SI-DRIVE
Social Innovation: Driving Force of Social Change

SOCIAL INNOVATION IN HEALTH AND SOCIAL CARE

STATE OF THE ART SUMMARY

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1 INTRODUCTION

The state-of-the-art report provides a policy field specific study on social innovation and the related governance system. It addresses recent challenges, corresponding practice fields of social innovation as well as illustrating social innovation projects. Thereby, the European, national and global level will be taken into account. **This document is a summary of the first draft of the policy field report. It is intended to serve as a stimulus for public comment and debate on the issues it contains.**

With its emphasis on the (governance) context of social innovation in the policy field, this report is complementary to the SI-Drive mapping which asks for details of concrete social innovation practices and projects, as well as to the SI-Drive report on social innovation in the different world regions, which elaborates main strategies and distinctions of social innovations according to a global context.

This summary considers three complementary areas:

1. How does the policy field's European and global governance systems address specific challenges and what role does social innovation play?

2. How do the challenges and the approaches of tackling them and the role of social innovation practice fields and projects differ across the countries? What can we learn regarding the relation between the context of social innovation and the nature of social innovation (drivers, barriers, scaling, stakeholders, bottom-up SI, policy-driven SI)?

3. Which social innovation practice fields can be found at the European and global level? What are their characteristics?

Due to the iterative approach of SI-DRIVE this report is an initial attempt to describe the policy field background and context for social innovation. Done by desk research and restricted to language constraints this report has to be seen as a starting point and a first overview mainly focusing on the countries of the involved partners. A second version will be further elaborated on the basis of the results of the first empirical phase (global mapping) and the regional reports, completing the missing countries and regions as well (beginning of 2016). A third and final version will be established after the second empirical phase of in-depth case studies at the end of the project (end of 2017).

1.1 HEALTH AND SOCIAL CARE: RELEVANCE TO SOCIAL INNOVATION

New challenges have emerged over the past few decades, with respect to health and social care. We are witnessing such challenges as: a global rise in non-communicable diseases (NCDs); pervasive health inequalities; a rapidly ageing population that has dramatically increased demands on health and care services, as well as public and personal budgets; and new lifestyles that have brought with them problems of diet-related diseases and chronic diseases such as diabetes. At the same time, some areas of the world are still struggling with the health problems that arise from poor nutrition and sanitation, including communicable diseases, and a lack of access to basic health and social care. Many of these problems are deeply rooted in complex societal and structural issues, thus, social innovation is needed to foster the advancement of new approaches to health and social care.

Overall, we broadly consider anything to do with the delivery of health and social care to be in scope for this paper, which can be as broad as new modes of service delivery, ways of improving access to care, new business models, etc. Innovations which are purely scientific are out of scope, including: the development of new drugs, bio-technology, genetic testing, technical development of robotics, prosthetics etc., and technological development of new equipment. We consider frugal engineering to be in scope if a social dimension is present.

The following countries are covered in this report on health and social care: Austria; Belgium; Brazil; China; Costa Rica; Germany; Ireland; Italy; Netherlands; Oman and the GCC countries; Paraguay; Russia; South Africa; Sweden and the Nordic countries; United Kingdom.

2 SYNTHESIS OF KEY FINDINGS

This chapter lays out preliminary findings of the country reports and compares the challenges and approaches of tackling health- and social care challenges, and the role of social innovation and its practice fields across 15 countries. In this section we review differences in the system and structures of health and social care and the extent to which social innovation and practice fields are taken up in the various country contexts. This preliminary analysis will be expanded upon iteratively, after the mapping phase of the larger SI Drive project.

2.1 POLICY CHALLENGES

Across all the countries studied, there are many clear patterns of policy challenges in health and social care. Globally, in terms of public health issues, high on the agenda of the more developed countries examined include high rates of chronic and non-communicable diseases, a rapidly ageing population, complex, multiple problems and co-morbidities, and pervasive and persistent health inequalities. Issues around mental health are additional challenges in many countries, from Sweden to Oman. Developing and emerging countries such as Brazil, Paraguay, Russia, and South Africa further experience disproportionately higher rates of deaths related to injury and violence, infant mortality, communicable diseases, such as tuberculosis and HIV/AIDS, extreme poverty, and lower access to safe water and sanitation. These are also countries with younger populations (e.g., South Africa, Oman) that are not yet facing the ageing demographic changes as seen in most other countries. Overall, the demands on health and social systems across the globe are increasing.

