

Valuing SROI:

Social Return on Investment Techniques and Organizational Implementation in the Netherlands and United States

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EXECUTIVE SUMMARY

Project Introduction

Strategic decision-making in philanthropic giving and social investment requires good information about the potential and actual social benefits and impacts of that investment. But this information about social impact is hard to find and to generate. Methods for valuing social benefits are complicated, haphazard, and often unknown to most social investors and organizational leaders. This relative absence of standardized legitimized ways to document the social impact of philanthropic giving and social investments means that the complete, complex value of this work in advancing the public good is underappreciated.

One way to meet this need for more information and valuation methods is by calculating a social return on investment (SROI) measure. Borrowing the concept of a return on investment from the private sector, which measures financial performance, an SROI is designed to measure the social performance of a given program or social investment.

This report seeks to identify and describe state-of-the-art approaches to valuing social returns on social investments, to review the organizational challenges to implementing an SROI measurement process, and to examine in detail organizations in the Netherlands and the United States that have attempted to use SROI measurements. The focus of each piece of the project was SROI methods and valuation in the health care field, specifically. In the conclusion, the report distills some best practices and practical tips for conducting SROI measurements.

Social Return on Investment – Literature Review and Field Scan

Social return on investment methodology was developed in the philanthropic and nonprofit community by Roberts Enterprise Development Fund in the United States, but in recent years organizations and scholars in the United Kingdom and Europe have been most responsible for elaborating and expanding SROI method. In addition to sophisticated scholarship that has created and tested a number of SROI concepts and models, there are a variety of practical tools being used by organizations and funders. One of these is Social E-valuator™, a user-friendly SROI software that leads users through a series of measurement steps leading to a final, comprehensive SROI ratio.

Valuation methods are seen as the hardest part of any SROI calculation because they involve complex techniques for monetizing diverse aspects of social benefit, such as present and future value and value for specific populations compared to value for society. Valuation methods in the health care field have become especially important in recent years, including human health metrics used to quantify morbidity and mortality outcomes and to compare interventions across populations and frameworks. For example, Willingness-to-Pay and Willingness-to-Accept are used to assess the subjective value of specific health interventions, and Quality-Adjusted Life Years are designed to be objective (value-neutral) measures of health, which can then be monetized.

Research has shown that in addition to valuation/monetization challenges, implementing an SROI measurement process entails a number of practical organizational challenges such as selecting the right group of stakeholders to define the most important impact measures, building consensus around the various indicators, determining the proportion of an observed change that is due to the activities under consideration, overcoming resource limitations and the lack of incentives to implement SROI measures, and dealing with inadequate commitment among stakeholders to gather and track necessary information. In addition, there is disagreement over the appropriate format for SROI calculations, with some scholars urging caution in using a single ratio, especially when trying to compare the social efficacy of different organizations with different missions and services.

There has been too little research and writing about these practical organizational challenges, even though the organizational process is the most essential step toward implementation of impact measurement and tracking. The four case studies in this research project – of social-venture organizations, two in the Netherlands and two in the United States – that have implemented some sort of SROI measurement are meant to help fill this knowledge gap.

Netherlands Case Studies

CareFarm Paradijs is a social enterprise working to improve the well-being of marginalized groups of people, including the chronically unemployed and individuals with chronic health conditions such as autism, dementia, and Down's syndrome. Care farming (or social farming or green care) provides these individuals with supervised physical activity, which produces positive mental or therapeutic effects, employment, and education in addition to revenue generated from agricultural products.

As part of a financial investment from Noaber Ventures, CareFarm Paradijs and consultants engaged in an SROI measurement process using the Social E-valuator software. The organization was able to clarify the theory of change for the care farm, identify and interview several categories of stakeholders, and monetize the identified set of social outcomes. Several challenges in the process were identified, such as quantifying specific cost-savings estimates for deferred or avoided medical care, and determining where to limit the measurement of "ripple effect" social impacts caused by the organizational activity. However, staff observed that the process of talking about, identifying, and specifying the many social benefits caused by the care farm was valuable in itself. The process forced stakeholders and analysts to focus closely on the nature of the benefit being provided, which reinforced a shared sense of purpose and vision.

VitalHealth Software, an eHealth solutions enterprise with a keen focus on social impact, is the subject of the second Netherlands case study. The company provides personalized collaborative health management systems for general practitioners and patients that are designed to be proactive in health management, tailored to the patient, and delivered through seamless health networks. The company assessed the extent to which its activities led to social benefits, such as reduction in the incidence and severance of complications and fewer and shorter consultations and (re)admittances.

VitalHealth staff, with the assistance of consultants provided by shaerpa, also used the Social Evaluator software tool, and instituted an intensive and ongoing organizational process of generating input of social returns and tracking social impacts in an iterative fashion. While committed to the SROI process, VitalHealth staff indicated that a serious challenge for the analysis was the need for expertise to conduct the necessary technical calculations and research. They also noted the importance of being transparent about the assumptions used in estimating value, as the result of the calculations are very sensitive to these assumptions (e.g., deadweight and attribution percentages). Again, the primary lesson learned was that the process of bringing stakeholders and information together to measure SROI was more important than the product (the SROI ratio).

American Case Studies

The Wellness Center at Pan American Academy is a school-based wellness center in northeastern Philadelphia that provides primary and preventive care to underprivileged children with chronic diseases, such as serious allergies or asthma. The wellness center's goals are to decrease the number of missed school days and visits to the emergency room (ER) by students with these chronic illnesses.

An SROI evaluation of the wellness center conducted in 2011 focused on one particular activity of the center – asthma home assessments – and estimated an \$11,000 in cost savings per student because of ER diversions. Limited resources and lack of available outside expertise led to a very limited focus and scope of the SROI process for the wellness center – although focusing on one particular social impact was a good choice given the lack of resources. This case also shows how important it is to agree on a plan for the use of the assessment before conducting the assessment, to avoid the problem of the analysis becoming a “one-off” event that is not used proactively by the organization.

The Pennsylvania Fresh Food Financing Initiative (PFFFI) was a public-private partnership designed to foster development of supermarkets and other fresh-food retail outlets in low-income neighborhoods that have been typically classified as “food deserts.” The PFFFI sought to reduce the high incidence of diet-related diseases (e.g., obesity), stimulate investment of private capital in low-wealth communities, prepare and retain a qualified workforce, and create living-wage jobs. The PFFFI concept was so successful that it is being replicated across the United States, with encouragement from national policymakers.

Public and private partners of PFFFI assessed the program's economic impacts – e.g., improved real estate values, increased tax revenue, and the creation of an estimated 5,023 jobs. The initiative's partners did not, however, conduct similar analyses on the social impacts of their efforts. A one-time SROI analysis was conducted by graduate student researchers, and this estimated a reduction in chronic-disease expenditures, an increase in worker productivity, and other social and economic benefits totaling a projected \$2.23 billion SROI over six years. Like the other American case, the lack of allocated funding and expertise to conduct a full, multifaceted SROI was the primary challenge in this case. For programs hailed as success stories, such as

PFFFI, there is clear value in doing more to assess the SROI, given that replication efforts can maximize those aspects of this sort of program that yield the greatest returns. This case also provides further evidence of the importance of creating a sustained SROI measurement process, rather than a single, one-time assessment.

Conclusions and Lessons Learned

While there are both proponents and opponents of SROI measures, our review shows that all sides agree that calculating something like an organization's full and accurate social return on investment in valid, reliable, and useful ways is difficult and time-consuming. And while emerging techniques for valuing social returns are being developed by scholars and practitioners alike – innovative “venture social investors,” health care economists, the consultants and scholars in the SROI Network – these techniques are not widely known or used in detail by organizations and social ventures.

Nevertheless, the primary conclusion of this project is that there are benefits and costs to instituting an SROI calculation process, and practitioners should be aware of these benefits and costs – and the best practice suggestions that derive from them – when implementing an SROI process.

There are a number of lessons learned from our review and case analysis:

- One benefit of a well-executed SROI calculation process is a learning benefit. Organizations come to a better understanding of their own mission and how well they are achieving that mission, and in some cases improve the mission-orientation as the focus of organizational culture by bringing stakeholders together to identify social returns. Talking about, identifying, and specifying an organization's social returns is valuable in itself. The SROI *process* is often more valuable than the *product*.
- There are clear costs to implementing an SROI measurement process for organizations, especially the time commitment required by multiple stakeholders within and outside the organization staff, the need for expertise that often requires outside consultants, and the commitment of resources to build staff capacity.
- The sophistication in the measurement methods that we identified in the scholarly literature far exceeds the sophistication of the methods used in practice, and certainly the methods used in the four case studies in this project. We identify ways in which contingent valuation methods could have been used effectively in each of the four cases. There could be many reasons for this lack of use of state-of-the-art methods, but lack of funding and expertise are likely the most significant.
- A major challenge to measuring SROI is specifying the wide range of social returns that are related in some way to the activities and intended outcomes of the organization. Capturing all of these social benefits that might be in the “ripple effect” of organizational activities is a nearly impossible measurement task.

