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# 1st NEWSLETTER



The SPRINT project aims to *give meaning to the concept of social investment as applied to long-term care provision.*



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SPRINT is a three-year research project seeking to elucidate how long-term care (LTC) can be located within the concept of social investment. It conducts research with a view to define the “social” character and impact of LTC schemes and to propose a set of tools, guidelines and policy recommendations that will support successful implementation of



### Applying social investment principles to the provision of LTC: first steps

The SPRINT project is set to discuss and substantiate whether a social investment perspective can be used in the field of LTC. It departs from a basic framework that relates to Social Return on Investment (SROI), with similarities to conventional cost-benefit analysis where the focus is on maximizing the social welfare function. This framework is primarily concerned with identifying all the potential stakeholders – those affected by an action. It then moves on defining the value of a specific action to those stakeholders and the positive, and negative, changes they experience.

The preliminary action of SPRINT involved mapping the understanding of social investment by the different partner countries with a focus on LTC. Not surprisingly, in most countries there is no explicit reference to what social investment is outside the academic milieu and even less in the field of LTC. In some cases there is just a blank, in others some fuzzy notions overlapping concepts such as social enterprise or social innovation. In a few there are some developments but very much centered on issues of funding.

**Figure 1. The social investment flow in LTC**

Investors	Investment	Returns
Those allocating resources	LTC provision	Results of LTC: costs and benefits
<ul style="list-style-type: none"> <li>• variety of agents: public/private; formal/informal; commercial/not for profit</li> <li>• variety of resources: monetary; time; effort; infrastructures</li> </ul>	<ul style="list-style-type: none"> <li>• tackling different types of needs: health/social care; ADL's/IADL's; dementia; needs of carers</li> <li>• focusing on different approaches to needs: prevention; rehabilitation; assistance; palliative; hospice care</li> </ul>	<ul style="list-style-type: none"> <li>• may be experienced as positive or negative; may be of a material or of a non-material nature; may be experienced individually or collectively</li> <li>• variety of costs: fiscal; social expenditure; private expenditure; social costs; opportunity costs; preventive costs</li> <li>• variety of benefits: social wellbeing; economic benefits; efficiency; opportunities; quality</li> </ul>

Since LTC is not the typical field of reference for the debate on social investment, the first task of SPRINT was the clarification of what it means to address LTC from a social investment perspective and what that involves for the different countries: who are the stakeholders? What resources are allocated to LTC? What needs and whose needs are being tackled by different LTC initiatives? What are the returns to be analyzed?

The diagram depicts the general framework that was used as a guide to compiling relevant information at the national level and to start defining the scope of analysis of LTC from a social investment perspective.

By Prof. Alexandra Lopes  
University of Porto



## **SPRINT project common vocabulary public consultation**

**Your input and ideas are important to us!**

### **Introduction**

The SPRINT project team has established a common vocabulary (glossary) for social investing, permitting the definition of key terms and concepts. For this purpose, an open wiki-based stakeholder engagement consultation to solicit the views of social policy experts, care providers, beneficiaries and other actors on the terminology that can best encourage the uptake of new forms of investing in LTC, is currently up and running: [www.sprint-project.eu/wiki](http://www.sprint-project.eu/wiki).

The purpose of the glossary is to facilitate efficient communication via creating definitions and explanations of important terms regarding the resourcing aspects of LTC that arise in the normative analysis. Moreover, the glossary will elucidate the fundamental concepts, allowing for greater understanding of the social investment notion by all stakeholders.

### **Duration**

The consultation will be open from 1 June 2016 until 30 September 2016.

### **Who should be involved?**

The consultation on SPRINT project common vocabulary ([www.sprint-project.eu/wiki](http://www.sprint-project.eu/wiki)) is addressed to all interested stakeholders in the public

and private sectors, in industry, including small and medium-sized enterprises (SMEs), research and academia in Europe, as well as to all interested citizens who would like to share their views on relevant definitions and consultation for social investment in LTC. International partners are also invited to contribute. Your input and ideas are important to us!

