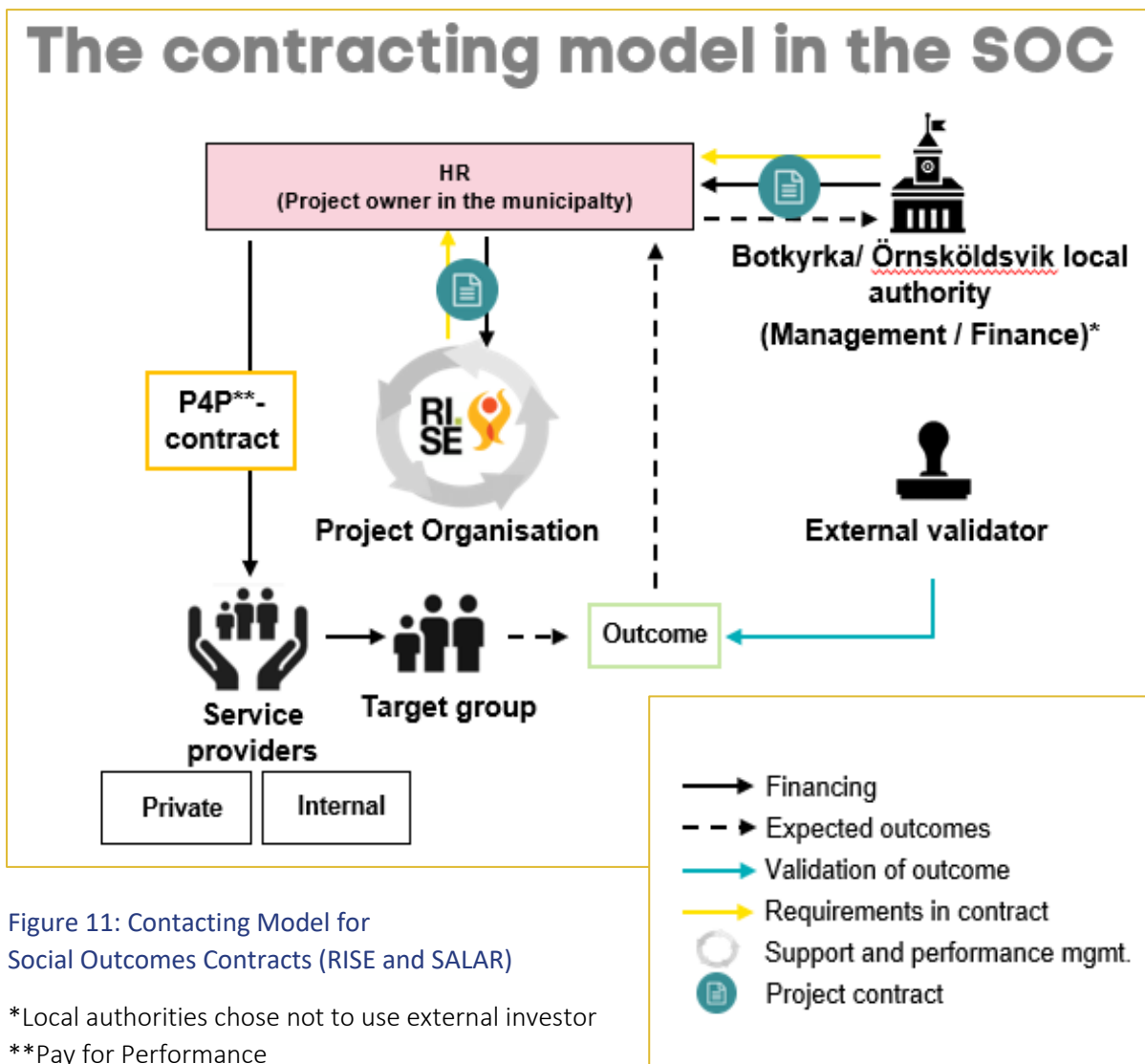


Figure 11: Contracting Model for Social Outcomes Contracts (RISE and SALAR)

*Local authorities chose not to use external investor
 **Pay for Performance

The **benefits of an outcome-based contract model** are due to its approach to public service management that seeks to improve value and impact. The payment mechanism can differ, as arrangements can include a proportion of upfront or activity-based payment that is not contingent on the achievement of a specified outcome. Some form of upfront payment or ‘fee-for-service’ has the potential to make the scheme more attractive to providers and investors. This is because the fee can be used to help start-up costs and reduces the risk they take on in agreeing to the contract.

While governments have progressively been using, or investigating the possibility of using, outcome-based contracting to deliver public services that address complex social challenges, a note of caution must be given. The idea of finding investors when traditional ways of paying for services might have been ineffective is commendable. However, there are still concerns over what services, conditions, areas, and people are left behind when private investors choose where to invest to maximise their profits. The

Social Outcomes Contract for a preventive and healthy workplace in Sweden

The project employs a multi-level approach to target both individual and organisational factors impacting occupational health. The health support enables early identification of ill-health and sick leave absence which, in combination with structural interventions (manager support), enables preventive and health promoting actions. Additionally, the interventions aim to generate long-term competence at the human relations department in terms of identification and implementation of preventive actions – **thus establishing capacity for prevention** in a broader perspective.

The structure of the SOC enables performance management and programme improvement as well as collaboration between private and public sector organisations. The occupational health service provider is procured and contracted by the local authorities to perform services (health support and identification of risk groups). **The public sector has played a big part in implementing** the SOC, compared to other countries where SIBs have been adopted. Although the actors involved in a SOC or SIB may vary, the investors often include private actors. In the occupational health SOC in Botkyrka and Örnsköldsvik, the project is solely financed by the local authorities themselves, making it a unique example of a publicly-financed SOC. The project management organisation, consisting of a new entity formed by state-owned RISE and SALAR, assists with project monitoring, evaluation and support during the implementation process.

The **contractual partners** in the SOC are the finance and HR departments in the local authorities, as well as the intermediary organisation (RISE and SALAR). The total investments in the SOC of two municipalities are 17,4 million Swedish Krona and 22,870 million Swedish Krona respectively (€4 million in total) over a three-year period.

A financial instrument referred to as **Sustainability Bond with Impact-Linked Return (SBIR)** was designed to allow for institutional investors and a large investment volume (€100 million). The SBIR combines a loan (approx. 90%) with a social outcomes contract (approx. 10%) in order to achieve enough investment volume and a suitable risk profile. However, the Swedish local authorities decided to finance the SOC on their own.

During the procurement process of external service providers, various parameters were considered, including proposed risk-share agreements. The service providers were offered to bid on risk appetite - between 25% and 75% of reimbursement to be dependent upon the outcomes of the SOC. The contracted providers bid for 50% and 75% in each municipality. The financial commitments between the investors and service provider is **regulated with a pay-for-performance contract** based on this financial risk sharing with a potential premium for over-performing which is capped at half the risk level. **Thus, there is financial risk sharing between the municipalities and the service providers.**

Based on international experience, various case scenarios were outlined, **defining the financial outcomes for all parties.** All scenarios include a total intervention period of 36 months and a 9-month ramp-up to full intervention effect. Aiming for the low case scenario (12%) average reduction in net sick leave days will result in a break-even point. The expected base case scenario is on average 18% reduction, and the best case is 34% reduction of net short-term sick leave days. The estimated likelihood for achieving at least base case is 80%.

The share of repayment is dependent upon the financial risk of the service providers, but the cash flow also depends on the estimated cost for the service delivery per employee, the number of employees at the baseline measurement and the outcomes achieved. **Evaluation** is done by calculating the trend adjusted change of net sick leave days compared to the historic baseline. Reductions beyond break-even will result in repayments to the local authorities (66,25% and 81,6%) and to the service providers (33,75% and 18,4%). The cap on payments to the providers means that reductions above 150% of the investment value will go solely to the local authorities. **Box 16**

cautious development of contracts, return on investment calculation, and tools to manage resources are fundamental to providing health promoting services for all.

One tool that has potential to be used across financial approaches and health promoting services is a **Health Inequalities Impact Assessment (HIIA)**⁶⁹. A HIIA is a tool to assess the impact on people of applying a proposed, new or revised policy or practice. HIIA assesses the impact on; health inequalities, people with protected characteristics, human rights, and socioeconomic circumstances. Many policies, plans, proposals or decisions have the potential to impact on health and potentially widen health inequalities. By conducting an HIIA the potential impacts can be considered and action taken to reduce those impacts.

Impact assessments help to:

- ensure non discrimination
- widen access to opportunities
- promote the interests of people with protected characteristics.

The HIIA should be conducted when the policy, plan or financial instrument is still in draft. It should be well enough developed to understand the potential impacts, but not so far developed that changes are not possible as a result of the assessment.

14

EU Funds available for investment support

EU Funds

The reduction of health inequalities has been a key priority of the WHO Europe 2020 Strategy. Actions are also supported through European Union agendas. Improving health and reducing health inequalities are included in investment objectives for the European Structural and Investment Funds (ESIF) for 2014-2020^{cx}, for the proposed ESIF+ (2021-27) and for the upcoming InvestEU programme^{cvi} (2021-27) which has a specific policy window on social investment and skills (*see Annex 5 for InvestEU - Draft Investment Guidelines*).