- Another primary measurement challenge is assessing the extent of the myriad social impacts that can be attributed to the organizational activities in question, especially when we know that most social outcomes are “caused” by multiple factors.
- As expected from the literature scan, the valuation process of quantifying and monetizing the social returns was another difficult component of the SROI measurements in the case studies.
- The use of software such as Social E-valuator – with a careful, step-wise process for calculating SROI – was a helpful tool for making SROI calculations.
- The SROI measurement is only as good as the data collected to use for the measurement, and often the systems of data gathering for evaluation in organizations are not sophisticated or comprehensive enough to provide the data needed for an adequate SROI calculation.
- An ongoing SROI process is better than a “one-off” because the iterative adjustments (based on actual values replacing estimated, for instance) and the longitudinal data lead to a more accurate and legitimate calculation. It also helps maintain organizational focus on social impacts.
- It is best if the SROI data-collection process involves gathering information from a wide range of stakeholders with different sorts of inputs.
- There are few incentives for organizations to commit the resources needed to implement an SROI process.

A number of the lessons learned above, and other specific findings from this research, point to certain best practices for organizations and social investors who want to make most effective use of SROI techniques:

- Be transparent about assumptions in the model and data used.
- Acknowledge the sensitivity of final calculations to the decisions used in creating the calculation.
- Be inclusive in identifying stakeholders, and seek input from as many as possible; this is particularly important when using contingent valuation methods.
- Use the most sophisticated methods – especially for valuation and attribution/deadweight measures – that organizational resources will allow.

- Be clear about the limits of monetization and valuation techniques, and identify “softer” social returns that do not lend themselves easily to inclusion in monetary SROI.
- Avoid overstating social returns; err on the side of conservative estimates.
- Measure SROI in continual process, not “one-off.”
- Set up organizational systems to gather appropriate data and to track identified measures.
- Identify a designated team and influential “champion” of the process within the organization, preferably one with organizational respect and power.
- Recalculate and revise the SROI measures based on actual values and new research or data, a constant iterative process.
- Be realistic about the resources needed for a useful SROI analysis – time, people, money, expertise.
- As funder or organizational leader, support organizational capacity to commit the necessary resources for a valid and useful SROI measure.
- Frame SROI calculations in informative and easily understandable ways so that all stakeholders can grasp and support the use of the measure, and see their role in it.
- Make SROI calculations public, even if they reveal organizational shortcomings; this is particularly important when creating the organizational culture of learning and commitment to maximizing social returns.
- Be cautious in making claims and comparing SROI measures across organizations with different missions, services, and products; SROI is most useful as a measure for assessing performance across time within one organization.

PROJECT INTRODUCTION

The Use of SROI

More and more grantmakers, social investors, and other donors are trying to be strategic about their philanthropic or social-investment activities. To make these strategic decisions, they need good-quality information about the actual or potential social impact of their grants and investments, including the full, multifaceted value generated by those investments.

However, this sort of information is hard to find and to generate. Most social investors have no adequate means for expressing or measuring the value of their grants, and are unaware of the emerging models that do exist for valuing impact. Similarly, supported organizations often feel that the full value of their work is not sufficiently documented, and they struggle to find the tools to demonstrate to funders, government, and their clients the positive social value they believe their work creates. Moreover, the multiple parties involved in varied social venture vehicles lack a shared, objective set of metrics to use as they compare potential ventures.

More broadly, this relative absence of standardized legitimized ways to document the social impact of philanthropic giving and social investments means that the complete, complex value of this work in advancing the public good is often underappreciated. Claims about the value of philanthropy and the nonprofit sector in any society have less force than they might. From the social investor's perspective, the inability to value the full impact of the activities it has funded in the past hinders future decisions about areas or targets of new ventures. We know those with more complete information about social impact make better decisions, and measuring social impact helps identify which organizations, programs, and types of funding vehicles created the most value in the intended ways. This knowledge is valuable for improving philanthropy in general.

In recent years, a number of new techniques, concepts, and strategic models from the for-profit sector have been adapted for use by grantmakers, and the boundaries between grantmaking and investing have blurred as so-called social investors adopt a more sector-neutral approach to creating social value. For example, the development of “venture philanthropy” – social investors using techniques from venture-capital investing – has been widely noted (Moody, 2008), and is responsible for sparking several innovations in grantmaking techniques in the United States and Europe. Some venture philanthropists, such as the Noaber Foundation in Europe and the Omidyar Network in the United States, have deliberately diversified the sorts of investments they make, funding socially responsible for-profits and hybrid social enterprises as well as nonprofit charities.

Similarly, many of these investors and grantmakers are looking to enhance what they call their due diligence processes – again, taking a concept from financial investing – and some are exploring the idea of developing marketplaces for grantmaking where choices are driven by

public and quantitative information about grantees, past performance, and other measurements. In general, this trend is part of the increased emphasis on performance measurements and on requiring funded entities to track and report outcomes and impact metrics. In this new frame, social-investment decisions, like financial investments (ideally), are driven by objective assessments of the potential value created by the investment. The value created in these cases, however, is social rather than only financial, and is often more difficult to measure for that reason.

The general theory behind social investing is that a philanthropic dollar or euro invested in the social mission of a nonprofit or social enterprise today generates economic and social returns in excess of the initial value of that dollar/euro. The challenge is to *measure* that social return in effective, valid, and reliable ways that can provide a common language and metric for comparing various potential social-impact ventures. There are many different methods available for performance and social impact measurement, although none have become widespread in the venture philanthropy field, and most users of these methods continue to struggle with the specific techniques for assessing social value.

One approach to such measurement is the calculation/estimation of a social return on investment (SROI), akin to the approach used in business analysis. Return on investment (ROI) is a common financial performance measure comparing the efficiency of an investment through a ratio or percentage. A positive ROI indicates there are financial net gains, actual or expected, from an investment; a negative return suggests the opposite. SROI as a performance measure takes this same approach but assesses the *social* gains or values generated by an investment (e.g., the value of improved quality of life for caretakers of individuals receiving some health care intervention, or the cost savings for government or other providers due to philanthropic efforts to improve public health). Social value in this sense is defined as “the general concept and practice of measuring social impacts, outcomes, and outputs through the lens of cost” (Tuan, 2008, p. 5).

As our review will show, a growing number of grantmakers and funders in the United States and Europe have been developing methods and tools for SROI measurements, and some have been calling for the development of shared, industry-standard methods. The most notable early SROI method was developed by REDF, a venture philanthropy organization in San Francisco that actively disseminated the method – and its struggles in using it – as a way to help build the field. The individuals behind this process at REDF, including Jed Emerson, Melinda Tuan, and Fay Twersky, have continued to promote the use of SROI-type methods in philanthropy; Emerson through his development of the “blended value” concept and Tuan and Twersky in their work to develop impact-measurement systems for the Bill & Melinda Gates Foundation and others.

SROI techniques have also come into wider and more sophisticated use in the United Kingdom and Europe, where the SROI Network helps advance SROI practice. Two Dutch foundations, the Noaber Foundation and the d.o.b. foundation, spearheaded an initiative to develop a user-friendly SROI software tool. The tool, entitled Social E-valuator™, leads organizations, funders, or other stakeholders through a series of steps of data entry, such as identifying stakeholders, estimating inputs and outputs, and quantifying and monetizing social outcomes and impacts, leading to a final projected SROI ratio.

Despite these recent efforts to improve SROI measurements, the various methods of valuing social returns are mostly complicated, difficult to use, and still in need of fine-tuning. They often require skills and knowledge that are not always common, particularly among foundation and nonprofit staff, and not many people in the field who might use these methods even know about them.

Even the most sophisticated approaches to of SROI measurement have particular trouble with the *valuation* part of this measurement process. Valuation methods require complex techniques to quantify/monetize different types and aspects of value (e.g., present versus future value, value for specific populations versus value for society). And valuation methods usually involve time-intensive and sensitive data gathering from multiple, sometimes hard-to-access stakeholders.

Summary of This Study

The development of methods for assessing the full value of social and philanthropic investments is a significant advance in the field that could help improve strategic decision-making and demonstrate the broad social impacts of these investments. But while these methods have been proposed and occasionally applied by scholars, and used by a few entrepreneurial organizations and funders, there has been little assessment of their implementation in practice settings and few summaries of SROI techniques specifically.