### Protection of personal data

For transparency purposes, all responses to the present consultation are made public in the [www.sprint-project.eu/wiki](http://www.sprint-project.eu/wiki)

### Please read:

- the Legal & Privacy notice (<http://sprint-project.eu/legal-privacy-notice/>)
- the Specific privacy statement

### Editorial



### LTC resources – who will provide?

We are living longer – and often healthier – lives than earlier. Family structures have changed, and societies are more diverse. This raises a crucial issue: how can we ensure that there are resources to help and take care of frail elderly members of our society, including the growing number of people with dementia?

LTC has been a latecomer in many welfare states. This is related to the fact that historically it was mainly taken care of within each family or extended family. Other factors include the fact that the number of years of retirement used to be a lot less, meaning lower need for LTC, and, where this need did exist, the health care sector was usually the part of the state that bore the greatest burden.

In the SPRINT project we study the mixture of existing approaches in Europe to provide resources in order to help those in need of care and support. We observe a combination of resources from the state, market and civil society in several and very different varieties. In most countries, the family still have a central role in providing LTC, however with a very diverse picture of state support, and an involvement of the private sector in the provision of LTC.

Given the strong emphasis in many countries on the family's role, this also implies that the data and information on resources available for LTC are not always very precise or updated. This is a consistent discrepancy because activities in private households is not incorporated into our measure of GDP, and therefore we do not have, as in other fields, a clear and systematic knowledge of the resources available for LTC.

The blurred boundaries in many countries with activities in the health care and LTC sector also implies that the available data and information is often scarce and very difficult to use in a comparative context.

Furthermore, the issue of the level of quality within LTC is not very precise or well developed in many countries. This means that estimating the resource landscape is difficult because the expenditure on resources is dependent on the level of quality which is delivered in the different welfare states.

Overall there seems to be, in a broad understanding, differences between countries belonging to different welfare regimes, with Nordic countries having stronger state support, whereas Eastern and Southern

Europe to a larger degree focus on the role of civil society. In liberal and continental model countries, the market plays a stronger role. An interesting outcome is that in all countries family and civil society plays a very important role with regard to the provision of LTC services.

By Professor Bent Greve,  
University of Roskilde Denmark



### LTC sector stakeholders

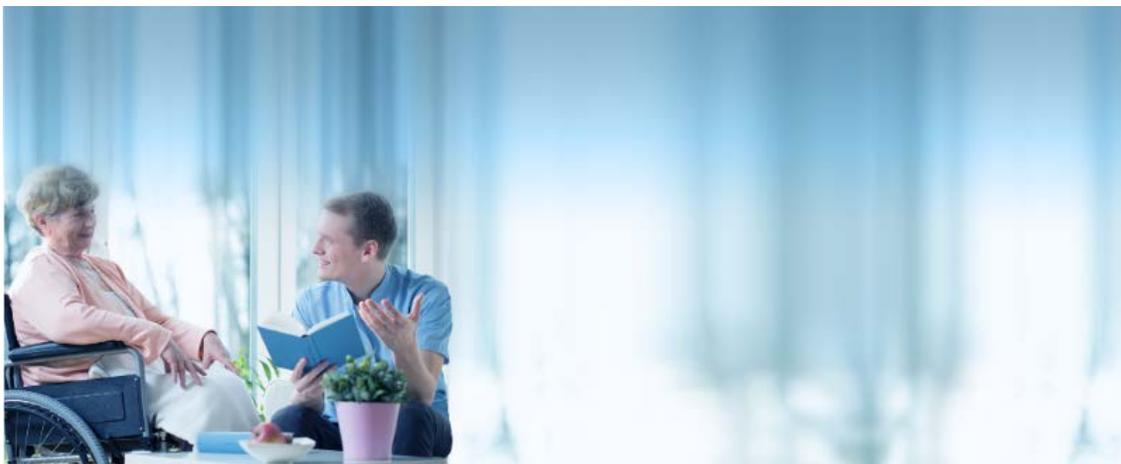
LTC sector has been viewed for a long time as very traditional in its management and administrative structure. Over the last two decades, the challenges posed by the economic crisis and new policy orientation have had a positive impact on the innovative approach of the role of public and private actors in LTC. Furthermore, LTC has contributed to the innovative role of social cooperation and social enterprise in Europe.