The European Structural and Investment Funds (ESIF) are financial instruments through which the EU invests in local and regional projects that contribute to 'smart, sustainable and inclusive growth'. The total budget of the ESI funds for 2014-2020 is over €450 billion. ESI funds have been found to be useful for tackling a wide range of health concerns^{cvi}.

While such instruments are not long-term solutions in themselves to the challenges faced, as they are frequently used to fund initial programmes or step in where national budgets are insufficient, they offer underused opportunities to make shifts in approaches, to test initiatives, to initiate partnerships and to establish good practices. Help desk advice is available for bodies looking at these funds, including for forward strategies 2021 onwards as it is crucial to ensure health equity and relevant priorities are included in EU, national and sub national programming priorities.

Box 17

National governmental funding is the key resource for health promoting services. Yet the demand for health services is growing while health budgets remain constrained. There are various **mechanisms offered at the European level** which could benefit the transformation envisaged by the national organisers of public health.

The European Structural and Investment Funds (ESIF) have made an important contribution to health promotion and disease prevention, supporting programmes that target population level changes, ageing issues, and workplace health and safety^{vi}. The total budget of the ESI funds in the 2014-2020 spending programme period was over €645 billion, which represents more than half of the total EU budget. In the next MFF the use of the ESIF funds will be more closely aligned to the EU semester process as well as the EU's cohesion policy objectives.

In addition, multi-sectoral collaboration is essential for interventions addressing the social determinants of health^{cx}. A better use of ESI funds would include the mandatory adoption of health in all policies within all actions implemented. This requires paying attention to the protection of health as enshrined by Article 9 of the Lisbon Treaty. Such an approach would allow for systematic consideration of health implications throughout policy-making. Addressing the complex causes of ill health requires health promotion interventions to be complemented by government policy in other areas (e.g. taxation, fiscal, or consumer policies) as we have outlined in previous chapters.

The next *Multiannual Financial Framework (2021 – 2027)*, the European Union budget, will include new programmes for Social Funds, Regional Development Funds, Cohesion and Structural Funds, Rural and Urban Development Funds, Vocational Training Funds, Research Studies and more which offer a range of tools and mechanisms to benefit social progress. For instance, the **Structural Reform Support Programme (SRSP)** foresees €25 billion in support of priority reforms in all EU Member States. This can contribute to health system transformations towards more preventative and community-based services and the strengthening primary care. Furthermore, the European Union's future investment programme proposes to develop a €4 billion (European Commission proposal) guarantee to support around €40 billion worth of private investment into social measures to facilitate -amongst other targets- the reduction of health inequalities in the EU. *See Box 17 for more information on EU funds and Annex 5 for InvestEU programme and one of its key elements - the Social Investment and Skills window.*

15

Concluding remarks

The guide to financing health promoting services produced by EuroHealthNet, in close cooperation with WHO is a critical instrument and comes very timely.

It is urgent for policy makers and health promotion planners to have access to the right know how, the competencies and deep understanding of the socio economic rationale to rapidly increase investment in health promoting services and innovative methods and tools and seize the new opportunities to make a leap forward in providing better health and wellbeing for all, within a sustainable framework.



The people's mindset worldwide is changing from remedial care to a preventive approach and this promises for a potential of tremendous growth in the wellbeing and health promoting services if invested in well. Therefore, policy makers and planners need the support and the arguments to make this shift happen.

The guidance hereby provided is timely because the new incoming leadership in the European Commission and the Parliament could show political leadership by strongly endorsing it. In addition, the increased investment funds that will become available with InvestEU working in partnership with many other public and private investors could create the scale and the momentum in the direction of long term investments and innovation for the benefit of wellbeing and health of the people.

Finally, the guide's case studies and practical examples provide a real contribution to help achieve the United Nations Sustainable Development Goals and for all to work across sectors for the benefit of citizens.

Dr Lieve Franssen
Co-author of *Boosting Investment in Social Infrastructure in Europe*
Former Director for Social Policies and Europe 2020, Directorate-General for Employment, Social Affairs and Inclusion, European Commission

This carefully sourced and well thought out guide has potential to inform the current debate around the Economy of Wellbeing. This is the main theme of the Finnish EU Presidency. Originally, the concept of the Economy of Wellbeing was developed by Finnish social and health sector NGOs and therefore, the EU Presidency is an excellent opportunity for NGOs to make their wellbeing-generating work visible and to influence EU policies. It is based on a broad concept of wellbeing.



The Economy of Wellbeing considers wellbeing to consist of individual resources and participation. Individual resources include satisfactory health, sufficient material resources, social wellbeing and empowering social relationships, self-confidence, trust in the community one lives, and critical consciousness. Participation refers to the opportunity of people to participate in the decision-making of one's own community, and in the development of the community, as its full members. Building the Economy of Wellbeing ultimately consists of strengthening the above factors and investing in them.

It is crucial to invest in the types of social infrastructure and health promoting services which best respond to the needs and expectations of people, especially for those who are most disadvantaged. Long-term solutions and alternative financial instruments must be considered and developed to fill existing gaps in investment.

This is a key message that I take from this guide - health is an investment not a cost. It is a message that we must spread. The guide is part of a vision for how we can build more equitable, healthier societies. This fits succinctly with the Economy of Wellbeing vision that can be described in one sentence, 'Working together to build a good life for everyone'. This is also the mission of SOSTE.

Vertti Kiukas
Vice-President, EuroHealthNet
Secretary General, SOSTE Finnish Federation for Social Affairs and Health, Finland

Annex 1: Case Study examples

Prioritisation Framework (PF) for public health investments - Public Health England



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**Newcastle
University**

1. What is it? (Objective)

The Prioritisation Framework (PF) provides a platform to aid local authorities using the PF to make decisions regarding budget allocations in a structured and transparent manner. The notion that public health resources are scarce relative to needs and demands of publicly funded goods and services is not new. Within the constraints of a fixed budget, a decision to provide one service may result in another service not being provided due to lack of resources. Thus, knowing the resources used and benefits of various services or interventions within public health allows comparisons and choices to be made in order that the combination of the services invested in maximises benefit from the fixed budget.

One method of facilitating the application of health economics principles to public health priority setting is through the use of Multi-criteria decision analysis (MCDA). MCDA is a domain of operational research that is beginning to be used in healthcare decision-making. The technique recognises that decision-makers employ multiple and disparate criteria when making decisions (for example, introducing new health care interventions or facilities), and that it is important to make explicit the impact on any decision of all the criteria applied and the relative importance attached to them. In MCDA, criteria affecting a decision are identified and weighted using explicit, transparent techniques. Different options (strategies, interventions) are scored against each criterion and the weights are used to provide summary scores for comparative purposes. It helps to make more transparent assumptions underpinning decisions, which in principle may improve accountability and consistency of decision-making.

The PF is based on MCDA largely because it has been used effectively to support strategic decision making in many different public health circumstances and contexts such as multi agency working. The PF allows for consideration regarding the programmes that can offer the best value, the current states of the programmes, the budgets and how they are currently allocated across programmes, and how easy it could be for the programmes to change and improve. The process allows public health programmes to be scored on the potential state, current state and the programme budgets while, at the same time, considering what is achievable. The purpose of this is to be able to make informed recommendations on whether to increase, decrease or maintain budget spending in each public health programme.

2. What is it for? (Context)

How best to achieve better investment and disinvestment decisions has long been a challenge facing policy-makers but, following deep cuts to public spending in England since 2010, the issue has become more urgent and acute.

In 2012, a group of UK researchers, some initially based at Durham University, and then at Newcastle and Northumbria Universities together with colleagues from the Universities of Sheffield and Kent, undertook a number of linked studies exploring the application of priority-setting tools that local authority public health decision-makers might find useful for investment and disinvestment decisions. Funding for the research came from the National Institute for Health Research (NIHR) School for Public Health Research (SPHR) and full details of the programme of research conducted from 2012-2016 and its findings can be found here (<https://sphr.nihr.ac.uk/wp-content/uploads/2019/01/SPHR-Public-Health-Evidence-Briefing-Local-authority-decisions.pdf>) and also under Current Research Projects (<https://research.ncl.ac.uk/davidhunter>).

The findings from the *Shifting the Gravity of Spending? Exploring methods for supporting public health commissioners in priority-setting to improve population health and address health inequalities* project informed a new Prioritisation Framework developed by Public Health England (PHE) and launched in March 2018.

3. How it works

The PF comprises eight essential steps that can potentially take place over a number of workshops. Those taking part in the workshops would ideally be stakeholders from each of the health programmes under consideration.

Step 1 defines the criteria against which programmes will be evaluated. Operational criteria are selected during this stage of the process, representing key factors of what is to be achieved within each local authority and weights are then applied to each of the criteria in **Step 2**. The weights that are assigned to each represent the importance of each criteria relative to all others with the total score summing to 100.

Step 3 involves gathering evidence from each programme area that is relevant to the criteria. The evidence gathered relates to what could potentially be achieved by each programme area against each criterion.

Step 4, after collecting evidence, rates each of the programmes from 1 to 5, with a score of 1 representing the poorest and 5 the best. The higher the score indicates which programme areas have the best potential to achieve positive outcomes.