Scholars have often focused on the development and diffusion of new measurement innovations, or on definitional debates created by these innovations (e.g., over the meaning of “social enterprise” or “venture philanthropy”). The organizational challenges of implementing specific techniques such as SROI have been less extensively studied. And there has been almost no attention paid to variations in the use of these measurement methods across cultural contexts.

To help fill these gaps in our knowledge about SROI and to help improve social investment decisions, the Noaber Foundation provided a grant to the Dorothy A. Johnson Center for Philanthropy at Grand Valley State University in Grand Rapids, Mich., to fund a research project to be conducted in collaboration with the Center on Philanthropy at Indiana University. The project set out to review existing and emerging approaches to measuring social returns and valuing social impacts, to compare how organizations in the United States and Europe have implemented SROI calculation processes, and to distill some best practices and practical tips for organizational valuation of social returns. This report summarizes the findings from the research project.

This research sought to identify and describe state-of-the-art approaches to valuing social returns on social investments, review the organizational challenges to implementing an SROI measurement process, and examine in detail organizations in the Netherlands and the United States that have attempted to use SROI measurements. The focus of each piece of the project was SROI methods and valuation in the health care field.

The first section of this report provides a comprehensive literature review and field scan summarizing existing techniques used in SROI assessments, especially in health care. That review also presents findings and existing field knowledge about the strategies and challenges for organizational implementation of SROI measurement and valuation techniques.

Valuation techniques, in particular, are still in the early stage of development and more studies of their use in specific subfields, such as health care, are especially useful for advancing practice and illustrating the benefit of such measurement. While valuation techniques have been used in the health care sector in various ways for commercial uses (such as setting prices), more research is needed, especially on health-related grantmaking and the social returns of cutting-edge health care ventures.

The second section of the report presents four in-depth, original organizational case studies – two in the Netherlands, two in Pennsylvania – analyzing and comparing how health care-related enterprises have sought to measure their multiple social returns, and the key lessons they learned. In the Netherlands, one case focuses on a “care farm” that provides hands-on therapeutic farming activities for autistic and dementia patients; the other case examines a social enterprise providing “e-health” software solutions. The American cases involve a primary care wellness center inside a multicultural charter school in a disadvantaged neighborhood and a financing collaborative designed to increase access to fresh-food alternatives in traditionally underserved areas.

Data for all four case studies comes from both background research and field research, including on-site interviews and observations. Interviews were conducted not only with representatives of these organizations that attempted some sort of SROI measurement, but also with funders, analysts, and other experts familiar with the four innovative social ventures. A full list of individuals interviewed is provided in the Appendix.

At the heart of this project is a collaboration between two major U.S. philanthropy research centers, the Johnson Center for Philanthropy in Michigan and the Center on Philanthropy at Indiana University. Each center brought distinctive expertise needed to complete the separate pieces of the project, including economics acumen and evaluation research skills from the Indiana team and expertise in venture philanthropy and qualitative research skills from the Michigan team.

Through this collaboration, this research will advance scholarship about SROI techniques and organizational challenges, as well as contribute to our nascent understanding of the similarities and differences in social enterprises and nonprofits in Europe and the United States. In addition, this project will have clear benefits for practitioners. It will present a set of lessons learned and best practices for SROI measurement (e.g., systems for data-gathering and tracking, stakeholder involvement, and staff training) and will describe some promising innovations to help future social entrepreneurs and social investors.

In sum, the title of this report – *Valuing SROI* – carries a dual meaning that captures the purposes of this project: valuing social returns and valuing the SROI process. This report will examine techniques and challenges for valuing social returns on social investments; it will also assess the value of an SROI measurement process for organizations and suggest ways to increase that usefulness.

SOCIAL RETURN ON INVESTMENT – LITERATURE REVIEW AND FIELD SCAN

The purpose of this review and scan is to introduce further the practice of measuring SROI, and to review critically a number of state-of-the-art techniques for measurement and valuation used by scholars and analysts. Some attention is given to the known organizational challenges of implementing an SROI calculation and tracking process, although as noted there is little research on this practical topic. The organizational challenges will then be the primary focus of the case study part of this document.

SROI – Origins and Current Uses

In recognition that traditional accounting practices do not capture the impact of activities that do not have an established monetary value, social accounting – defined as “a systematic analysis of the effects of an organization on its communities of interest or stakeholders, with stakeholder input as part of the data that are analyzed for the accounting statement” (Richmond, Mook, & Quarter, 2003) – was developed as an accounting approach to consider the value of social and environmental impacts in addition to those traditionally measured on balance sheets and income statements. This interest in quantifying, measuring, and monetizing the impact of the nonprofit sector gave rise to an effort by a number of organizations, funders, practitioners, and stakeholders to normalize the practice of measuring the social value of various nonprofit activities.

Social return on investment is a methodology developed by Roberts Enterprise Development Fund, now known as REDF, which designed an SROI measure to capture the value of the impact nonprofits were making in addressing needs or improving conditions in communities, and thereby to help REDF make funding and renewal decisions. The initial methodology for calculating the value of the impact included six stages and resulted in a Blended Index of Return, a ratio of the return on investment resulting from an organization’s enterprises combined with the value of its activities in furthering its social purpose. The model distinguished between activities with a socio-economic value – those that could be monetized and included in an SROI analysis – and activities with an entirely social value – activities with a definite intrinsic value but difficult to monetize (REDF, 2001). In addition to allowing managers to assess and seek to maximize social benefits as well as financial benefits, the SROI approach is a practical management tool that provides additional information from which managers are able to make more fully informed decisions (Olsen & Lingane, 2003).

In 2003, the New Economics Foundation (NEF) in the United Kingdom further developed REDF’s methodology to include more emphasis on stakeholder involvement to identify pertinent indicators and their values, introducing an impact value chain (a logic model approach) and including “deadweight analysis,” which subtracts the value outcomes that would have happened regardless of the intervention. The NEF framework includes planning an SROI analysis,

implementing the analysis, reporting its results, and then embedding the process of analyzing SROI into the organization's operations (Clark, Rosenzweig, Long, & Olsen, 2006; Context International Cooperation, 2006). In that same year, Olsen and Lingane sought to standardize an approach to SROI by introducing 10 guidelines to performing SROI analysis (Olsen & Lingane, 2003; Olsen & Nicholls, 2005).

Building on the work done by REDF, NEF, and others, in 2009 the SROI Network – a membership organization that promotes the use and development of SROI internationally and supports the development of a community of practice around the SROI concept – published an SROI guide that outlined six stages of conducting an SROI analysis (The SROI Network Intl., 2009):

1. establishing its scope and identify stakeholders,
2. mapping outcomes,
3. identifying evidence of outcomes and giving them a value,
4. establishing impact,
5. calculating the SROI, and
6. reporting, using, and embedding the analysis.

Further, the report distinguishes between evaluative SROI analyses, which are conducted retrospectively, and forecast SROI analyses that are meant to predict the impact of a particular intervention (The SROI Network Intl., 2009).

The use of SROI is much more widespread in Europe, Great Britain, and Australia than in the United States. It has extended beyond use by individual nonprofits or other social ventures to governments and advocates trying to influence public policy (Mulgan, 2010). There are also efforts to standardize the measures and methods used in determining SROI in different sectors.

One example is the Impact Reporting and Investment Standards (IRIS), a product of Global Impact Investing Network that is an effort to create a common language that allows comparison and communication across organizations that have social or environmental impact as a primary driver. Most of the definitions are focused on environmental performance or policies, but they also include definitions related to training and assessment and governance. The SROI method provides a process for determining which indicators to measure, and (for environmental performance) IRIS provides a set of performance indicators with standardized definitions (Global Impact Investing Network, 2012). As Bugg-Levine & Emerson, (2011) point out, IRIS is designed to organize the impact investing community to develop a common language to describe the social outputs they generate:

If an impact investor seeks to improve health for poor people, IRIS defines what words like *clinic*, *hospital*, and *patient treated* mean so that an impact report for one health care investment can be consistent with the impact report of a different one. (p. 175)

Another example is the wiki database of values, outcomes, and indicators for stakeholders (VOIS), which was developed and designed by the SROI Network as an open resource for collecting information. Rather than determining what these values, outcomes, and indicators should be in advance, users will be able to discuss and rank entries; members of the SROI Network will be able to edit entries. One of the objectives of Wiki VOIS is to develop more commonality in SROI (The SROI Network Intl., 2012).

An example of a software program that was developed to assist in determining SROI is Social E-valuator, a web-based software that enables organizations to measure and manage social impact based on the principles of SROI. The web tool provides explanations and sample cases that guide users through each step of preparing an SROI analysis, including determining your theory of change, your stakeholders, their inputs, the activities, the outputs, the outcomes, and the impact. Determination of impact includes a deadweight analysis (what would have happened anyway, without this intervention) and attribution (others contributing to these outcomes). Valuation (monetizing) of the impacts is one of the most difficult steps in the process (The SROI Network Intl., 2009).