The research conducted in the SPRINT project is examining themes of reflection on the integration between public welfare and private intervention. In general, advanced economies have registered an increasing demand for social protection. This is happening even in Italy, where health spending for pension and insurance funds continues to increase, despite the prolonged period of crisis and constraints on spending.

The SPRINT project has also considered the so-called “out-of-pocket”

phenomena (health spending directly supported by families). Out-of-pocket expenses incurred by households have also grown in countries where public welfare is more efficient, such as Sweden, Germany and Denmark. In the current economic and social climate, the added value of social enterprises involved in LTC service provision are one of the more innovative aspects studied in the SPRINT project. This may lead in the future to ideas about potential new instruments for investments in LTC.

By Pierluca Ghibelli  
[Gruppo Cooperativo CGM](#)



### Prescribing Donepezil for Alzheimer's patients: a social investment perspective

In late October 2015, the news media carried stories of a new Dementia drug that 'keeps patients out of nursing homes'. Although the drug – Donepezil – has no impact on underlying neural degeneration, we learnt that it is successful in delaying movement from home to a nursing home – almost halving the likelihood of a transition in the first year. Moreover, it does so at “modest cost”.<sup>1</sup>

But what does "modest cost" here mean? Nursing home care is expensive. This cost might be borne by the state – albeit subject to means-testing. This means there may be a public finance benefit to delaying institutionalisation. Even if patients paid for nursing home care themselves, the individual's assets might not be depleted as much,

meaning there would be something left over to bequest. And this means relatives or friends or others might profit, too.

On the other hand, if the person stays at home, he/she has to be looked after by someone. There are costs to this. Yes, domiciliary care services come cheaper than institutional care services. But much of the saving is likely to result from the substitution of formal carers with informal carers.<sup>2</sup>

And there is a cost to the latter in providing care. Informal carers might reduce the amount of work they do in the formal economy, which reduces overall output and has its own exchequer costs. Even if they do not have jobs, and have no intention of going out to work, informal carers, especially those caring for Alzheimer sufferers, might experience high psychological costs – stress and even depression.<sup>3</sup> Prescribing Donepezil is argued to be “of real significance to people with dementia who want to continue living at home as long as possible”, but the assumption is that the benefits are all positive, and potentially ignores the existence of disbenefits.<sup>4</sup> Maybe the bequest the carers expect from the person they have looked after compensates them for what they are doing, but...

The UK Department of Health’s National Institute for Health and Care Excellence (NICE) has already been criticised for restricting access to certain dementia medication on the ground that it is not cost effective. It has set these restrictions because it has considered only the health benefits of the person receiving the medication (not enough Quality Adjusted Life Years, or QALYs, are gained for the expenditure involved).

Instead, goes the argument, it should also look at the quality of life of those who have to care, at home, for Alzheimer’s sufferers. In the guidelines it is developing for social care, NICE does, indeed, recognise family members as a “stakeholder group” who might also experience cost and benefits from interventions on behalf of the principal client.<sup>5</sup> But these are not currently included in its “technical guidelines” for clinical treatments and medicines.

Discussions about Donepezil should be equally inclusive. A social investment approach – the subject of the SPRINT– is trying to show what might be implied if it is.<sup>6</sup>

By Dr Bernard H Casey,  
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<sup>1</sup> See Dementia drug 'keeps patients out of nursing homes' at <http://www.bbc.co.uk/news/health-34650370>. The study in question is Howard, R. et al, Nursing home placement in the Donepezil and Memantine in Moderate to Severe Alzheimer's Disease (DOMINO-AD) trial: secondary and post-hoc analyses, in The Lancet – Neurology. Published online October 27, 2015 [http://dx.doi.org/10.1016/S1474-4422\(15\)00258-6](http://dx.doi.org/10.1016/S1474-4422(15)00258-6).