With regard to social care, countries are reporting shortages of skilled social care workers (e.g., Germany, South Africa, Oman), challenges in coordinating health and social care policies (e.g., Sweden), and increases in poverty and weaker family support networks (e.g., Italy).

2.2 OVERVIEW OF HEALTH CARE SYSTEMS

Examining the different types of health care systems around the world is important for understanding the context in which social innovation can occur. Historically, there are three main types of health care systems. There is the Beveridge model (or national health model), which is characterised by universal health coverage, funded through general taxation (e.g., UK, Italy, Sweden, Ireland). There is also the Bismarck model (or social insurance model), which is characterised by compulsory coverage, financed through employer, individual, and private insurance contributions (e.g., Germany, Austria, Belgium, and the Netherlands). Lastly, there is the private insurance model, which is characterized by employment-based or voluntary and individual purchase of private health insurance (Kulesher & Forrestal, 2014). It is important to note that most countries do not align precisely to one model or another, but rather financing models can be a mix of sources (i.e., taxation, voluntary purchase, out-of-pocket, social insurance funds). Overall though, the current goals of most countries are to either find ways to reduce costs, and/or expand access and work towards universal healthcare coverage, both of which can act as drivers of social innovation.

For example, we are seeing innovations in health financing and a move towards universal health coverage. While many countries have well-established national health insurance models, this model is considered new and innovative in the context of other developing (e.g., China), and even developed countries (e.g., US). South Africa as well has embarked on steps to establish a National Health Insurance system

There is also significant variation in the percentage of GDP spent on health care, another measure for comparing health systems. At one end of the spectrum are countries like the Netherlands (over 12% of GDP) and Austria (11.5% of GDP), which have higher spending in long-term care as a result of an ageing population. At the other end is Oman, which is witnessing an expanding health sector, but the amount of resources directed to health is much smaller compared to OECD countries (2.6% of GDP). Understanding the relationship between resources available and spent and the role of social innovation will be important for the next phase of this project.

2.3 SOCIAL INNOVATION IN HEALTH AND SOCIAL CARE

With respect to the take up of social innovation in health and social care across these countries, there is, as would be expected, a broad spectrum. Broadly speaking, however, three main "levels" of involvement can be identified - from explicit integration of social innovation, through to little or none. The majority of the countries, however, report having **no specific, or explicit social innovation policies or structures in place at the national level, but that the environment is well suited for promotion and implementation of social innovations**. Countries such as these report evidence of social innovation at more micro, and grassroots levels, or programmatic levels.

In Italy, for example, there are no specific social innovation policies and structures. However, in the private and civil society sector, social innovation is attracting increasing attention. In fact, there are several major social innovation networks aimed at promoting social innovation businesses and initiatives. There is also very little explicit reference to social innovation in Oman, yet, there are a growing number of community-based initiatives aimed at stimulating local responses, community involvement, and local ownership of health actions.

Similarly, in South Africa there is a cultural sense that entrepreneurs and innovators are not bound by traditional solutions, and social innovation is growing at the grassroots level. However, at the governmental level, health innovation policy currently resides within the Department of Science and Technology, as opposed to the Department of Health. National government has enacted policies to promote entrepreneurship, but there are no explicit policies focused on *social* entrepreneurship, or social innovation. Social innovation in South Africa is more often implemented and tested at much more local, grassroots levels. There is thus a need for more channels to connect and bridge innovations between grassroots actors and government officials.

Then there are countries where social innovation is responding to issues around reaching vulnerable populations, or engaging communities, or fostering patient empowerment. In Brazil, the importance of community involvement was established as law in 1990, and social innovation has been basically in the form of models of health care focused on vulnerable populations and reaching remote populations. In this case, however, barriers exist within the public sector which is not involved to a great extent in major innovations due to risks of trying new models. In Germany, social innovation in health care is mainly centred on patients, through modes of participatory decision making, patient-centred care, etc. This is related to the significance and huge presence of self-support groups and patient advocacy groups. It is explicitly discussed among sickness funds, physicians, patients, and ministries, and is aimed at identifying and reducing over-use, under-use and misuse of health services. Costa Rica, although it is very progressive in terms of the health care system, has few explicit social innovations. Those that do exist are focused on addressing access to health among temporary migrants.