During **Step 5** the weights that were assigned to the criteria and the scores given to the programme areas are combined to calculate an overall score. This final score represents the overall outcome of what could potentially be achieved by each of the programme areas.

Step 6 is used to gather evidence regarding the current expenditure and outcomes of the programme areas. **Step 7** assigns scores, with the scoring based on the evidence of the current performance of the programmes against 3 measures: investment, outcomes, and feasibility. Each programme is given a score from 1 to 5 against each of these measures. Overall, the score gives a clear representation of how the programmes are currently doing in a numerical form.

Finally, in **Step 8**, the PF produces recommendations on whether to maintain, increase or decrease the current budget allocations. The stakeholders then have the option of following what has been advised or to decide their own actions in the light of other contextual factors.

A one-year evaluation of the PF was undertaken in the three early adopter local authorities in England. The study built on the earlier findings from the *Shifting the Gravity of Spending* research programme to assess the impact of the new tool on decision-making when it comes to investment and disinvestment decisions. The evaluation sought to establish the utility of the tool and to identify any barriers and/or enablers affecting its uptake. The final report can be accessed at <https://research.ncl.ac.uk/davidhunter/currentresearchprojects/shiftingthegravityofspendingpart2/>

Given the short-term nature of the study it did not prove possible to say much about the impact of the PF on priorities and on investment and disinvestment decisions or to conclude anything in regard to the extent to which it affected spending decisions. But it is important to stress that the PF is not primarily a health economics tool and is not seen as such by PHE. The primary value of the PF lies in providing structure and guidance for local decision-makers to agree the outcomes they regard as important. Consideration of the evidence in regard to effectiveness and cost-effectiveness is only one part of the overall decision-making process.

While the act of assigning numerical scores to the evidence is important, it is only a means to an end and should not be over-emphasised. More important than the scores are the conversations triggered by employing the PF which allows decision-makers to express their views, challenge assumptions, and agree on the best course of action.

PHE have accepted the main study findings and plan to incorporate these where possible in further versions of the PF, and in its future efforts to roll out the tool across all local authorities in England. Members of the team who developed the PF published a blog in response to the final evaluation report <http://fuseopenscienceblog.blogspot.com/2019/03/are-you-making-most-of-your-public.html>

Combined Lifestyle Intervention (CLI) in the Netherlands



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National Institute for Public Health
and the Environment
Ministry of Health, Welfare and Sport

1. What is it? (Objective)

The main goal of Combined Lifestyle Intervention (CLI) is to initiate and sustain a healthy lifestyle of the population. The intervention includes advice and guidance on forming healthy eating habits, healthy exercise pattern, and how to deal with factors impacting health, such as stress and lack of sleep. The programme is implemented at the national level and lasts two years, it includes one-year treatment programme and one-year programme ensuring the sustainability of results achieved.

People with elevated weight-related health risks are eligible for reimbursement for this intervention. The indicative criteria for this can be found in the Guideline for Obesity by the Dutch College of Practitioners and in the Standard of Care for Obesity. The CLI is reimbursed from the basic health insurance package, which is compulsory to everyone in the Netherlands.

2. What is it for? (Context)

The National Health Care Institute of the Netherlands, together with the Ministry of Health, Welfare and Sport played an important role ensuring that the Combined lifestyle intervention (CLI) is included in the basic healthcare package and covered by insurance.

There was no specific window of opportunity allowing for the service to start. It took more than ten years from the publication of a report on how prevention could fit into the healthcare system by the Dutch Health Care Institute in 2006, to the inclusion of such interventions in basic insurance packages in 2018. Some of the steps taken to turn an idea into a service are as follows:

In 2008, following the report prevention, National Institute for Public Health and the Environment (RIVM) published a report showing the cost-effectiveness of the CLI. Two years later, after reviewing all scientific data and practical findings, the Dutch Healthcare Institute concluded that CLI would be an effective intervention to tackle overweight and obesity, and that it could fit within the basic health-insurance package. In response to that, the Ministry decided to run various pilot projects to find out how the CLI could be implemented in practice.

As part of the preparation, RIVM carried out a budget-impact analysis of the CLI to estimate the required costs. The Dutch Healthcare Authority established a policy, including rates and the conditions for financing the intervention. The RIVM assessed the quality, effectiveness and feasibility of the interventions that were available and in 2018 recognised three of them. In consultation with the

Association of Dutch Healthcare Insurers, the Dutch Healthcare Institute decided which of the interventions that were assessed by the RIVM would be included in the basic health insurance package. The Dutch Healthcare Authority developed a description of costs and performance specifications under the Dutch Healthcare Market Regulation Act, following which health insurers included available interventions in their insurance packages. The RIVM monitors the implementation of the CLI on behalf of the Ministry of Health, Welfare and Sport.

3. How it works?

The RIVM assesses candidate Combines Lifestyle Intervention (CLI) programmes in terms of their quality, effectiveness and feasibility. If programme measurements show that it has an effect on weight loss, physical activity, determinants of behaviour and quality of life, it will be recognised as having *first indications for effectiveness*.

After the assessment, the Dutch Health Care Institute decides which interventions can be covered by the basic healthcare package. Thereafter, healthcare Insurers decide which intervention(s) they include in their insurance package.

Currently there are three programmes accepted for inclusion in the basic insurance package. These have been evaluated in terms of both process and impact. All interventions have at least one pre- and one post-measurement after the treatment phase (year 1) and after the assessment phase (year 2). All interventions show weight loss and improvement when it comes to risk factors such as blood glucose and blood pressure, and improved physical activity levels. All health insurers have included one or more programmes in their health insurance packages.

All three programmes have an intervention owner who provides training to professionals who want to offer the programme in question. This training is mandatory. In addition, all programmes come with a manual, and various materials are available for programme implementation.

Prior to the implementation of a CLI, the professional must:

- Register as a professional qualified to offer the CLI
- Attend a training course on carrying out the relevant programme
- Obtain a license to carry out the intervention
- Conclude a contract with the healthcare insurer
- Collaborate with general practitioners and/or specialists who can refer the patient to them.

The RIVM is developing and conducting a monitoring and evaluation process to determine how efficient and cost-effective the CLI are within the basic insurance package. Data on weight loss and quality of life, and the rate of engagement of participants are among the factors monitored.

The expectation with regard to health-impact equity is that the impact the programme has, will be positive. This is because participants are not required to make a financial contribution, and because there are no costs associated with taking part. However, if the results show that the CLI is not cost-effective, the Ministry can decide to cancel the reimbursement of the intervention from the basic health insurance package.

Because the CLI is reimbursable under the basic insurance package, the government has ensured equitable distribution of the service across different sectors of the population. The basic insurance package is compulsory for every resident, so the programme is available to every adult who meets the

criteria for inclusion in it. Participation in the programme is not deducted from the participant's excess. Participation costs the patient/client literally nothing. The latter, in particular, is a measure that promotes access to good prevention for all residents of the Netherlands. People from low-income groups are more likely to be overweight and diabetic, but they have less money to participate in preventive activities such as the CLI. Inclusion in the basic package means that this offer will be available to a group of people who normally cannot participate.

€ 9 million has been reserved for the implementation of the service on an ongoing basis, starting in 2020. For 2019, € 6.5 million has been set aside. Health insurers reimburse lifestyle coaches and healthcare professionals who offer and carry out the programme.

Social Outcomes Contract for a preventive and healthy workplace in Sweden



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1. What is it? (Objective)

The objective of Social outcome contracting for a preventive and healthy workplace is to reduce short-term sick leave and improve health outcomes, while at the same time reducing overall societal costs. The results of the pre-study indicated that a great number of local authorities have similar trends of short-term sick leave – with a small group of employees accounting for a large proportion of the short-term sick leave. This imposes a high burden for local authorities in terms of costs and ill health of employees.

2. What is it for? (Context)

The proportion of employees on sick leave has been increasing nationally in Sweden and the costs for sick leave benefits have risen from 26.2 BSEK in 2013 to 39.8 BSEK in 2016. This trend is particularly noticeable in regions and municipalities, compared to private employers – thus posing a high burden on employers as they are covering the expenses of short-term sickness (day 1-14). In addition, a rise of indirect costs and negative effects such as ill health, productivity loss and lower quality in public services is also observed. A pre-study conducted in Swedish municipalities, in collaboration between Swedish Association of Local Authorities and Regions (SALAR), Research Institutes of Sweden (RISE), the European Investment Bank and Kommuninvest, found that 20% of employees account for 75% of the costs of short-term sick leave. The identified risk group of employees were found to be absent 3+ occasions during a 12-month period.

The pre-study further indicated that regions and municipalities do not put enough efforts into early identification and intervention in terms of reducing sick leave and improving employee health. Spending on occupational healthcare in municipalities is primarily (80%) targeting rehabilitation. As the results of early interventions tend to be observable years after the investments are made, there is a challenge in finding long-term financing due to annual budget cycles. In addition, the pre-study indicated a lack of systematic processes for early intervention and monitoring of outcomes. A Social Outcomes Contract (SOC) was identified as a valuable tool in terms of providing financing for early interventions and health promoting in workplaces as well as for capacity-building for implementation support and outcomes monitoring.