<sup>2</sup> See, for example, Knapp, M. et al, Scenarios of dementia care: What are the impacts on cost and quality of life? Personal Social Services Research Unit, London School of Economics and Political Science, June 2014.

<sup>3</sup> See, for example, Joling, K. et al The Two-Year Incidence of Depression and Anxiety Disorders in Spousal Caregivers of Persons with Dementia: Who is at the Greatest Risk?, in The American Journal of Geriatric Psychiatry Volume 23, Issue 3, March 2015, Pages 293–303.

<sup>4</sup> Here the evidence is much less certain than many might suggest. Quality of life (QoL) measures are often obtained from relatives rather than the people directly affected. Moreover, there are suggestions that these do not always correlate. See, for example, Sands, L. et al, What explains differences between dementia patients' and their caregivers' ratings of patients' quality of life?, in American Journal of Geriatric Psychiatry. 2004 May–Jun;12(3):272–80.

<sup>5</sup> See NICE (2013), The social care guidance manual. Manchester: National Institute for Health and Care Excellence (NICE) at <https://www.nice.org.uk/article/.../non-guidance-the-social-care-guidance-manual-pdf>.

<sup>6</sup> For more information about SPRINT, see, Ellis, G., Social investment in LTC, at <http://blogs.lse.ac.uk/healthandsocialcare/2015/07/03/social-investment-in-long-term-care/>.



## Integrated Care

Report on a one-day conference organised by CityForum and held in London, 27 April 2016

Integrated care, even if not hitting national headlines, has certainly been much talked about by health and social policy practitioners. To them, it tends to mean bringing together two services – medical and social – in a way such that needs can better be met and resources more effectively allocated. It has frequently been talked about with respect to “bed blocking” – the state of affairs that occurs when (older) people who have successfully completed clinical treatment cannot be released from hospital because either their homes are not suitable for someone with reduced mobility, or there is no family member able to look after them, or no domiciliary services can be organised, or no place is available in a care home or sheltered accommodation. The hospital beds they occupy cannot be used, so there is a knock-on effect for others requiring medical services. The (older) people in question end up being accommodated in a less than appropriate environment and the costs of continuing to care for them are probably higher than they otherwise should be.<sup>1</sup> Better coordination between medical and social services is believed to be the answer. In some counties – for example, England – social care delivers can be billed by medical care providers if they fail to make appropriate “care in the community” available for those who could be discharged from hospital but who also need further attention.

“Integrated care” was the subject of a one-day conference recently

organised by CityForum – a UK-based group of public policy analysts – in London (27 April 2016).<sup>2</sup> It had the distinction of being, if not the first, at least one of the first such gatherings where policy makers, practitioners and academics with an interest in the subject were brought together to compare experiences, expectations and challenges. Of immediate interest was the variety of bodies either present or whose potential contribution was alluded to. Voluntary bodies and charities were, of course, recognised as important, but so too were the police and fire services, pharmacists and, within local government, those responsible for housing, education and transport.

### **Integrated care as social innovation**

Integrated care involves “social innovation”. However desirable coordination might be, the latter requires both a substantial change in attitudes and sometimes the construction of new institutions.<sup>3</sup> Some participants at the conference suggested that current regulation hampered progress, but many pointed to inertia and a preference to avoid risk. Existing organisations wish to preserve their powers, competencies and budgets and are not always keen to share these with, or transfer them to others. Moreover, reorganisations tend to affect visible services – losses are often immediately obvious, but gains that might result are less visible, or take time to become so. So, political support is important and trust has to be generated. But also important is a change in the mind-set of existing managers and staff. Existing structures tend to operate on a “top-down” basis, yet the more ‘radical’ advocates of integrated care suggest there was a need to rebuild “from the bottom up”. Services that are successful are services that are close to those whom they serve.

Closely related to the emphasis on a bottom-up approach is the importance of bringing in, or at least giving a greater role to voluntary and not-for-profit organisations – both as articulators of need and as deliverers of services. Some of those advocating integration were doing so because it fitted a broader programme of devolution and subsidiarity. Others were doing so because it met the objective of engaging with those needing care services or with those living together

with them and contributing to their care.