One area connected to the SROI concept that is generating interest seems to be social-impact bonds, financial instruments for raising capital for social-purpose ventures (McKinsey & Company, 2012). Measuring social impact becomes especially important because investors earn a profit on their investment to the extent the venture can demonstrate a savings to government as a result of its efforts. Social impact bonds or pay-for-success contracts have been piloted in the U.K. and Australia, and they are now being actively discussed in Massachusetts (Massachusetts Governor, 2012).

Applying SROI in a Health Economics Environment

As health care costs have increased in the United States and around the world, interest in controlling costs and increasing efficiency through economic evaluation of health care interventions has expanded. Simply put, the goal of economic evaluations within a health care perspective is to maximize the health benefits that can be derived from a limited amount of resources (Adeoye & Bozic, 2007). From that broad perspective, health evaluation models can have various theoretical paradigms from which they approach the concept of utility maximization; from a social perspective, a welfarist approach is used to examine improving an individual's or group of individuals' overall well-being without compromising the well-being of others (Adler & Posner, 2000).

Overall well-being is a measure of health represented by a sum of lifetime welfare units (measures of utility) that can then, from a health economics perspective, serve as a basis of comparison between multiple states of health or treatment options (Adler & Posner, 1999); given wide-ranging cultural constructs and moral views across the world, however, it can be difficult to compare diverse populations within context of overall well-being (Adler M. D., 2006). The traditional welfarist, utility-maximization approach seeks Pareto-efficiency (or Pareto-optimal outcomes), in which resources are allocated so that no further alternative exists that

could make at least one person better off and nobody worse off (Folland, Goodman, & Stano, 1997). Another welfarist approach, Kaldor-Hicks efficiency, uses a somewhat less stringent approach in that it proposes an outcome more efficient if a Pareto-optimal outcome can be reached by arranging sufficient compensation from those who are better off to those who are worse off so that all would end up no worse off than before, thus allowing for more flexibility in providing solutions that meet the spirit of Pareto-efficiency through compensation (Hicks, 1939; Kaldor, 1939; Adler, 2006). At the same time, however, the introduction of compensation to achieve Pareto-efficiency has been argued to encourage wealth maximization rather than utility maximization (Posner, 2000).

Scholars in the health economics field recognize that health evaluations can be oriented from a number of perspectives, including those of the patient, physician, hospital, payer, device maker, or society in general. The perspective of an approach informs the questions asked in an analysis, the research conducted, and the relative importance of various findings; as a result, the perspective of the analysis should be predetermined and should guide research design. Furthermore, research that informs public policy should be taken from the broadest perspective possible and should take into consideration the ethical dilemmas between individuals and society (Adeoye & Bozic, 2007). By its very nature, a Social Return on Investment analysis implies a societal perspective.

Elicitation and Valuation

A critical challenge in SROI is monetizing the benefits provided by an intervention or other activity by a nonprofit actor. This challenge is also present in the field of health economics: There is no consensus on how to accurately value the extension of life or an enhancement to the quality of a life, or how to separate the value of a treatment that has multiple impacts; for example, a diabetes prevention program that incorporates diet and lifestyle changes may also reduce the risk of cardiovascular disease and hypertension, but separately accounting for multiple positive impacts from one intervention can be difficult.

Furthermore, there is often difficulty in assessing the amount of impact attributable to an intervention as opposed to the amount of impact that would have happened anyway. The gold standard for identifying impact attributable to an intervention is the randomized controlled trial, in which participants in the trial are treated exactly the same as a control group but for the intervention; however, randomized controlled trials are often expensive, can be difficult to administer, and may be unethical if they prevent treatment of an individual in need of treatment (Weatherly, et al., 2009; Jones & Rice, 2009). As a result, researchers often rely on observational, nonempirical sources of data to attempt to identify the causal impact attributable to an intervention; by their very nature, these approaches may be susceptible to inherent biases and other shortcomings (Jones & Rice, 2009). Absent such data, it is not possible to assess the efficacy of an intervention, nor is it possible to assess the amount of impact attributable to deadweight as required by the prevailing SROI methodology. Without data derived from randomized controlled trials, SROI analysts should be transparent about the limitations of deriving impact from other approaches.

Many economists see cost-benefit analysis as the soundest approach to deriving the value of an intervention given its costs; because of ethical considerations and the difficulty in assigning monetary values on health outcomes, however, true cost-benefit analyses are rarely published in medical literature (Adeoye & Bozic, 2007). Furthermore, some researchers argue traditional cost-benefit analysis does not necessarily serve as a proxy for overall well-being and, therefore, may not be the best approach to assessing various health policies (Adler M. D., 2006). Finally, others suggest that it is anathema in public health circles to place a value on human life, which limits the degree to which a true cost-benefit analysis can be applied (Garber, 2000).

Cost-Effectiveness Analysis (CEA) – or Cost-Utility Analysis, which extends a CEA by seeking to monetize measures of health utility (Neumann, Goldie, & Weinstein, 2000) – are more widely used than traditional cost-benefit analysis in applied health economics and public policy decisions (Elixhauser, Luce, Taylor, & Reblando, 1993; Tuan, 2008). Cost-effectiveness analysis assumes a budget with a fixed ceiling and seeks to maximize health benefits within that budget. Such an approach seeks first to eliminate choices (more costly and less effective approaches) and then seeks to provide the greatest total health benefit for a predetermined cost-effectiveness ratio (increased health, as expressed in some unit of health utility, for a given cost per unit) (Adler M. D., 2006). Cost-utility analysis provides a framework for health economists to also consider a patient's subjective level of well-being, including a patient's quality of life, longevity resulting from treatment, and satisfaction relative to the effectiveness of a treatment. To make these comparisons, a patient's health state must be generalized into a measure of health utility (Adeoye & Bozic, 2007). Quality-Adjusted Life Years (QALYs) is the most common elicited measure of health utility (Neumann, et al., 2000; Diener, O'Brien, & Gafni, 1998).

Human Health Metrics

Human health metrics is a generic label for methods that attempt to quantify morbidity and mortality outcomes for the purposes of comparisons across diseases, ages, or other frameworks (Hofstetter & Hammitt, 2002). In the realm of health economics, two of the more commonly used human health metrics are Health-Adjusted Life Years (often represented in QALYs or Disability-Adjusted Life Years (DALY)) and the Willingness-to-Pay/Willingness-to-Accept (WTP/WTa) framework. Both approaches seek to quantify and compare various health options, and both are commonly used in analyses of health economics (Adler, 2006; Hofstetter & Hammitt, 2002; Hammitt, 2002; Hammitt & Haninger, 2011). The former, however, does so through eliciting a measure representing one's quality of life (and then seeks to uniformly monetize the quality of life metrics); the latter simply seeks to elicit a value associated with any given health state. In recent years, there have been attempts to combine the two measures to assess a WTP/WTa per QALY (or other health-adjusted life year measure) or some other hybridized approach (Adler, 2006; Hammitt & Haninger, 2011). Following the descriptions below, Table 1 summarizes the features of these metrics.

Willingness-to-Pay/Willingness-to-Accept

Willingness-to-Pay or Willingness-to-Accept are constructs designed to assess the value of specific choices that could potentially impact an individual. In traditional cost-benefit analysis, the sum of the WTP/WTa would represent the value of the benefit of a given intervention (Adler M. D., 2006). The WTP/WTa framework was developed to assess environmental and transportation-related risks and, therefore, tends to focus more on mortality events than morbidity (Hammitt, 2002; Adler, 2006; Richardson, 2004). Nevertheless, some researchers suggest that because WTP/WTa can be understood as a rate of substitution between health and wealth, it can be used to evaluate small changes in health states; however, those same researchers suggest that it is challenging to employ a WTP/WTa framework to the entire burden of disease (Hofstetter & Hammitt, 2002; Hammitt, 2002). Furthermore, researchers that have examined the applicability of the WTP/WTa construct to morbidity events have found difficulty in eliciting an appropriate value for events that are relatively unlikely or not seen as substantially adverse even though there is a benefit to removing the likelihood of a negative event (Hofstetter & Hammitt, 2002). As an example, individuals elicit relatively low WTP/WTa amounts to avoid influenza due to its relative familiarity (Hong & Collins, 2006). Finally, some researchers suggest, the WTP/WTa amounts need to be adjusted to correct for individual biases that inhibit individuals from being able to assess the true nature of a beneficial activity (Adler & Posner, 1999; Adler, 2006).