Sweden is also witnessing an implicit increase towards integrating social innovation in health and social care for patient organising. In traditional care, social innovation is not explicit, but Sweden is seeing an increase in patient organising and social media activism. Some university initiatives recognise social innovation as well. This is driven by the need to improve information delivery and health services, and incorporate more holistic approaches to health. Reaching groups who are more often secluded (e.g., elderly, immigrants) is also central to some waves of social innovation. The barriers faced include tensions with traditional and mainstream actors.

In Russia, most of the influence on the innovation process is coming from non-profit organisations. President Putin recently put forth subsidies to non-profit organisations for the implementation of socially important projects, although most innovation projects are focused on those around nuclear, space, biological and nanotechnology. The drivers to social innovation are to address demographic ageing, an increase in the number of persons with disabilities, and increased emphasis on preventative public health measures.

Similarly, countries such as China and Ireland are witnessing, to a lesser degree, implicit efforts to improve systems and make positive change, although social innovation as a concept is generally new in these contexts.

Substantive integration of social innovation

There are several countries in which a greater integration of social innovation into approaches in both policy and practice is evident. In the Netherlands, for example, the decentralisation of the health care system, coupled with a shift in perspective on health and greater emphasis on citizen participation has led to more initiatives and innovations coming from local actors, service providers, and Ministries. The Ministries of Health, Welfare and Sport, and of Social Affairs and Employment, and of Economic Affairs closely follow regional and local activities and sometimes grant funds to local innovation networks for testing and developing innovative solutions for specific issues. Thus, innovation is more explicit at all levels and is in response to a recognition that the "old system" is not sustainable.

In Austria, while "social innovation" is not explicitly stated in health policy, there are efforts to improve the system which would fall under the concept of social innovation. Terms used include "reforms," "initiatives," and "improvement." Austria is seeing this through improved coordinated and integrated care, and e-Medication initiatives. Their frameworks also integrate the Health in All Policies approach. The concept of social innovation is more explicitly used with a major private foundation, which issues a prize for social innovations.

In the United Kingdom, social innovation is present on multiple levels. In 2012, the NHS published 'Innovation, Health and Wealth: Creating Change One Year On' which documented some of the measures that the NHS is taking to promote innovation, including challenge prizes and the creation of Academic Health Science Networks. These are intended to be the driving force behind the identification, adoption and dissemination of innovative healthcare in the NHS. The new Health and Social Care Act specifically gives local commissioners more agency in order to support innovation on a local level. Additionally, the 2012 passing of the Social Value Act (applicable to all public services, not just health) requires commissioners to consider how the services which they procure might promote wider social value in the locality. It was intended that this would help commissioners to consider innovative approaches which might deliver cross community benefits; however, there have been concerns about how widely the act has been implemented within the NHS.

Predominantly government-led social innovation, top-down

Belgium is an example of a country where there is little room for grassroots innovation due to corporatist control, although governments are shifting their focus towards a Health in All Policies approach. However, the government retains strong control of financing and rules in the field, thus limiting the possibility for major changes in the policy and practices of the Belgian health and social care systems. A "social innovation factory" has been created to stimulate bottom-up innovations in the Flanders region; however, there has only been one initiative relevant to the health care sector. Another factor limiting grassroots mobilisation is the fact that most Belgians do not consider their health care system to be necessarily or sufficiently problematic.