3. How it works

The project employs a multi-level approach to target both individual and organisational factors impacting occupational health. The health support enables early identification of ill-health and sick leave absence which, in combination with structural interventions (manager support), enables preventive and health promoting actions. Additionally, the interventions aim to generate long-term competence at the human relations department in terms of identification and implementation of preventive actions – thus establishing capacity for prevention in a broader perspective.

The structure of the SOC enables performance management and program improvement as well as collaboration between private and public sector organisations. The service provider is procured and contracted by the local authorities to perform services (health support and identification of risk groups). The public sector has played a big part in implementing the SOC, compared to other countries where SIBs have been adopted. Although the actors involved in a SOC or SIB may vary, the investors often include private actors. In the occupational health SOC in Botkyrka and Örnsköldsvik, the project is solely financed by the local authorities themselves, making it a unique example of a publicly financed SOC. The project organisation, consisting of a new entity formed by state-owned RISE and SALAR, assists with project monitoring, evaluation and support during the implementation process.

The contractual partners in the SOC are the finance and HR departments in the local authorities, as well as the intermediary organisation (RISE and SALAR). The total investments in the SOC of two municipalities are 17,4 MSEK and 22,870 MSEK respectively (€4 million in total) over a three-year period.

A financial instrument referred to as Sustainability Bond with Impact-Linked Return (SBIR) was designed to allow for institutional investors and a large investment volume (€100 million). The SBIR combines a loan (approx. 90%) with a social outcomes contract (approx. 10%) in order to achieve enough investment volume and a suitable risk profile. However, the Swedish local authorities decided to finance the SOC on their own.

During the procurement process of external service providers, various parameters were considered, including proposed risk-share agreements. The service providers were offered to bid on risk appetite - between 25% and 75% of reimbursement to be dependent upon the outcomes of the SOC. The contracted providers bid for 50% and 75% in each municipality. The financial commitments between the investors and service provider is regulated with a pay-for-performance contract based on this financial risk sharing with a potential premium for over-performing which is capped at half the risk level. Thus, there is financial risk sharing between the municipalities and the service providers.

Based on international experience, various case scenarios were outlined, defining the financial outcomes for all parties. All scenarios include a total intervention period of 36 months and a 9-month ramp-up to full intervention effect. Aiming for the low case scenario (12%) average reduction in net sick leave days will result in a break-even point. The expected base case scenario is on average 18% reduction, and the best case is 34% reduction of net short-term sick leave days. The estimated likelihood for achieving at least base case is 80%.

The share of repayment is dependent upon the financial risk of the service providers, but the cash flow also depends on the estimated cost for the service delivery per employee, the number of employees at the baseline measurement and the outcomes achieved. Evaluation is done by calculating the trend adjusted change of net sick leave days compared to the historic baseline. Reductions beyond break-even will result in repayments to the local authorities (66,25% and 81,6%) and to the service providers

(33,75% and 18,4%). The cap on payments to the providers means that reductions above 150% of the investment value will go solely to the local authorities.

Performance management is ensured through regular monitoring by the project organisation. There is a quarterly review of process and outcomes which gathers all stakeholders to assess progress and discuss adjustments. The final evaluation of the project outcomes will be conducted by an external auditor at the end of the project (36 months).

The main outcome measurement used for financial evaluation is the direct costs for reduction in net short-term sick leave days (day 1-14), adjusted for national trends in sick leave. The average reduction during the intervention period will be compared to a baseline of historic data from the municipality. To be able to evaluate the impacts of the interventions on employee health, studied outcomes also include Sustainability Employee Engagement and work capacity. Other outcomes measured and used for comparing with the trends of short-term sick leave are: long term sick leave (day 15+), purchasing of occupational health care services (in addition to intervention), size of risk group, “healthy workplaces” with low numbers of short-term sick leave and productivity loss due to presenteeism. Additionally, a thorough analysis of the risk group is conducted, monitoring parameters such as age and gender distribution.

The knowledge and capacity attained during the implementation process of the first two cases targeting occupational health can be used to transfer the programme to other municipalities in Sweden. Manuals guiding the implementation process have been developed, which could be applicable in future cases. Several other local authorities have shown interest in the interventions and the project organisation is currently planning an additional pre-study in Stockholm City.

The Activate program, Canada



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1. What is it? (Objective)

Activate was designed to prevent the onset of high blood pressure among older adults. Hypertension is the number one risk for stroke and leading risk factor for heart disease. Without intervention, half of all pre-hypertensive people over 60 in Canada will develop hypertension within 4 years. Heart disease & stroke are leading causes of death, taking the lives of more than 66,000 Canadians every year. This program is an opportunity to assess the impact of preventative health measures on hypertension. The target for success was set by cardiologists at no increase in blood pressure readings, but an overall decrease is even more desirable.

Funding for Activate comes from a pay-for-success (PFS) model or social impact bond (SIB). Working closely with the MaRS Centre for Impact Investing, Heart & Stroke has attracted philanthropically minded private investors to provide upfront capital. The federal government, through the Public Health Agency of Canada, repays the investors based on successful outcomes. This is only the second time in Canada that this funding model has been used, and the first time for a large-scale chronic disease prevention initiative.

2. What is it for? (Context)

The Heart & Stroke Foundation is responsible for organizing and implementing the Activate program to participants, who are members of the general public that are pre-hypertensive, not diabetic, not on blood pressure medication, and at least the age of 40. For the final phase of the 3-year initiative, the Activate program also accepted those who were not diabetic within a blood pressure range.

3. How it works?

Key stakeholders in the Heart & Stroke Activate program are: the Heart & Stroke Foundation of Canada (PHAC), Public Health Agency of Canada, The Social Research and Demonstration Corporation (SRDC), MaRS Centre for Impact Investing and Investors.

The Activate program was developed in collaboration between the Heart & Stroke Foundation of Canada and MaRS Centre for Impact Investing. The Heart & Stroke Foundation is responsible for the overall development and execution under the advisory of MaRS Centre for Impact Investing. The SRDC serves as a third-party data validator and external evaluator of key program metrics.

The program is implemented in collaboration with external partners such as NexJ Health, Loblaw Companies Limited (Shoppers Drug Mart and Loblaws), YMCA-YWCA Associations across Canada, and the University of Ottawa Heart Institute.

- NexJ Health manages the digital health platform that participants use.
- University of Ottawa Heart Institute also provided the health coaching protocol for participants in the Activate program, which they deliver in partnership with NexJ Health.
- Shoppers Drug Mart, Loblaw's, and YMCA-YWCA locations are being leveraged as public recruitment locations.
- Shoppers Drug Mart, Loblaw, and YMCA-YWCA also provide key services for participants in the program including operational and program support.
- Participating YMCA-YWCA locations have provided free 2-month memberships to all Activate participants and co-developed in-person community days.
- Participating Loblaw's locations have also provided free workshops with in-store Registered Dietitians, which are also open to the public.

The program is financed through a social impact bond (SIB) that follows a pay-for-success framework. In other words, investors make payments to the Heart & Stroke Foundation of Canada to execute and run the Activate program. Depending on outcomes of the program, primarily volume of participants and overall change in blood pressure, the Heart & Stroke Foundation receives payments from the Public Health Agency of Canada, which are then paid out to investors. The investors get paid after the recruitment phase of each Cohort based on volume, as well as a final payment based on blood pressure reading. We won't be certain of the exact proportion until after the program as it based on the overall outcomes for blood pressure and volume.

While the funds come from the federal government, the outcome payments were not negotiated to come out of an existing fund for services (e.g., hospitals). The federal government stepped in and drove it forward through their innovation agenda. They saw the value in the scalability and opportunity for impact. In Canada, the large portion of the health spending is provincial while preventative funding comes from the federal level.

The Activate program has primarily 3 mechanisms that assure the quality of delivery of the program:

1. The Activate program is tied to the outcomes of the social impact bond.
 - The program has volume targets, which is the number of participants enrolled in the program over the course of 3 years as well as blood pressure change targets.
 - The volume target is enrolment of 7,000 pre-hypertensive adults in Canada.
 - The BP target is to halt the increase in blood pressure between the time of intake and follow-up after 6 months of being in the program.
 - The outcome payments are based on the achievement of these targets. If targets are achieved, then the investors' rate of return will depend on the degree of change in the average blood pressure of participants.
2. The Activate program is also overseen by a project board made up of key stakeholders in the program. The project board receives weekly e-mails from the Activate team and bi-monthly meetings are conducted to ensure that the milestones are being met and the project is on track.
3. Finally, target-related data collected through the Activate program is evaluated and validated by SRDC, a third party. Every year, SRDC validates both the volume and blood pressure outcomes of the program before the outcome payments are issued.

Currently, the Activate program has completed evaluation for the first year of the program and has exceeded both volume and blood pressure targets. In the first year of the program, 527 hypertensive adults were enrolled into the Activate program and qualified for the outcome payment, exceeding the volume target of 500. The average change in blood pressure was -5 mmHg systolic, exceeding the target of a flattened blood pressure trajectory over the course of 6 months. The program is scheduled to be completed at the end of 2020, after the third and final cohort of participants.