WTP/WTa falls into a category of methodologies for eliciting the value of a particular outcome through a reductive process, broadly referred to as contingent valuation method (CVM) (Klose, 1999). The value of an individual's WTP/WTa for a given outcome can be elicited by direct or indirect methods; direct methods are derived from individuals' expressed preferences, whereas indirect methods are elicited from secondary data sources (e.g., wage-risk studies). Both approaches have some shortcomings. Direct methods can result in a variety of biases based on the way the questions are posed, the order in which the questions are posed, or in biases resulting from the context of the respondent; however, methodologies have been developed and deployed to attempt to limit the potential for bias (Klose, 1999). Indirect methods, such as wage-risk studies, may not serve as reliable proxies for health economics evaluations because of their intended purpose (setting compensation for risky occupations) and due to weak perceptions of risk by economic agents (Abelson, 2007). There is considerable literature (extensively cited in Klose, 1999) regarding the theoretical validity of WTP/WTa as it is correlated (or not) with income; most studies found the approach to be theoretically valid, but several also showed a positive correlation between social class and WTP.

Some critics suggest that WTP/WTa elicitation suffers from its theoretical approach, suggesting that individuals who actually face the disease state may value an intervention differently from those who have an abstract viewpoint (Klose, 1999). A related concern is that individuals may value an intervention differently for themselves than they do for those in their care. Research suggests, for example, that individuals value the prevention of harm to their children at a greater level than they do their own health (Hammitt & Hanniger, 2010). Another consideration

pertinent to an SROI analysis is the value that can be derived from a WTP/WTa from a societal perspective. Research suggests that WTP/WTa is influenced by whether the WTP/WTa reduces one's own risk for mortality/morbidity or if it offsets risk for a person in the general population (Klose, 1999). Furthermore, social WTP may be influenced by a respondent's economic situation or social awareness (Ubilava, Foster, Lusk, & Nilsson, 2010). Researchers in Australia have sought to minimize these concerns through introducing a (Relative) Social-Willingness to Pay (RS-WTP) instrument (Richardson, Iezzi, Sinha, & McKie, 2010).

Quality-Adjusted Life Years (QALYs)

QALYs (along with other measures of health-adjusted life years such as DALYs) measure the quality of life associated with one's state of health, with 1.0 being perfect health and 0.0 being death; some models allow for measures less than zero to represent states that are worse than death (Hofstetter & Hammitt, 2002; Wagstaff, 1991). QALYs are calculated by multiplying the measure of quality of life (or health-utility score) over a period of time; for example, a constant health state of 0.75 over 10 years would yield an undiscounted 7.5 QALYs (Whitehead & Ali, 2010). This construct allows for various states of health to be compared across diseases through reducing any state of health to a figure between the 0.0 to 1.0 state of health continuum, and it also allows for comparison of the expected health profiles of individuals through summing the states of health by year for the remainder of an individual's expected lifetime (Wagstaff, 1991; Hofstetter & Hammitt, 2002; Adler, 2006). Further, as a generic measure of health, QALYs can be aggregated across a population in a way that treats individuals blindly and therefore equitably (Hammitt, 2002). QALYs are designed to be value neutral in their application (Wenstein, 1988), whereas WTP/WTa can be inclusive of contextual information pertaining to an individual such as his or her wealth, risk tolerance, and perception of whether a potential event is seen as uncontrollable, unfamiliar, or dreaded.

To compare QALYs within a health economics (and hence an SROI) context, the QALY figure must first be elicited from a variety of health states and then a value per QALY must be assigned to monetize the QALY. Health-related quality of life may be elicited through direct methods – the most common of which are the Standard Gamble approach or Time Tradeoff approach – or may be elicited through generic health scales (Hammitt, 2002).

The Standard Gamble (SG) elicitation approach asks respondents to choose between two alternatives, one assuming normal health with some probability of immediate death and a second of living in a given state of health for a predetermined number of years. The probabilities are adjusted until the respondent is indifferent between the two options and that probability becomes the utility weight given to that state of health (Hofstetter & Hammitt, 2002; Hammitt, 2002; Whitehead & Ali, 2010). Humans have difficulty dealing with probabilities near zero and one, so some research has suggested transforming those probabilities through additional treatment, such as through use of probability-weighting functions (Stalmeier & Bezembinder, 1999; Hofstetter & Hammitt, 2002; Richardson, et al., 2010).

The Time-Tradeoff (TTO) method is more widely used than SG, in part because it does not involve the difficulty of deriving probabilities near the extremes (Richardson, Iezzi, Sinha, & McKie, 2010). This approach requires respondents to react to choices between a number of years in perfect health versus varied amounts of more years in a state of current health until the respondent is indifferent between the two choices; the number of years in perfect health divided by the number of years in the current state represent the health-utility measure (e.g., 15 years in perfect health versus 30 years in the current state reflect a 0.5 health-utility measure for that current health condition) (Hammit, 2002; Hofstetter & Hammit, 2002). However, some researchers have found that this method may not yield valid results when tradeoffs between relatively minor health impairments are considered (Mackeigan, O'Brien, & Oh, 1999).

In a social health context (and hence an SROI analysis) three major issues must be resolved: 1) how to combine morbidity and mortality impacts, 2) how to aggregate those impacts across time, and 3) how to aggregate those impacts across individuals (Hofstetter & Hammit, 2002). Given those challenges, there is some suggestion in the literature that the Person Tradeoff (PTO) elicitation approach is a more appropriate methodology. In this approach, respondents are asked to make a choice between a certain number of people living in perfect health relative to a larger number of living people in some less-than-perfect state; the resulting ratio is the health-utility measure. This approach removes the consideration of individual risk for a broader societal approach to risk (Hammit, 2002; Hofstetter & Hammit, 2002).

In addition to health-utility measures elicited through direct methods, there are those that are derived through indirect methods using generic preference-based measures. The most common method of choice for this type of measure is the EQ-5D, which examines five domains of quality of life: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. For each domain respondents have three choices regarding the level of their quality of life, therefore yielding 243 possible health states (Richardson & Manca, 2004; Whitehead & Ali, 2010). A broader measure of quality of life has been developed and deployed by the World Health Organization. Their framework, the WHOQOL, encompasses health classifications as well as self-esteem, body image, and general feelings. The WHOQOL includes 24 attributes grouped into six domains: physical, psychological, independence, social, environmental, and spiritual; the latter three typically fall outside of a traditional QALY-based approach (WHOQOL Group, 1998; Adler, 2006). Additional general generic preference-based measures are also available, including the SF-6D and the Health Utilities Mark 3 (HUI3). Both measures provide a variety of attributes and a framework for judging the level of health with regard to each attribute. In total, the SF-6D instruments provide for 18,000 unique health states and the HUI3 approach provides for 972,000 health states (Whitehead & Ali, 2010; Adler, 2006).

Table 1. Summary of Human Health Valuation Metrics

	Willingness-to-Pay/ Willingness-to-Accept (WTP/WTa)	Quality-Adjusted Life Years (QALYs)
Brief Description	<ul style="list-style-type: none"> Assesses the value of specific choices or interventions that could impact an individual Originally developed to assess environmental and transportation-related risks, thus tends to focus on mortality events rather than morbidity Can be used to evaluate small changes in health states 	<ul style="list-style-type: none"> Measures the quality of life associated with one's state of health (1=perfect health, 0=death); some models allow measures less than zero to represent states that are worse than death Similar to other health-adjusted life years, such as Disability-Adjusted Life Years (DALY)
Methodology	<ul style="list-style-type: none"> Contingent valuation method (CVM) Determines the value of an individual's willingness to pay for or accept a given outcome using direct or indirect methods <ul style="list-style-type: none"> Direct methods: uses surveyed individuals' expressed preferences Indirect methods: uses secondary data sources 	<ul style="list-style-type: none"> Calculated by measuring a health-utility score over a period of time (e.g., constant health state of 0.75 over 10 years yields an undiscounted 7.5 QALYs) Standard Gamble (SG) approach: respondents choose between normal health with some probability of immediate death, and living in a given state of health for a predetermined number of years; adjustments are made until the respondent is indifferent between the two options Time Tradeoff (TTO) approach: respondents react to choices between a number of years in perfect health versus varied amounts of more years in a state of current health until the respondent is indifferent between the two choices Person Tradeoff (PTO) approach: respondents determine a ratio between a certain number of people living in perfect health relative to a larger number of living people in some less-than-perfect state Generic health scales: e.g., EQ-5D (five domains of quality of life); WHOQOL (24 attributes of health classifications and self-esteem, body image, and general feelings); SF-6D (18,000 unique health states); Health Utilities Mark 3 (HUI3) (972,000 health states)

Table 1. Summary of Human Health Valuation Metrics (cont.)