### **Integrated care and social investment**

Integrated care also involves “social investment”. Constructing “incubators of change” was seen as requiring resources. Whist successful integration reduces transaction costs, restructuring and establishing new institutions is not cost free. It is not only that existing organisations are jealous of their budgets – new money is also needed. Moreover, involvement of not-for-profit organisations and voluntary bodies is likely to be considered risky – it means giving relatively unknown and/or inexperienced organisations new tasks and responsibilities. However, taking on risk tends to be an inevitable corollary of innovation and investment.

English local authorities have been charged by law with the provision of “preventative services”, although realisation is still in an early stage.<sup>4</sup> The fact that integrated care has, at least potentially, a preventative as well as curative or palliative role also suggests that it has the character of investment. After all, public health bodies are not only interested in reducing hospital readmissions but also in improving life styles such that some hospital admissions become unnecessary and more people are able to live independently. However, preventative investments pay off only in the longer term. And even the returns on investing in a better integration of more conventional health and social care services are likely to be realised only well beyond the end of the usual (five-yearly) budgetary cycle.<sup>5</sup>

### **Evaluation of integrated care**

Whether the benefits that integrated care are claimed to offer are delivered was a question that the conference found difficult to answer. First, there was the question of how the outcomes might be measured at all. Bodies responsible for checking value for money of public expenditure tend to be interested in the impact of integrated care on hospital discharge rates, but those responsible for the quality of care tend to be interested in results from the equivalent customer satisfaction surveys.<sup>6</sup> At least one observer was sceptical of whether

measurement was possible at all. Integrating care means “intervening in complex adaptive systems”, and the outcomes, rather than being something that could be predetermined, is actually what results. Again, this uncertainty might well have to be an integral part of innovating.

Second, the evidence base with respect to the consequences of integrating care is remarkably thin. There were a few examples of evaluation mentioned in the course of the conference and only one example that seemed to involve a proper control group.<sup>7</sup> A summary review of findings from the literature appears to indicate that initiatives have:

1. had little impact on health
2. led to small reductions in acute bed utilisation, but this reduction was often not maintained
3. sometimes brought care nearer to home, and
4. sometimes revealed new needs, hence possibly producing new costs.

A recurrent suggestion in the literature (and one that was repeated at the conference) is that the impediment to better integration of care is not so much an inadequacy of resources and rather the perspectives and attitudes of those responsible for existing delivery structures.<sup>8</sup>

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<sup>1</sup> The charity Age UK estimates that bed-blocking has cost the English NHS £669m and the loss of 2.4m bed days over the past five years. See The Daily Telegraph, 17-6-15.

<sup>2</sup> For more information about CityForum, go to <http://www.cityforum.co.uk/index.asp>.

<sup>3</sup> Here, there is a difference between England and Scotland. In England the emphasis has been on coordination. In Scotland, legislation dating from 2014 requires structural change. Local authorities and local health boards are obligated to establish an “integration authority” in every area, and this body then manages an integrated budget.

<sup>4</sup> See the 2014 Care Act.

<sup>5</sup> For more on social investment and LTC, see [www.sprint-project.eu](http://www.sprint-project.eu).

<sup>6</sup> See, for example, Adult social care in England: overview. Report by the Comptroller and Auditor General. London: National Audit Office, 2014.

<sup>7</sup> See JSEC Briefing on the approach and findings from the matched cohort evaluation of the Age UK Living Well programme, available at <http://knowledgebucket.org/new-interactive-poster/>.

<sup>8</sup> See, especially, Financial Mechanisms for Integrating Funds for Health and Social Care: An Evidence Review, and Testing the Bed-Blocking Hypothesis: Does Higher Supply of Nursing and Care Homes Reduce Delayed Hospital Discharges? Centre for Health Economics, University of York, UK (both 2014). See, also, Buffer management to solve bed-blocking in the Netherlands 2000-2010, in International Journal of Integrated Care, Vol. 11, 2011.

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The SPRINT Project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 649565

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