Finansol, France



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1. What is it? (Objective)

Solidarity-based finance is a concept that satisfies the solidarity desires of the individual savers and the financing needs of the solidarity-based enterprises, non-profits, and other beneficiary organizations with a social and/or environmental impact. Ethical banks, solidarity -based investment funds and others act as intermediaries between these savers, by proposing traditional investment vehicles – savings and life insurance accounts, investment funds, - to which solidarity mechanisms have been incorporated.

Launched in 1995, Finansol is an association that brings together financial institutions engaged in the promotion and/or management of solidarity financing vehicles and tools (banks, insurance companies and asset managers) and a variety of solidarity-based enterprises, associations, cooperatives, investment clubs and others whose missions and activities are directly linked to addressing a social and/or environmental challenge.

The Finansol label regulations are based on three main criteria:

1. The product's solidarity nature, which ensures the solidarity aspect of the product (all or part of the savings collected finance activity and/or solidarity projects).
2. A transparency and information criteria, ensuring that the investor is giving information on the financial and solidarity characteristics of the investment at the time of subscribing, and regular information is provided after the subscription.
3. A commercial action criterion, to ensure that the circulation of labelled products does not remain hidden.

The Finansol label has three main objectives:

1. To offer a guarantee of confidence to the savers and investors from an external third-party;
2. To distinguish a solidarity-based investment from other savings products;
3. To benefit from the association's collective support.

2. What is it for? (Context)

In 1997, the Finansol label was introduced in order to identify the various solidarity-based financing vehicles available in France through intermediaries, such as those offered by banks, investment funds, insurance companies, mutual funds and employee savings accounts, to name a few. Largely based on transparency and solidarity criteria, as well as various management aspects, the label provides security for solidarity-oriented investors that the assets they place through intermediaries will indeed serve to

finance projects with strong social and/or environmental impact. In 2018, the Finansol label was awarded to more than 160 recipients.

The label was created two years after the creation of the Finansol association, a group of solidarity-based finance players in France. A truly excellent promotional tool, its image is inseparable from the one of the association, which has always positioned itself at the heart of its historic mission: to promote the principle of solidarity in savings and finance. The Finansol label was launched in May 1997.

Finansol can trace its origins back to 1983 when the first solidarity-based mutual fund, Faim et Développement (Hunger and Development) was launched by a cooperative bank on behalf of a Christian NGO. The aim was to provide access to credit for small businesses in developing countries that were excluded from traditional banking systems. During the same year, and inspired by the booming stock market and the success of traditional investment clubs, groups of private investors seeking alternative ways of managing local community savings accounts convened to form the CIGALES clubs.

At the time, it was difficult to make the initiatives known to the general public. Some savers even harboured a degree of mistrust towards these investments, linked to the fact that the concept of savings and solidarity, and finance and solidarity seemed to them to be an oxymoron. Designed for and awarded only to solidarity-based investments, the label was created on the one hand to reassure and comfort savers in their choice of solidarity-based investments, and on the other hand to raise the profile of these ‘solidarity-labelled’ investments, through complementary initiatives implemented by the association (e.g. ‘baromètre de la finance solidaire’, an annual overview of solidarity-based initiatives, ‘Semaine de la finance solidaire’, a week promoting solidarity-based finance, raising awareness among the general public and the public decision-makers, etc.).

During the years, several legislations have emerged to create a better environment for solidarity-based saving. For instance, in 2001 and in 2008, public authorities passed regulations requiring companies to propose at least one solidarity fund among their employee saving schemes, creating the funds called “90-10 funds” because they are characterized by the obligation to invest between 5 and 10 % of the fund’s assets in social companies.

Consequence of this environment but also of the dynamism and innovative capacity of the solidarity-based finance actors, and since its beginning, solidarity-based funds haven’t stopped to grow. End of 2017, it represents more than 2.4 millions of solidarity-based savings products subscribed by private individual investors and institutional investors with 11,5 B€ solidarity-based savings of total assets.

3. How it works?

Solidarity-based finance and SRI (socially responsible investing) are all too often confused and incorrectly used interchangeably, despite being very distinct concepts. SRI is a method of selecting listed or unlisted companies in which to invest, based on a combination of their financial performance and the manner in which they address social and environmental performances. Solidarity-based finance is a more active means of identifying investment opportunities in small or medium-sized unlisted companies that were established with the specific mission of addressing a persistent social and/or environmental challenge.

In practical terms, a solidarity savings product is a “classical” saving product with at least one process of solidarity saving mechanisms: social investment and sharing products. A sharing product is a saving product which part of – or all of - the interest earned is donated to an NGO or association partnering with the saving product. These products are usually sold by banks to retail customers. This form of donation, through savings, is sought by associations because it grants them a perennial resource and enables to support their beneficiaries in the long run.

But solidarity finance is primarily a social investment. If a return on investment is possible, it's not the primary objective (achieving a social impact). Money deposited into a solidarity saving product is used to finance activities that have high social or environmental benefits, via debt or equity investments. These solidarity investments are generally made directly by the organization that has collected the solidarity savings - most often a financial institution – to the final beneficiary (a company or an association that generates high social or environmental benefits). Other investments are realized through intermediaries, the solidarity investors, which are experts in financing activities with important social benefits. They support these activities by providing long-term financial support in addition to technical support, particularly for companies that are in a launching process. Some of these investors raise money directly from the savers themselves. Lastly, the investment might be executed directly by the savers themselves, who purchase shares of a social enterprise.

By 2017, the solidarity finance had resulted in total assets under management of €11.5bn, divided into 4 investment vehicles. The saving accounts, distributed by banks and insurance companies, represent €2,2bn, and allow two investment possibilities: the funds can be used to invest directly in social enterprises; or 25 to a 100% of the annual interest payment from the fund can be donated to an NGO or association. The solidarity funds are distributed by banks, funds and corporate employee saving schemes, and represent €8,6bn. This investment vehicle works through mutual funds, where 90 to 95% of the portfolio is invested in stocks and bonds of listed companies, and 5 to 10% in social companies.

The direct investments, representing €548m, consist in the purchase of shares or bonds offered by a social enterprise: individuals can invest directly in social enterprises; in order to assist them in their growth and development. According to European rules, those engaging in this type of activity are entitled to a reduction in income tax. Finally, solidarity finance is divided into life insurance, channelled through banks, insurance companies and mutual societies. It represents €188m and takes the form of life-insurance policies (in euros and/or unit-linked).

Reconnections – Impact Bond, England



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1. What is it? (Objective)

Reconnections is a personalised service that aims to reduce loneliness and social isolation in Worcestershire. There are up to 35,000 older people may experience loneliness and around 11,000 of those may suffer from chronic loneliness within Worcestershire. Commissioners from the health system, local authority adult social care and Public Health came together in 2014 and agreed that the relationship between loneliness, health and service use provided a rationale for expanding services to address loneliness.

Beginning delivery in August 2015, it is the world's first Social Impact Bond to tackle loneliness. Funded through a 'Social Impact Bond' contract – socially motivated investors fund the service up front and the health service and local government only pay if and when the outcome of reduced loneliness is achieved. This outcomes-based contract and the availability of flexible investment has stimulated and enabled significant service adaptation.

2. What is it for? (Context)

Reconnections is the UK's leading services providing personalised support to older people to overcome chronic loneliness. It is a service that takes a very tailored approach, with a volunteer or case worker supporting the person over 6-9 months to re-engage with interests and social relationships of their choice and overcome practical and emotional barriers. Since its launch in 2015, over 1,300 older people have been supported. On average, self-reported loneliness is significantly lower at 9 months and 18 months after entering the service; people report an average reduction of -1.4pts at 9 months and -0.9pts at 18 months on the UCLA 4 questions loneliness scale (compared to an expected -0.8pts reduction). Early evaluations by the London School of Economics are also positive and the service has been held up as an exemplar by national policy makers on loneliness.

The rationale for establishing the Reconnections service is to combat the growing health concerns of loneliness in older age. Loneliness is increasingly being shown to have significant impacts on health, wellbeing and communities. A meta-analysis in 2015 found that those who were identified as chronically lonely had a considerably higher risk of mortality. To reduce pressure on overall health and social care budgets, commissioners have been focussing on reducing the growth in non-elective admissions. There is a strong hypothesis that reducing loneliness will achieve such an impact in the short and long term.

3. How it works?

As a new intervention, commissioners were keen to transfer some of the delivery risks in developing the programme, and keen to stimulate innovation and adaptation. Consequently, they were attracted by a Social Impact Bond mechanism, under which investors fund the service up front and commissioners only pay if outcomes are achieved. They considered that this would share financial risk and introduce greater rigour in delivery. Central government provided some of the outcomes funding in recognition of the innovation. The share of outcome payments for commissioners reflected the likely benefits to different commissioners – for example, health commissioners making a greater proportion of the payments 18 months after starting the service once some health savings are predicted to have accrued.

The service and investment model was developed by a social investment intermediary, Social Finance, and a local older people's charity – Age UK Herefordshire and Worcestershire. Having reviewed international evidence and local experience, they concluded that a personalised approach to addressing loneliness would be most effective; responding to older people's particular interests and barriers to reconnecting with others rather than putting on general activities.