	Willingness-to-Pay/ Willingness-to-Accept (WTP/WTa)	Quality-Adjusted Life Years (QALYs)
Advantages	<ul style="list-style-type: none"> • Theoretically valid; valuations usually not correlated to income of respondent • Methodologies have been developed to eliminate potential biases • Tailored to specific health choices • Can be used to evaluate small changes in health states 	<ul style="list-style-type: none"> • Allows various states of health to be compared across diseases • Allows for comparison of the expected health profiles of individuals through summing the states of health by year for the remainder of an individual's expected lifetime • Can be aggregated across a population in a value neutral manner
Disadvantages	<ul style="list-style-type: none"> • Biased results possible based on questioning methods, order, and/or context, including: <ul style="list-style-type: none"> • valuation may differ depending on whether the intervention is in the abstract or a real possibility for the individual • valuation may differ if the intervention is for the individual or someone else, like children • valuation may be affected by the individual's economic situation and/or social awareness 	<ul style="list-style-type: none"> • SG: Difficulties with probabilities near zero and one • TTO: Results may be invalid for tradeoffs between relatively minor health impairments

Monetization

Regardless of how the health-utility measure is derived, within a health economics context that measure must then be monetized. Monetization of each QALY can be derived in a number of ways:

- set at a consistent level per QALY (e.g., \$100,000 per QALY) – an approach commonly used by the U.S. Food and Drug Administration (Adler, 2006; Hammitt & Haninger, 2011);
- indexed according to a Value of a Statistical Life (VSL) or Value of a Statistical Life Year (VSLY) – another approach used by the FDA (Adler, 2006);
- elicited using a WTP/WPA per QALY-gained approach (Hammitt & Haninger, 2011); or
- a hybridized approach (Adler M. D., 2006).

Treatment of the various options for valuing QALYs is the subject of various reports and articles (Abelson, 2007; Baker, et al., 2011).

While there are a number of ways to monetize the health-utility measures, there is also no shortage of shortcomings in trying to do so. At the most basic level, in public health circles there is a relative reluctance to assign monetary value to human life (Garber, 2000). Beyond that, there is relatively little consensus on what the value of one life – VSL – should be and whether it should be considered in its whole or its component parts – VSLY – and whether those years should be indexed to some quality-of-life metric (Baker et al., 2011; Adler, 2006).

Even if all of the above could be answered in the affirmative, there is no consensus on how to index a VSLY to a health-utility measure, which health utility to use, or whether such an index should consider contextual issues such as age, disability status, or economic status. Should age be considered, there is no consensus around what is the age until which individuals should expect to receive equal treatment in terms of utility maximization (known as the “fair innings argument”) (Hofstetter & Hammitt, 2002; Robberstad, 2005). With respect to disability status, there is a concern that indexing a health-utility measure to determine the VSLY and incorporating disability status into the quality-of-life rating results in double jeopardy, arguing that individuals with disabilities suffer the consequences of their disability and then are less likely to receive benefits if resource allocation follows QALY maximization (Hofstetter & Hammitt, 2002; Robberstad, 2005). Additionally, there is some difficulty in eliciting health-related quality of life in individuals with disabilities – especially with those who have had the disability their entire lives – as they generally self-report relatively high quality of life (Grosse, Lollar, Campbell, & Chamie, 2009). With regard to the context of economic status, there is a concern insofar as WTP/WTB contributes to the monetization that principles of equity could be violated as populations, in the global sense, with a higher ability to pay would inherently benefit more (in terms of economic value) from an investment, thereby making an investment in a developed country appear to be more attractive than one in an underdeveloped country (Hofstetter & Hammitt, 2002; Robberstad, 2005). Hofstetter and Hammitt (2002) and Robberstad (2005) offer additional distributional and ethical considerations.

There is considerable discussion in the health economics literature as to whether present investments in health should be discounted and, if so, at what amount (Weinstein & Stason, 1977; Hofstetter & Hammitt, 2002). The principle behind discounting in economic valuations is the fact that individuals generally prefer income today rather than at some point in the future and, therefore, should be compensated for any deferral of income (Parsonage & Neuburger, 1992); in short, a dollar today is worth more to an individual than a dollar tomorrow. The argument against discounting is reflected in the idea that if discounting is applied, an intervention becomes more cost-effective the longer one waits to employ it; researchers have argued intrinsic time preference is normative, suggesting health interventions should not be discounted (Adler, 2006). Furthermore, some argue that the principles that suggest real income should be discounted are not present in terms of nonmonetary health benefits (Parsonage & Neuburger, 1992). However, Hofstetter and Hammitt (2002, citing Cropper & Sussman, 1990; Hammitt J. K., 1993) argue that this approach assumes the rate at which money can be exchanged for health remains constant and the relative social benefit of monetary value and measures of health do not change, an assumption they find to be unrealistic (Hofstetter & Hammitt, 2002). Others suggest that the value of health interventions should be discounted, however, perhaps not at the same rate as a typical dollar considered in economic evaluation.

This line of reasoning suggests that there is some immediate value (greater than the future value) of health interventions; but decisions concerning the allocation of resources in health decisions are often made according to factors other than economic choices. This line of reasoning also suggests that there are instances in which a positive rate of time preference may not be appropriate, such as concerns around equal treatment of individuals regardless of age (Richardson, 2004).

One point that should be emphasized is that, for the most part, SROI analysis does not attempt to definitively quantify and capture all aspects of the benefits of a successful program, but to identify direct, demonstrable cost savings or revenue contributions that result from that intervention. Some methods of social valuation attempt to use proxies to monetize self-esteem or satisfaction with services. Determining SROI is dependent on subjective considerations, so monetary values may differ between stakeholders and determining a monetary value for some benefits can be extremely difficult (Gair, 2009; Tuan, 2008).

Challenges of Implementing SROI in Organizations

While there is tremendous benefit for funders and practitioners alike in conducting SROI analyses – not the least of which is a better understanding of the financial and social impact of practitioners' efforts and the development of data that can be used to drive improvements in current practices – there are also a number of challenges associated with conducting SROI analyses. These include sufficient resources and commitment to gather and track the necessary information, as well as the difficulty, complexity, and subjective variability of the valuation techniques themselves (Tuan, 2008; Arvidson, Lyon, McKay, & Moro, 2010).

There has been much less research and writing about these practical organizational challenges, even though the organizational process is the most essential step toward successful implementation of impact measurement and tracking. The case studies in this research project are meant to help fill this knowledge gap.

One key challenge that has been identified is selecting the stakeholder groups that will define the most important measures of impact and building consensus around the various indicators. This is a challenge that can be exacerbated if the organization lacks clearly defined indicators of success or the data necessary to determine outcomes attributable to the organization's efforts. Building consensus around the value of any number of social and environmental impacts can also be challenging, particularly if such outcomes have a limited history of being monetized (Context International Cooperation, 2006; Mass, 2009; Mulgan, 2010).

A related concern is that the SROI methodology assumes a relatively linear process in which the value of inputs and activities can be measured and compared with the value of the population outcomes that are caused by an organization's outputs. In reality, change occurs in a much more nonlinear, chaotic way that can be difficult to measure (particularly in measuring component parts of outcomes attributable to outputs). Finally, at the organizational level, substantial financial and human resources are needed to conduct an SROI analysis; a specific commitment

by an organization and its funders is generally needed to ensure that SROI analysis is incorporated into an organization's daily operations (Context International Cooperation, 2006). Even REDF, the pioneer in SROI methodology, acknowledges the complexity and limitations of the existing approaches and discourages traditional SROI analysis, at present (Gair, 2009).

Tuan (2008) suggests additional challenges in conducting SROI analyses. One is that there are many assumptions involved in any SROI calculation and some cannot be easily tested or measured, while others – including projections of outputs or outcomes – can be measured retrospectively for their accuracy, but this is not usually done. An examination of assumptions and their application shows that they tend to be overly optimistic in their projections. Many organizations use methodologies that involve making multiple assumptions to project the future benefits. Very few of the organizations reassess those assumptions, and if the assumptions aren't being tested or adjusted, they will have little influence in informing the development of more accurate assumptions and calculations.

Another challenge Tuan (2008) notes is that determining the proportion of an observed change that is due to the activities of a single organization is difficult because of the complexity of change and the difficulty of determining what would have happened anyway. In addition, most SROI methodologies do not incorporate a consistent approach to dealing with value judgments. Each analysis reflects the values of the researcher as to how the costs and benefits are distributed among stakeholders and how the various outcomes are valued.

Tuan (2008) also notes the lack of agreement on the definition of terms when measuring social impact. This presents a challenge if we want to compare and contrast methodologies and results among various organizations and programs. Similarly, very few common measures are being used to evaluate social impact in the social sector, whether within a program area or across program areas. Even the very best methodology cannot compensate for the lack of common measures, as each intervention is measuring its results differently. The health field is the one area that stands out in its use of common measures, namely DALYs and QALYs, which then allows for comparison of cost-effectiveness ratios of all health interventions.