Role of technology

Most countries report an important role for technology with regard to social innovation. In particular, digital and technological solutions are allowing individuals to take a more proactive role in managing their health. Technology is most commonly associated with e-Health and m-Health strategies, with e-Health being led from a more top-down approach. In Belgium and Oman, for example, they are seeing more top-down approaches with respect to eHealth and personal health records. Germany is witnessing increasing discussions around telemedicine, telehealth, telecare, and telemonitoring, although these are not yet available on a large-scale basis. With respect to mHealth, high mobile penetration is a major driver of mHealth strategies. In South Africa and Brazil, the use of technology is focused on reaching hard-to-reach and remote and vulnerable populations, and delivering interventions through mobile phones. In the Netherlands, the driving force of technology innovation is in the health care market, but they are faced with challenges of finding a balance of enhancing performance and managing complexities and cost. There is an increased focus on "DIY Health," based on new technological solutions, and more emphasis on citizen participation and patient empowerment.

2.4 MAIN POLICIES, FRAMEWORKS AND REGULATIONS

At the EU level, there are several strategies and policies of note from a social innovation perspective:

- The EU Health Strategy "Together for Health" (European Commission, 2007) was adopted in 2007 and supports the overall Europe 2020 strategy.

- In April 2012, the Communication "Towards a job rich recovery" ('Employment Package') proposed to mobilise EU funds to boost jobs in three key economic sectors, including healthcare, in order to promote economic growth in the EU. The staff working document "Investing in Health" published in 2013 as part of the Social Investment Package explicitly lays out the importance of sustainable health systems, and the need to improve cost-efficiency through "sound innovation" (European Commission, 2013). Although support for *social* innovation is arguably implicit in this strategy, it is not explicitly identified as a potential route to reaching its objectives.
- The EU Cohesion Policy works to reduce economic and social disparities through the European Structural and Investment Funds. Within this, there is the European Regional Development Fund, which funds health infrastructure, equipment, e-health, etc., and the European Social Fund, which funds health activities focused on healthy and active ageing, health promotion, capacity building of health workforces, and addressing health inequalities.

2.5 SIGNIFICANT ACTORS IN HEALTH AND SOCIAL CARE SOCIAL INNOVATION

What follows is a selection of relevant and major actor groups in health and social care at the European level. Many of these explicitly address innovation, and implicitly social innovation, in their strategies towards improving health and social care outcomes.

- European Innovation Partnership on Active and Healthy Ageing
- The Health Technology Assessment Network
- EC High level group on nutrition and physical activity
- The European Patients' Forum
- The European Chronic Disease Alliance
- European Partnership for Action Against Cancer
- EU Committee on National Alcohol policy and Action
- European Pact for Mental Health and Wellbeing
- World Health Organization and the UN, including the WHO Kobe Centre, the WHO Innovation Working Group (IWG), and the United Nations Foundation
- The Commission on Intellectual Property Rights, Innovation and Public
- The World Bank Institute
- The Social Innovation in Health Initiative (an international collaboration between The Bertha Centre for Social Innovation and Entrepreneurship (University of Cape Town), the Skoll Centre for Social Entrepreneurship (Oxford University), and TDR, the Special Programme for Research and Training in Tropical Diseases, hosted at the WHO).

2.6 PRACTICE FIELDS

There are some commonalities in the types of social innovation (or practice fields) although the exact manifestation and implementation may be very different from country to country, thus illustrating the highly context-dependent nature of social innovations. For example, in the UK, "task shifting" is associated with the development of roles such as the "nurse practitioner" who now carry out some tasks previously only done by doctors. Similarly, in South Africa, task-shifting is exemplified by the shifting the task of prescribing anti-retroviral drugs from doctors to nurses, as well as better use of community health workers to fulfill basic nursing tasks, in an effort to increase anti-retroviral provision. On the other hand, in Austria, the Defi project, which made automatic external defibrillators operational for lay persons is considered a social innovation around task-shifting, as it aims to change how the lay population considers and acts in cases of emergency in the public area, and shifts the task to lay bystanders.

Below is a summary of the main practice fields which are present in multiple countries.

E-health

E-Health has emerged as a priority for global health organisations such as the WHO and is broadly defined as the use of information and technology (ICT) for health. E-health is a broad practice field that encompasses health information management and networks, electronic health records, telemedicine services, wearable and portable monitoring systems and health portals (European Commission, 2013). The EC is supporting this field through actions such as the Action Plan on e-Health and the EU e-Health Network. The latter is a network of members from 28 Member States and operates under the mandate of applying patients‘ rights in cross-border healthcare.[1] The Action Plan 2012-2020 “provides a roadmap to empower patients and healthcare workers, to link up devices and technologies and to invest in research towards the personalised medicine of the future.“[2] In addition, the EU has an initiative called ‘Policies for Ageing Well with ICT’ which funds research into e-health initiatives which support healthy ageing.