Social Finance brought together a small number of investors to cover the up-front costs, led by NESTA Impact Investments (the investment arm of NESTA, national charity focused on promoting innovation) with capital worth £650,000 (c.EU750,000). This reflected NESTA's strategic interest in innovation to address the needs of an ageing population. As seeking to address loneliness at scale required service development and innovation, Social Finance also raised c.£400,000 (c.EU460,000) of grant funding in order to help cover initial service design, mobilisation and evaluation and learning. This was raised from a combination of the Calouste Gulbenkian Foundation, who have been a strategic funder of approaches to understand and address loneliness, and a NESTA led grant fund.

Reconnections is financed using a Social Impact Bond and is the first service in the world using this financial mechanism to tackle loneliness. Social Impact Bonds are outcome-based contracts and involve a socially-motivated investor providing up-front funding for a service that will have a positive social impact. This social impact often aligns with a similarly positive financial impact for commissioners.

In the case of Reconnections, the social impact being sought is a reduction in loneliness. Investors receive outcome payments for each aggregate reduction in self-reported loneliness using the UCLA self-reported loneliness question (a 12-point scale). The payment metrics are:

- £740 (c.EU850) per point reduction after 9 months after service start
- £240 per (c.EU275) (sustained) point reduction 18 months after service start.

These outcome 'tariffs' were set due to growing evidence on the relationship between loneliness and poor physical and mental health, and consequent healthcare and social care usage. A London School of Economics interim evaluation found that reducing loneliness in people who feel lonely most of the time could potentially save up to £6,000 per person in costs to the system over 10 years. The tariff takes into account that this £6,000 would involve a multiple point reduction and needs to be discounted for impact over ten years and likely reduction in impact over time. The initial modelling suggests a correlation with lower A&E attendances and GP appointments in the short term and potential longer-term reductions as a consequence of reduced risks of dementia, depression and health conditions associated with low mobility (e.g. stroke). Particularly of relevance to the council was the impact of reducing loneliness on possibly delaying/reducing the need for social care in elderly patients.

The service costs approximately £330,000 (EU380,000) each year to support up to 430 older people a year (c. £750-800 per participant). At the start of the service, investors provided £650,000 in up-front

capital - £565,000 as debt and £85,000 as equity. In the first two years of running the service was loss making – however, as impact has grown, and 18 months payments have increased, the service is now making a small surplus.

Reconnections is led by a project manager, currently supported by a programme director, who has project oversight and is responsible for team management. They are also responsible for most of the marketing and local partnership building. Employed by the delivery partners, caseworkers oversee a specific geographical patch. Caseworkers are responsible for client assessments and personal planning with clients. They will also have sole responsibility for a small number of clients who cannot receive volunteer support due to their being too complex or living in a remote area. This is a change to the original model which was more volunteer heavy and was a response to clients having more complex needs than initially anticipated. Many of these caseworkers have a history of working as assessors, or support workers, and therefore are capable of dealing with often quite difficult conversations.

Employed by the central team, the volunteer co-ordinator is responsible for matching clients to volunteers and building a peer support network between the volunteers. Given the flexibility and responsiveness of the service to client needs and wishes, there is ample support available for volunteers to ensure they are equipped to do their role well and have a sounding board. The Reconnections service is heavily reliant on volunteers who are matched with clients and who support them to reconnect with society. As mentioned, volunteers are supported by the central team and are not placed with the more complex patients referred to the service.

Koto-SIB fast track training and employment programme for immigrants in Finland



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Highlights from the case study:

- A three-year pilot Koto-SIB for the employment of immigrants kicked off in 2015, as a response of the Finnish government to unprecedented global displacement crisis that hit its peak in 2015.
- Intervention process is a match making service between an immigrant and labour market. The personalised search for organisations which are in need of employees starts with looking into sectors like logistics, cleaning, IT and entrepreneurship and ends with ensuring that the commitment from both, immigrant and the workplace is achieved.
- The intervention period is three years (2017-2019) followed by another three years of follow-up period. The expected return on investments is between 5% and 8%. In practical terms, private investors bear almost all the financial risk, since the government pays to the fund only a very low compensation based on implemented legal services and the major part of bonus is based on outcomes.
- In the Finnish SIB structure, the Project/Fund Manager is not only in charge of establishing the Fund (Limited partnership) and raise the capital to the fund, but also to choose the best possible service providers and coordinate everyday operation in practice.
- From the Government point of view the overall and sustainable success is measured by two indicators: decreased labour market benefits paid to unemployed and increased amount of paid income taxes. Those two indicators are showing the level of employment, which is seen as a strong factor in terms of integration and quality of life.

The Sugar Sweetened Drinks Tax (SSDT)



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Highlights from the case study:

- The SSDT is one of a number of measures being implemented under Ireland's obesity policy and action plan "A Healthy Weight for Ireland – Obesity Policy and Action Plan 2016-2025" to reduce levels of obesity
- It was initially applied to water and juice-based drinks which have added sugar and a total sugar content of five grams or more per 100 ml
- The scope of the tax has since been extended with effect from 1 January 2019 to include certain plant protein drinks and drinks containing milk fats
- Drinks with an added sugar content above 5g and below 8g per 100ml are taxed at 16 cent per litre (20 cent including VAT). Drinks with more than 8g of added sugar per 100ml are taxed at 24 cent per litre (30 cent including VAT)
- It is anticipated that the introduction of a SSDT will result in reduced consumption by incentivising individuals to opt for healthier drinks, as well as encouraging the soft drinks industry to reformulate products.
- The funds generated through this are allocated to general funds as hypothecation (the dedication of a specific tax for a particular expenditure purpose) is not a feature of the Irish tax system.

Maternal and child health promotion in Portugal



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FUNDAÇÃO
Nossa Senhora
do Bom Sucesso

Highlights from the case study:

- Established in 1951, the Nossa Senhora do Bom Sucesso Foundation (FNSBS) specialises in health education, health promotion and disease prevention in women and children.
- Their services are open to everyone despite their social status. Families who cannot afford access to services, after socioeconomic evaluation by a social worker, receive discounts according to their income level or receive services without charge.
- Besides the Foundation's revenues from services, it is financed through citizens donations and private Portuguese entities:
 - Citizens: in Portugal, people can allocate a part of their VAT and Income Tax to an institution they choose when delivering the Annual Income Declaration.
 - Private entities: Portuguese government offers tax benefits to private entities for donations to not-for-profit institution operating in the social sector. Acting in accordance with their social responsibility commitment, they invest in building healthier and more sustainable society.
- FNSBS have created two additional and complementary ways to encourage private-sector mobilisation:
 - a prepaid Visa debit card, that gives access to Foundation's services with discounts. It's not a personalised card hence it can be used by both its carrier and others (e.g., as a gift-card);
 - FNSBS accepts Ticket Care as a payment method. Ticket Care is a card used by private companies to offer specific health services to their employees that is accepted as payment method in a limited number of healthcare facilities.

A Healthy Overvecht neighbourhood: An integrated social and medical approach



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Highlights from the case study:

- Robust basic social and medical care oriented towards prevention entails an integrated approach for residents with elevated health risks and problems in several areas. It focusses proactively on the 15 - 20% of those in the population who have elevated health risks and/or high healthcare costs.
- The 4-Domain model has been designed by general practitioners based on their experience and further developed in consultation with professionals from other disciplines. This model is used for communication and analysis by professionals in the medical and social fields. The model enables GPs to work together with a patient and allows them to understand what is going on in different areas of their life and how this influences patients' perception of their health. The model is also used as a tool for a common language for cooperating, for assessing risks, and for approaching problems together with the client.
- Good ICT and good data management support the general practitioner's practice and the neighbourhood. The dashboard in the general practitioner's information system makes it possible to identify who has high health risks, and who is vulnerable. Professionals can see what the patient's particularities are and who is involved in their healthcare. In addition, patients can use a digital platform to communicate with healthcare providers, make appointments and find health information.
- Healthcare professionals have direct lines of communication with social workers and exercise coaches, which makes this is well-being by prescription. Patients can make an appointment with social workers to find an activity in the neighbourhood that suits them.

Appropriations for Health Promotion in Finland



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NATIONAL INSTITUTE
FOR HEALTH AND WELFARE
FINLAND

Highlights from the case study:

- Government of Finland distributes aid for health promoting projects yearly. The initiative is funded by the Ministry of Social Affairs and Health.
- Projects are complex and mainly focus on development and research.
- The themes for projects vary yearly and are demand driven. They are e.g. preventing alcohol and drug abuse, promoting healthy nutrition, physical exercise, mental health, sexual health, ensuring safety and injury prevention, and developing structures of health promotion in municipalities and regions.
- Projects are requested to establish cooperation and ensure quality, to develop structures and methods of health promotion and should try to narrow health inequalities between population groups.

Annex 2: Glossary of finance instruments relevant to improving health and wellbeing

PAYMENT BY RESULTS

Payment by results is the practice of paying providers for delivering services after agreed results have been achieved. The advantage for a service commissioner of this model is that public money is only spent when the results are achieved, so money isn't spent on unproductive services. However, payment by results schemes have proven to be complex and costly to set up, and often mean providers taking a very high level of risk. Voluntary sector providers, particularly smaller organisations, usually need start-up and revenue funding to enable them to deliver a service. In payment by results contracts, this funding can be provided by a prime contractor or by a social investor in the form of a loan or a social impact bond.