A report on three dozen interviews of representatives from foundations, corporations, and other organizations engaged in proactive social investment (Kramer, 2006) explores how these organizations manage their social investments and measure their financial and social benefits. One theme is that there is a trade-off between completeness and credibility with regard to measuring social benefits, and their interviewees suggested that credibility is the most important consideration. This motivates one of their "lessons learned" to concentrate on only a few simple performance indicators. In their case study section, looking at Renewable Energy Enterprise Development (REED), they note that REED followed a conservative valuation approach, aiming to calculate the minimum demonstrable benefit rather than the full range of benefits that may result:

REED appears to have accepted the inevitable trade-off between completeness and credibility. Being able to demonstrate a minimum of \$14 million in socio-economic and environmental benefits from a \$1.6 million investment is

sufficiently compelling that they have chosen an irrefutable methodology for a narrow definition of impacts, rather than aiming for higher returns by falling back on more speculative calculations. (Kramer, 2006, p. 49)

Another challenge is that there are no incentives for nonprofit organizations to be transparent in sharing the results of their analyses. As Trelstad (2008) notes, if the social sector is able to generate data to allow analyses and comparisons of organizations or programs based on their social return, there will be clear winners and losers based on these analyses. Without incentives for organizations to be transparent about their data, whether good or bad, the poorer results will likely be buried and only the good results shared (Tuan, 2008).

According to Bugg-Levine and Emerson (2011), data integrity in SROIs should be seen as a public good that everyone interested in the future of the impact-investing field will need to steward carefully. But among investors, social entrepreneurs, third-party institutions, and government regulators, it is not clear who should invest the necessary time to develop tools and capabilities to ensure data integrity.

Bugg-Levine and Emerson (2011) note that there seems to be a tension between business management and data integrity: “Too many systems [of measurement] make impact investing too hard by creating burdens of proof for claims of social impact that cost too much to implement and risk distracting management from running their business” (p. 180). Some social entrepreneurs take the position that if investors want quantifiable numbers, then investors themselves should pay for creating the systems that gather and verify them, while some investors insist on only those measurements paid for by other institutions. Bugg-Levine and Emerson also note that auditing and assurance firms may be eager to provide verification services “partly as a corporate responsibility commitment and partly out of the awareness that social impact auditing could become a major business line” (p. 181).

Partially in response to the challenges outlined above and in recognition of a natural evolution of SROI analyses, in 2009 REDF proposed three “must haves” for the next generation of SROI analyses:

- An analysis must use credible financial and social outcomes data from proven systems and the analysis must create analytical reports fed by that data.
- An analysis must capture and analyze return in both nonmonetary and monetary units of value.
- An analysis must be designed in such a way that it provides answers to the questions that are being asked.

REDF suggests that to meet these three criteria, innovation in software to assist organizations in developing pertinent metrics and effectively and efficiently tracking data relevant to those metrics will be necessary (Gair, 2009).

Two additional precautions have been outlined by practitioners, funders, and academics in the SROI arena: 1) caution in reducing all activity associated with an organization's activities to a single SROI ratio, and 2) the related concern of using the SROI ratio to compare the efficacy of different organizations with different missions and services (Clifford, 2010).

While SROI is intended to include impacts that can be monetized – which feed the SROI metric – and those that cannot, practitioners and funders often tend to focus only on the SROI ratio. These “returns” have generally been cost savings for government entities due to the difficulties of monetizing other social benefits; as a result, the ratio does not necessarily encompass all of the social benefit derived from an organization's activities.

Another problem with reporting SROI as a single benefit-cost ratio is that the ratio does not stay constant as you change the size of the project. For example, given two projects with blended index numbers greater than one, the project with a higher blended index number is not always better.

Consider Projects I and II. Project I has a social benefit of \$100 and a social cost of \$1. Project I's benefit to cost ratio (B/C) = 100, and its net social benefit (NSB) is \$99. Project II has a social benefit of \$15 million and a social cost of \$10 million. Thus, Project II's B/C = 1.5 and its NSB is \$5 million. Obviously, Project II has a higher net social benefit, but Project I has a much higher B/C . Projects I and II could be the same project at different points in time. Project I could be the pilot phase, Project II could be the same project being brought to scale. According to the ratio method of reporting SROI, you would mistakenly believe that going to scale was a disaster (Steinberg, 2012).

Blended value returns reported as a single ratio are also prone to certain transparency problems. According to the Foundation Strategy Group, a blended value return

is less useful in comparing different social investments ... precisely because it blends financial returns with social benefits. For example, a blended value return of 12% does not distinguish between an investment with an 8% financial return to the investor and a 4% socio-economic benefit to society, versus a 4% return to the investor and 8% to society, although two social investors would likely view these investments quite differently. (Kramer, 2006, p. 42)

They suggest that taking into account the enterprise index of return as well as the social purpose index of return separately, or providing additional information about the substance and context of social value could help provide an accurate interpretation of SROI.

Even if all benefits could be accurately and consistently accounted for, there are a number of contextual differences within which nonprofits operate, and these various contexts are likely to pose challenges that will affect the SROI ratio. A nonprofit working to address the most challenging issues could be penalized if compared generally to all other organizations simply because of the challenges posed by their work; caution should therefore be exercised in comparing SROI figures across organizations, programs, projects, or interventions (Gair, 2009; Olsen & Nicholls, 2005; Tuan, 2008).

The following sections provide the four case studies of social-venture organizations that have implemented some sort of SROI measurement. The sophistication and extent of organizational integration of the SROI measures vary considerably. All provide some insight to extend the existing knowledge of SROI techniques and implementation challenges. It will become clear overall, however, that the scholarly explorations of state-of-the-art SROI techniques are much more advanced than their practical uses (at least so far) in organizations.

NETHERLANDS CASE STUDY – CAREFARM PARADIJS



Background

CareFarm Paradijs is an organic, social farming enterprise in the Paradijs region of the Netherlands, near Barneveld. The farm produces and sells vegetables, strawberries, eggs, and meat while also pursuing broader social goals: mitigating the effects of chronic illness, improving the quality of life, and delaying the institutionalization of targeted vulnerable populations by providing outstanding care and therapeutic activities in a natural environment.

Care farming (also called social farming or green care) evolved from the belief that social services and health care could be delivered in a way that would improve the well-being of individuals through interacting with nature and agriculture, while also serving as a catalyst for rural economic development and contributing to the economic viability of local farms. “Social farming includes all activities that use agricultural resources, both from plants and animals, in order to promote (or to generate) therapy, rehabilitation, social inclusion, education and social services in rural areas” (Di Iacovo & O’Connor, 2009, Introduction). Care farming adopts a multifunctional view of agriculture including generating revenue through saleable products, as well as providing community-based social benefits such as employment, education, and therapy (Dilacovo & O’Connor, 2009, p. 21). Such a multifunctional strategy recognizes the need to diversify farm revenue streams so as to be sustainable.

Care farming is a legally recognized form of business in the Netherlands, where the number of care farms has grown from 75 in 1998 to more than 800 in 2008 (Ellings & Hassink, 2008, as cited in Hopkins, 2011).

CareFarm Paradijs and other working farms in the Netherlands enable people with specific human service needs to engage in farming activities with direct supervision from farmers, social practitioners, and volunteers. Improved quality of life is the overall intended benefit; more specifically, care farming increases physical activity, provides mental or restorative therapeutic effects, allows for social inclusion, and fosters a sense of self-worth in contributing to the operations of a farm. As Hopkins (2011) states in a previous study of Paradijs, “It seemed as if caring for one another, whether client, staff, family and so on, created an environment in which people could focus on their abilities rather than their weaknesses” (Hopkins, 2011, p. iv).

Paradijs was founded in 2005 after a two-year due diligence process to determine how to best repurpose a dairy farm with 80 milking cows and 50 hectares of land. The resulting social enterprise blended two types of social farming: employment-oriented and care-oriented. Employment-oriented care farming “employs” marginalized groups such as children and adults with autism; the elderly, with and without dementia; the formerly incarcerated; people with Down’s syndrome; mental health patients; the chronically unemployed; and those who are no longer able to work because of severe burnout. Care-oriented social farming provides direct care to such people.

CareFarm Paradijs serves the elderly, adults with a range of mental health challenges, and autistic children. Work-oriented adult day care and weekend care for children with autism are the two primary services, offered to approximately 150 clients. The farm’s client workers are integral to farm production, but their work is uncompensated – a typical care-oriented business practice. The philosophy of CareFarm Paradijs is to be client-centric and integrated with the client’s support network, and to value individuality, teamwork, and innovation. These elements are integral to the overall experience and incorporated into the culture of the organization and service delivery.