Examples of e-health on a global level include System "Care" in Russia, which facilitates real-time monitoring of a patients' health state. The Netherlands, as well, is witnessing an increase in e-Health initiatives, including innovations around improving digital health records (*Here is My Data*), social networking services for ‘consumer eHealth,‘ and the development of wearables and activity trackers.

Mobile health (mHealth)

mHealth has emerged as a segment of eHealth and is of particular interest to developing countries, given the rapid rise of mobile phone penetration there. Within the mHealth space, projects operate with a variety of objectives, including increased access to healthcare and health-related information (particularly for hard-to-reach populations); improved ability to diagnose and track diseases; timelier, more actionable public health information; and expanded access to ongoing medical education and training for health workers.[3] According to the EC’s digital agenda for Europe, nearly 100,000 mHealth apps are available globally. The EC recently sought public consultation for a Green Paper on mHealth, which entailed gathering responses from a variety of stakeholders, including public authorities, healthcare providers, patient organisations, etc. The process sought to uncover the potential of mobile health.

Examples include TickerFit in Ireland and DrDoctor in the UK, or *txtAlert*, in South Africa, which sends text messages to people with chronic conditions, reminding them to take their medication and keep their appoints. Also being used in South Africa is *Babyinfo*, a mobile phone application that seeks to improve maternal and child health by providing expectant mothers with high quality information.

Task shifting

This involves the shifting of tasks between healthcare workers to ensure the best use of the available resources. The World Health Organisation offers recommendations and guidelines for task shifting as a way to strengthen and expand the health workforce (WHO, 2008). We can see this occurring in the UK, predominantly led by NHS England, Royal College of Nursing, and the Nursing and Midwifery Council, and involving the expansion of the Nurse Practitioner role. The profession of physician assistant, originated in the US, has also reached other nations such as the Netherlands and Germany, and seeks to address physician workforce shortages (Merkle, Ritsema, Bauer, and Kuilman, 2011).

In South Africa the increase of anti-retroviral provision was made possible by shifting the prescribing function of these drugs from doctors to nurses. Similar programmes have been implemented across other countries such as Mozambique and Uganda. The WHO supports this practice in a number of other fields, such as maternal health, with clear recommendations on how tasks can be shifted to improve outcomes and optimise the workforce. Examples of the practice can be seen across the world, but particularly in Africa and Asia, including countries such as Malawi and Nepal.

Gamification

[1] http://ec.europa.eu/health/ehealth/policy/network/index_en.htm
[2] http://ec.europa.eu/digital-agenda/en/news/ehealth-action-plan-2012-2020-innovative-healthcare-21st-century
[3] http://www.vitalwaveconsulting.com/pdf/2011/mHealth.pdf

Gamification is emerging as an innovative approach for delivering health education, social support, behaviour change, etc., through the use of game design and mechanics. In Italy, for instance, there is a virtual reality tool ("Smart Ageing) that allows early diagnosis, self training, and monitoring of cognitive impairment among elderly people. Other examples include "Jerry the Bear" for children with diabetes in the US, and *I Move to Learn* in China. *Games for Health* is an initiative based in the US which aims to bring together video gaming and health professionals to improve community outcomes and "serious games" is a field which has gained global traction.

Peer support for chronic diseases

This is an example of citizen led healthcare delivery, using patients' expertise to help others. Examples of this can be seen globally in both developed and less developed countries. For example, Mothers2Mothers is an organisation in South Africa which allows mothers affected by HIV to provide treatment, counselling and support to other newly diagnosed mothers, while the Early Intervention Center in Oman provides peer support to families with special needs. Similarly, the AAL-Pilots in Germany is a project based on the idea that older persons teach other older persons about technical devices and how to handle them. This includes the use of mobile devices and everyday living technologies (e.g., televisions, domestic appliances). In the UK, there are many examples of both offline and online peer support strategies, such as Synergy Cafes, which is a way for patients and carers to connect and support each other.