MODELS OF PAYMENT BY RESULTS

Payment by Results comprises an assortment of different models, including:

Binary model: The provider must achieve an absolute target. The model is binary in the sense that there is an absolute yes/no distinction as to whether they receive payment; payment is not graded for achieving lesser results. An example is the Work Programme where service users needed to return to work for a fixed period or no result is funded.

Frequency scheme: As opposed to the binary model, rewards are staggered along agreed frequency of results, with payments increasing as results increase. This was the model used in Ministry of Justice pilots to address reconviction numbers.

Hybrid grant and payment by results model: This is a mixed model where the cost of delivering a service is funded, but additional payments are rewarded as bonuses if additional impacts are demonstrated at the end of a programme.

SOLIDARITY-BASED FINANCE AND SRI (SOCIALY RESPONSIBLE INVESTING)

Solidarity-based finance and SRI (socially responsible investing) are all too often confused and incorrectly used interchangeably, despite being very distinct concepts. SRI is a method of selecting listed or unlisted companies in which to invest, based on a combination of their financial performance and the manner in which they address social and environmental performances. Solidarity-based finance is a more active means of identifying investment opportunities in small or medium-sized unlisted companies that were established with the specific mission of addressing a persistent social and/or environmental challenge.

BONDS

Social Impact Bonds (SIB) are a form of outcomes-based contracts between the public and private sector. The former agrees to pay for substantial improvement in social outcomes for a specific population, which will reduce the public sector's costs in the long run. The private sector initially pays for intervention, which is delivered by service providers with a proven track record. The private sector will only be repaid if a significant social impact is achieved. Social Impact bonds are designed to overcome the challenges governments have in investing in prevention and early intervention. They

mitigate the risks of failure and bring in impact investors, who want to test innovation and scale successful programmes. Investors provide flexible funding to programmes that are designed to be responsive to the needs of vulnerable groups to improve their lives.

Charities and social enterprises can issue bonds (*Charitable Bonds*) as a form of long-term debt to expand business operations. An organisation may be able to issue bonds if it has a viable underlying source of revenue with which to repay the bond holders (e.g. an organisation which operates a chain of charity shops). In some cases, investors may also receive the repayment in non-monetary terms, such as the goods and services provided by the enterprise. In addition, tax relief for investors may be granted by central governments. For example, this allows investors to reduce their tax bills by 5 per cent a year for five years.

LOANS

This is a traditional form of finance that involves a sum of money which is borrowed and has to be paid back, usually with interest. A Secured loan is one that is protected (for the issuer – collateralised) against a tangible asset e.g. building, equipment and land. The borrower will pledge a tangible asset such as a building or equipment to receive a loan. In the event of a default, the lender can take possession of the asset which can then be sold to recoup the loan. Loans can involve a Standby facility which is a commitment by a lender to advance a specified amount of funds for a period of time (i.e. a line of credit) for a particular project, which may be drawn down only if budgeted income does not materialise.

COMMUNITY INVESTMENT

Community investment works by selling a share in an enterprise to people in the community. Members of a community benefit society can become community shareholders and invest in local enterprises providing goods and services that meet local needs. Members expect a modest return on their investment. The return payable is based on the principle that interest should be no more than is sufficient to attract and retain the investment. Members invest on the understanding they will be rewarded primarily through a social dividend rather than a monetary dividend.

This long-term alignment of the interests of owners, investors and customers is at the heart of the community enterprise movement: the community purpose of the enterprise is the primary motive for investment. The central task of all community shares initiatives is to build membership. Community investment works by selling a share in an enterprise to people in the community, who become members of the enterprise.

EQUITY INVESTMENT

This means investment through the purchase of share capital. If a civil society organisation's legal structure allows it (i.e. a company limited by shares), it can sell its shares to individuals or institutions. The funds can then be used for start-up, growth or working capital.

A company limited by shares is able to sell some or all of its shares to investors. However, this may dilute ownership and control of the company as shareholders may be able to make their demands on the management team to change operational strategy. Investors will also expect dividends, so not all funds will be re-invested in to the company.

QUASI-EQUITY/REVENUE PARTICIPATION

Quasi-equity, also known as revenue participation investment, is usually structured as investments where the financial return is calculated as a percentage of the investee's future revenue streams and bridges between debt and equity and aims to reflect some of the characteristics of both.

A quasi-equity investment can be a useful source of finance when debt financing is inappropriate or too onerous for charities or social enterprises, or where share capital may not be possible due to the investee's legal structure. Unlike a loan, this investment is dependent on the financial performance of the organisation. If future expected financial performance is not achieved, a lower or possibly zero financial return is paid to the investor. Conversely, if performance is better than expected, then a higher financial return may be payable. A quasi-equity investment may be structured so that its return is capped (e.g. revenue participation payments cannot exceed double to the original investment size), or be limited in duration (e.g. the right to revenue participation is extinguished after a specified period of time).

CROWDFUNDING

Crowdfunding is a way of raising money to finance projects, 'start-up' businesses, or charitable events. It enables fundraisers to collect money from a large number of people via online platforms. The platforms must be managed and administered to ensure money raised goes to the intended parties. However, some platforms will ask for a percentage fee to manage the crowdfunding operations but this can be on an all or nothing basis (this means if you do not meet your target, you do not pay their fee and all money is returned).

Crowdfunding is most often used as a way of accessing alternative funds. It is an innovative way of sourcing funding for new projects and can be a way of cultivating a community that is based around the new project – e.g. a social concern or issue. The most types of crowdfunding include:

Peer-to-peer lending: The crowd lends money to a company with the understanding that the money will be repaid with interest. It is very similar to traditional borrowing from a bank, except that you borrow from lots of investors.

Equity crowdfunding: Sale of a stake in a business to a number of investors in return for investment. The idea is similar to how common stock is bought or sold on a stock exchange, or to a venture capital.

Rewards-based crowdfunding: Individuals donate to a project or business with expectations of receiving in return a non-financial reward, such as goods or services, at a later stage in exchange of their contribution.

Donation-based crowdfunding: Individuals donate small amounts to meet the larger funding aim of a specific charitable project while receiving no financial or material return.

Profit-sharing / revenue-sharing: Businesses can share future profits or revenues with the crowd in return for funding now.

Annex 3: Health and wellbeing quality criteria and investment framework for investors^{CX}

Criterion	Definition	Sub-Criteria	Assessment Factors (indicators)
Security	Guarantee of reliability of funding and/or any extra support funder agrees	Ethical Agreement between all parties	<p>Proponent demonstrates a consistent track record and relevant experience and expertise in similar or relevant circumstances as described in the proposed project/programme</p> <p>Proposed financial structure (funding amount, financial instrument, tenor and term) is adequate and reasonable in order to achieve the proposal's objectives, including addressing existing bottlenecks and/or barriers.</p> <p>Demonstration that the programme/project will help to 'crowd in' private and other public investment</p> <p>Agree and sign ethical agreement that will include intellectual property rights guarantee, transparency guidelines, standards of behaviour for all parties during funding period, and complaints procedures</p>
Risk	Economic and, if appropriate, financial reliability of the programme/project	<p>Stakeholder consultation and engagement</p> <p>Agree accountability system, accounting measures, and governance structure</p>	<p>Proposal has been developed in consultation with civil society groups and other relevant stakeholders, with particular attention being paid to gender equality, and provides a specific mechanism for their future engagement in accordance with environmental and social safeguards</p> <p>The proposal places decision-making responsibility with implementing institutions and uses acceptable systems to ensure accountability. Governance agreement approved and signed by all parties.</p>

Return on investment	<p>Expected financial rate of return</p> <p>Agreed rate of return mechanism and indicator with investing parties</p> <p>Wider benefits and priorities of funded programme or intervention</p>	<p>Expected positive social and health impacts, including in other result areas, and/or in line with the priorities set at the national, local or sectoral levels</p> <p>Equity impacts aligned with health promoting services goals</p> <p>Expected positive economic impacts in line with the priorities set at the national, local or sectoral level</p>	<p>Potential for externalities in the form of expected improvements, for women and men as relevant, in areas such as health and safety, access to education, improved regulation and/or cultural preservation</p> <p>The relevant dimensions of equity are adequately and actively considered throughout the process of implementing the practice (e.g. age, gender, socioeconomic status, ethnicity, rural-urban area, vulnerable groups)</p> <p>Economic and financial rate of return with and without the investor support (i.e. hurdle rate of return or other appropriate/relevant thresholds)</p> <p>Potential for externalities in the form of expected improvements in areas such as expanded and enhanced job markets, job creation and poverty alleviation for women and men, increased and/or expanded involvement of local industries; increased collaboration between industry and academia; growth of additional private funds</p>
Sustainability	<p>Continued application of funded programme or intervention.</p>	<p>Sustainability of outcomes and results beyond completion of the intervention</p> <p>The programme or intervention has institutional support, an organizational and technological structure and stable human resources</p> <p>Potential for strengthened</p>	<p>Arrangements that provide for long-term and financially sustainable continuation of relevant outcomes and key relevant activities derived from the project/programme beyond the completion of the intervention</p> <p>Extent to which the project/programme creates new markets and business activities at the local, national or international levels</p> <p>Description of financial reliability in the long term (beyond the investor's intervention)</p>