Movement building

Awareness raising and movement building around healthy lifestyles and disease awareness is another practice field which appears in different forms all over the world. This is seen in the form of WHO initiatives (World Diabetes Day, etc) but also individual examples from different countries. The EU has been instrumental in funding specific campaigns, such as the 'Ex-smokers are unstoppable' campaign against smoking.[4] Examples of this in individual countries include the '1000 Leben Retten' campaign against bowel cancer in Germany and the Change4Life campaign in the UK. Due to government apathy regarding the HIV epidemic, community activist groups *(Treatment Action Campaign*) successfully raised the required awareness and mobilised anti-retroviral provision in South Africa. An example of movement building in Russia is the "Smoke free space" campaign.

Shift in care location

This practice field involves care being provided in the community rather than at hospital sites. This both decongests over-burdened primary care locations and also makes it easier for community members to access healthcare. For example, in South Africa 'Anti-retroviral clubs' have succeeded in decongesting facilities by allowing fixed patient groups to collect their treatment as well as provide the necessary emotional support to each other, while in Brazil Community Health Actions creates a healthcare delivery model to reach remote Amazon basin communities. In Germany, the Bielefelder Modell is a non-profit housing association whose project aim is to foster autonomous living with security of care and paying only for the services which were actually used. In Italy, there is a non-profit organization called Doctors for Human Rights that promotes access to health to vulnerable groups (e.g., migrants, roma, etc) through the use of mobile clinics.

Incentivising wellness

This describes insurers or healthcare providers making incentives available to encourage healthy behaviours. For example, in South Africa Discovery Health (South Africa's largest private healthcare insurer) has successfully supported its members to adopt healthy behaviour by incentivising gym membership, health foods and leisure activities. Similarly, Vitality, in the UK is a health insurance program that rewards people for being healthy.

Evidence based policy

[4] http://ec.europa.eu/health/tobacco/ex_smokers_are_unstoppable/index_en.htm

This refers to the innovation of making sure that social programs are based on evidence of what works. One global network which works to ensure that this takes place is the Campbell Collaboration, which compiles systemic reviews regarding the effectiveness of different interventions. Cochrane reviews perform a similar role. Another is the Abdul Latif Jameel poverty action lab, which undertakes randomised controlled trials of health interventions and innovations in developing countries. Based on their research, providing free chlorine dispensers at water sources has been identified as a policy approach which could yield significant results in the developing world.

Self-management

Self-management has become an increasingly important practice field given the rise in chronic conditions. The European Commission has initiated a reflection process on chronic diseases, in order to identify ways to optimize the response to chronic disease and co-operation between EU countries. 'Disease management with an emphasis on patient empowerment' has been identified as one of two main priorities for EU action on chronic diseases.[5] In order to do this, the EU facilitates information exchange on good practice between Member States, publishes action plans, and funds research activities. EU funding is now being given to one such project, 'Empowering patients in the management of chronic diseases'. Additionally, laws have been altered to better reflect this focus, such as Directive 2011/24/EU on the application of patients' rights in cross-border healthcare which requires all patients to be given clear information about their condition. The European Innovation Partnership on Active and Healthy Ageing includes a focus on strengthening the role of patients, namely through better adherence to treatment and scaling-up of personal remote monitoring and self-care solutions.[6] An example is the Living and Care lab in Belgium, and also Here is my Data in the Netherlands.

Open data

In order to facilitate more reliable and useful comparisons between countries, the EU has been instrumental in making national statistics as reliable and comparable as possible. Initiatives include the European Health Examination Survey and the development of morbidity statistics under the Statistical Office of the European Communities. A move towards open data is also happening in individual EU countries, with for example the launch of care.data in the UK which will allow researchers access to anonymised patient data

Other key practice fields include integrated care delivery, new models of care, remote training and supervision.

[5] http://ec.europa.eu/health/major_chronic_diseases/reflection_process/index_en.htm
[6] http://ec.europa.eu/health/major_chronic_diseases/docs/reflection_process_cd_final_report_en.pdf

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