		<p>regulatory frameworks and policies to drive investment</p> <p>Financial viability in the long run</p>	
Transferability	<p>The extent to which the implementation results are systematized and documented, making it possible to transfer it to other contexts, settings, countries or to scale it up to a broader target population or geographic context.</p>	<p>Potential for expanding the scale and impact of the proposed programme or project</p> <p>Develop a communication strategy</p> <p>Potential for exporting key structural elements of the proposed programme or project elsewhere within the same sector as well as to other sectors, regions or countries</p> <p>Potential to encourage and/or leverage investment</p>	<p>A theory of change for scaling up the scope and impact of the intended project/programme without equally increasing the total costs of implementation</p> <p>Plan to disseminate the results to be developed and conducted independently by intervention organisation</p> <p>A theory of change for replication of the proposed activities in the project/programme in other sectors, institutions, geographical areas or regions, communities or countries</p> <p>Potential to encourage private- and public-sector investment, assessed in the context of performance on best practices</p>

Annex 4: Resources and links to EU investment funds, investment banks and programmes

PUBLIC INVESTMENT BANKS

European Investment Bank
<https://www.eib.org/en/efsi/index.htm>

Council of Europe Development Bank
<https://coebank.org/en/>

The European Bank for Reconstruction and Development (EBRD)
<https://www.ebrd.com/home>

International Investment Bank <https://iib.int/en>

French Public Investment Bank (BPI)
<https://www.bpifrance.com/>

PUBLIC INVESTMENT FUNDS

European Investment Fund
<https://www.eif.org/index.htm>

European Structural and Investment Funds
<https://www.fi-compass.eu/esif/european-structural-and-investment-funds-esif>

European Development Fund
https://ec.europa.eu/info/about-european-commission/eu-budget/documents/european-development-fund-0_en

European Investment Project Portal (EIPP) - The EU Matchmaking Portal
<https://ec.europa.eu/eipp/desktop/en/index.html?2nd-language=en>

PROGRAMMES

InvestEU programme
https://ec.europa.eu/commission/priorities/jobs-growth-and-investment/investment-plan-europe-juncker-plan/whats-next-investeu-programme-2021-2027_en

Overview of EU funding programmes
https://ec.europa.eu/info/funding-tenders/funding-opportunities/funding-programmes/overview-funding-programmes_en

MISCELLANEOUS

European Association of Long Term Investors
<https://www.eltia.eu/>

KnowHow - Knowledge and e-learning for charities, social enterprises and community groups
<https://knowhow.ncvo.org.uk/>

Health Impact Bonds (Health Movement)
<http://healthmovement.eu/service/health-impact-bonds/>

Government Outcomes Lab
<https://golab.bsg.ox.ac.uk/>

GreenFin ethical finance label (France)
<https://www.novethic.com/greenfin-label-green-finance.html>

Social Finance - Impact Bond Database
<https://sibdatabase.socialfinance.org.uk/>

81 Largest Sovereign Wealth Funds
<https://www.swfinstitute.org/fund-rankings/sovereign-wealth-fund>

Annex 5: InvestEU – Draft Investment Guidelines

The InvestEU Programme builds on the Investment Plan for Europe. During the next EU budget period 2021-2027, it will bring together the European Fund for Strategic Investments and 13 EU financial instruments currently available. The Programme aims to give an additional boost to investment, innovation, and job creation in Europe. The suggested benefits of InvestEU are simplified and streamlined investment support and a single set of rules and procedures with one point of contact for advice. The intended outcome is that InvestEU will make EU funding simpler to access and more effective.

InvestEU consists of the InvestEU Fund, the InvestEU Advisory Hub, and the InvestEU Portal. It will mobilise public and private investment through an EU budget guarantee of €38 billion that will back the investment projects of financial partners such as the European Investment Bank (EIB) Group and others, and increase their risk-bearing capacity. The financial partners are expected to contribute at least €9.5 billion in risk-bearing capacity. The guarantee will be provisioned at 40%, meaning that €15.2 billion of the EU budget is set aside in case calls are made on the guarantee. Moreover, the initiative offers member states the possibility to channel up to 5% of Cohesion funds by policy area to the EU guarantee.

The InvestEU Fund will be a market-based and demand-driven instrument. However, it will also be policy-focused. Investments will come under four policy areas which represent important policy priorities for the Union and bring high EU added value: sustainable infrastructure; research, innovation and digitisation; small and medium-sized enterprises (SMEs) and small mid-caps; and social investment and skills. The budget guarantee is divided between the policy areas: Sustainable infrastructure - €11.5 billion; Research, innovation and digitisation - €11.25 billion; SMEs - €11.25 billion; Social investment and skills - €4 billion.

A key element of InvestEU is the Social Investment and Skills window. This window makes provision for technical assistance and capacity-building support to final recipients or may benefit from it to build the required capacity and skills. Organisations within EU member states are available to apply for the funding via their national managing authority.

SOCIAL INVESTMENT AND SKILLS WINDOW

Support under the Social Investment and Skills window shall facilitate the deployment of projects strengthening the social dimension of the European Union as underscored in the European Pillar of Social Rights. In particular, actions under this window shall aim at upwards convergence, reducing inequalities, increasing resilience and inclusiveness through promoting employment including entrepreneurship and self-employment, social enterprises and social economy, social inclusion, improving citizens' health, well-being and overall quality of life and supporting a just transition to a low carbon economy. The window shall facilitate skills and key competences development and higher skills utilisation through education, training, including on the job training and related activities. In particular, the Social Investment and Skills window shall support microfinance, social enterprises, where the provision of investment of up to €500 000 should be encouraged but where larger investment to foster expansion and scaling up of social enterprises should also be targeted, the supply of and demand for skills, education, training and related services (including investments in infrastructure), social infrastructure (including for education, training, health, social and student housing) as well as projects involving social innovation, health, ageing and long-term care, inclusion and accessibility, and cultural activities with a social goal.

Investment and financing operations shall also support projects from private sector organizations active in the social investment space or in need of such investment to tackle, for example, education and job training of those in need, addressing skills deficiencies or improving their skills utilisation. Such organizations include, among others, SMEs, large corporations, cooperatives, foundations, venture philanthropists, social impact investors, education and training institutions. Their activities cover different sectors and sub-sectors, including smart and inclusive mobility, urban renewal, rural socioeconomic revitalizing community building and intergenerational solidarity, inclusive communities, homelessness, integration of vulnerable populations including people with disabilities, mental health difficulties and dementia, community development, integration of third country nationals addressing demographic and migratory challenges and integrating new populations, and digital inclusiveness and entrepreneurial skills. The window shall target in particular projects that involve a reasonable degree of (prospective) financial viability but that are not delivered or not to a sufficient extent by the market due to higher risks, lack of collateral, not achieving optimal scale without public sector support or other market barriers. The supported projects shall not crowd out market-based offering of the targeted social services. Investment and financing operations aim at addressing these barriers and the provision of social infrastructure and connected services will include: healthcare, housing, education, training and related services (covering both initial and continuing education and training) as well as childcare or long-term care.

Where applicable and possible the services provided from the supported operations shall be delivered at the community based local level. Regarding social infrastructure in particular, this shall be done to develop models moving from the institutional care to the community-based care, fully in line with the UN Convention on the Rights of Persons with Disabilities. In addition to financial products provided by traditional financial intermediaries, the provision of in-kind services may also qualify organisations, such as education institutions, or health and social care providers, to benefit indirectly from the EU guarantee through an implementing partner. The window shall have a special emphasis on the inclusiveness of vulnerable people and their access to quality services. It shall aim at broadening self-employment and social integration of vulnerable people including third-country nationals by means of support to microfinance, social enterprises, social innovators, social start-ups and skills-investment markets. Special attention shall be paid to social enterprises and the activities they carry out such as scaling initiatives, fostering the development of digital and entrepreneurial skills for disadvantaged groups to address gender and other diversity gaps in these areas. The window shall address EU-wide market failures in social enterprise and social impact finance, microfinance, health, ageing, education and housing funding gaps and innovation through bringing about stronger EU intervention and more efficient market testing aimed enhancing the social dimension of Europe.

Combination with contributions from donors, philanthropists, foundations and other private sector actors shall be allowed. InvestEU Fund shall seek to strengthen private sector engagement to help deliver on the European Pillar of Social Rights, supporting, inter alia, quality employment, education and training, health, social inclusion and active participation in society. Private sector actors will have the possibility to contribute to the InvestEU Fund either through direct contributions (donations, repayable and non-repayable forms of support) for increasing the provisioning of the EU guarantee or through contributions to and/or co-investments into the projects or financial intermediaries supported indirectly by the InvestEU Fund. Likewise, grouping of smaller projects shall be encouraged by implementing partners and financial intermediaries, as many projects in the social sector are rather small to attract interest from private investors. For example, reforms in the social sector can entail implementation of social infrastructure and

services, such as for new healthcare models, in several locations in the jurisdiction of a national or regional authority through a number of small-sized projects. "Grouping" small projects in a single investment proposition may be necessary to raise interest from investors.

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