Each day clients perform specific activities such as harvesting eggs, tending to the organic vegetable garden, or cooking for the entire group. Their skills and capabilities are valued and often enhanced through the social farming experience. The clients perceive their work to be meaningful and take great satisfaction in contributing to the business operations of the farm. Clients place such a high value on their contributions that they consider agricultural production, not care, as the farm’s primary purpose.

The owner operators of CareFarm Paradijs are Ijsbrand and Caroline Snoeijs. Ijsbrand Snoeijs explained in a research interview that the farm is a social enterprise where profitability is a primary purpose, but that any financial benefit is tied directly to its stated social mission and impact goals. CareFarm’s articles of incorporation mandate that dividends are distributed only if the annual social targets and objectives set by the advisory board are met. If the targets go unmet, the board would recommend reinvesting any surplus in order to meet those social targets.

The Netherlands-based social investment firm Noaber Ventures loaned €100,000 to CareFarm Paradijs in 2005, to be repaid within four years. By year-end 2007, Paradijs broke even, and the farm has generated a profit each consecutive year. In 2010 revenue derived from agricultural sales and fees from care services totaled €1.1 million; the farm’s gross profit was 12 percent and net profit was 8.7 percent.

Revenue at the farm is derived from four sources. Public funding is one source for employment-oriented social farming; health insurers and care institutions also compensate CareFarm Paradijs for the two types of care provided to their clients. The fourth source, agricultural revenue, remains critical for sustainability. It is generated from exporting eggs from the farm’s 6,000 chickens, the sale of organic produce to local chefs, and the sale of products directly to

consumers at a store on site at fair market prices. Ijsbrand Snoeij promotes the farm by engaging with surrounding communities, creating goodwill and nurturing potential volunteers and customers. Community engagement is especially important because 20 credentialed people and 60 volunteers are required to operate the farm each day.

Snoeij's efforts have had positive consequences, both financial and nonfinancial. He reports that Paradijs is regarded by local communities as a nongovernmental organization or foundation even though it is a for-profit social enterprise. Community support for Paradijs is based on five important assets: the quality, taste, freshness, and organic character of the farm's products and its social mission. This support is expressed in donations of both time and money; volunteers renovated the farm kitchen with donated funds, for example. Social investors have funded Paradijs' group meeting room and a retail storefront. Paradijs' sustainable farming practices made it eligible for government funding to build a new chicken barn. An unintended consequence of the development of Paradijs was the community's enthusiasm for the local food movement. Most of the Netherlands population's food supply is imported from outside the region. Because of the distance between consumer and producer, consumers have limited knowledge of agricultural practices. With CareFarm Paradijs producing local products by local people, consumers have re-established a relationship with food by better understanding food distribution and the benefits of local farming.

SROI Process at CareFarm Paradijs

Care farming is a good example of the importance of SROI: It "produces" improved health, employment, education, and therapy in addition to generating revenue from agricultural products. Assessing the monetary value of social, emotional, and physical improvements for care-farming clients, however, is extremely challenging given the lack of associated market pricing.

As part of an investment and other consulting support from Noaber Ventures, CareFarm Paradijs engaged consultant Geert-Jan Baan to assess its SROI using the Social E-valuator software. According to Baan, "SROI tells the story of how change is being created by measuring social, environmental, and economic outcomes – and uses monetary values to represent them."

The Social E-valuator valuation was a 10-step process, with each step relying on the answers given in the previous step. The process started with clarifying the theory of change for CareFarm Paradijs, which was already fairly well developed. Several categories of stakeholder were then identified and interviewed to understand how to calculate what each stakeholder group puts into and gets from the enterprise and what sorts of social returns to measure. The first group of stakeholders consisted of the clients: elderly people with dementia, adolescents with autism, and people with mental illnesses. Other stakeholders were caregivers, volunteers, local followers from adjacent communities, families of clients, and funders.

Across all targeted groups and caretakers, improvements in quality of life were identified as the overwhelming benefit from participating at Paradijs. There were also specific outcomes associated with each type of client:

- Dementia clients received continued stimulation of their long-term memory and fewer clinical visits, and nursing home placement was postponed.
- Adolescents with autism formed a unique social cohesion during their weekends at the farm.
- Patients with mental illness reported requiring less clinical care and, at times, lower medication dosages.

The benefits to clients extend beyond the social returns from their involvement; they contribute to creating social returns as well. As Snoeij puts it, “Clients are not only involved in the farm for what they receive, but also for what they give to one another, and to the community and society.”

The SROI calculation process involved identifying and assessing the many social impacts for the stakeholders: extra time alone for caregivers of the clients working at the farm, greater quality of life or social integration for the clients, the value saved from avoiding institutionalization or other medical care, and the economic and scenic benefits of the farm itself. Many assumptions were made about the number of clients who benefited from their experience on the farm – assumptions that were, by design, extremely conservative. Through extensive research, proxy cost measures were identified to quantify each identified social impact (e.g., finding studies of the estimated medical-cost savings from improved activity for dementia patients).

One goal of the SROI process in this case was to provide better data about the benefits of social farming and to communicate those benefits in a way that could counter some misconceptions, such as the perception that people go to care farms merely to “work” rather than to receive quality care and develop skills. The process was successful in meeting these goals.

Challenges to Implementing SROI at CareFarm Paradijs

While there were clear benefits to this SROI process for the CareFarm Paradijs staff, funders, and other stakeholders, it required a tremendous amount of research and work to produce the assessment and proved difficult at many stages of the assessment. The difficulties arose on many levels and for the many outcomes connected to each stakeholder input and output.

First and foremost, the data to measure the social impacts was not provided by the stakeholders themselves. This process started actually in 2012. Quantifying and especially monetizing the identified social outcomes was made even more complex because the process of finding appropriate proxies and translating those into specific monetary measures was unprecedented in the social farming industry. This was in part a “substitutability” problem: determining whether a particular proxy measure taken from an outside source (e.g., research, government information) was an appropriate substitute measure for an outcome that was not directly quantified in practice. Quantifying specific cost-savings estimates for deferred or avoided medical care was particularly challenging, as was quantifying “softer” outcomes such as improved sense of personal well-being among the clients or additional quality time spent with

their grandchildren. Finally, doing this quantification and monetization consistently and uniformly across different social returns added a layer of difficulty.

Another major challenge was that the social returns caused (or potentially caused) by CareFarm Paradijs were not just multiple, but extensive and far-reaching. It proved difficult to find a place to put the limit on the “ripple effect” of social impacts caused by any one type of activity at the farm. Where do you stop measuring the impacts that seem to keep leading to other impacts? Similarly, the social impacts were “caused” by a variety of overlapping, interactive factors that are impossible to disentangle for purposes of analysis. Snoeij emphasizes this as a reason why the overall enterprise works in an integrated way, noting that “social impact arises because of the combination of entrepreneurship, stakeholder’s involvement, community-building, and the green productive environment.”

Lessons Learned

Perhaps the primary lesson to take from this case is that the process of talking about, identifying, and specifying the many social benefits caused by this care farm was valuable in itself, probably even more valuable than the calculation and final SROI ratio number produced by that learning process. It helped improve transparency in the organization, as well as forcing stakeholders to think through and share their understanding of the social returns their work engenders. Even the difficult process of quantifying what seems unquantifiable had the benefit of forcing the stakeholders and analysts to focus closely on the nature of that benefit. In a sense, then, conducting an SROI assessment can be a way for organizations to learn about themselves and reinforce a shared sense of purpose and vision.

The Paradijs case also points to the importance of talking to a wide range of stakeholders in doing an SROI analysis, not just to the primary ones (e.g., staff and funders). Talking to families and to the clients, as well as to each type of client, filled out the SROI picture in a more complete and therefore accurate way.

Because quantification is so difficult and some amount of subjectivity is inevitable in the measurement process, it is important to avoid over-claiming the extent of a social return, especially when there are rippling, compounding returns. The SROI measures in this case could have come out much higher than is reasonable, and that would have raised questions about the legitimacy of the measurement itself.

Attempts to track and measure social impact continued after the intensive initial CareFarm Paradijs SROI assessment, as new information on social impact started to come from stakeholders a few years later. There was a delay from the initial analysis, however, and the social-impact assessments were not conducted in the same quantitative manner. Those involved saw this disjuncture in the measurement process as a lost opportunity. Furthermore, there were no continuous efforts made to measure directly and track social, emotional, and physical health improvements among the clients. The lesson from this is that there are clear benefits to monitoring social-return measures in a similar (though refined) way over time and to refining those measures with experience, rather than to conduct formal SROI assessment as a “one-off”

process. The benefits of SROI as a tool for learning and communicating the value of a social enterprise are diminished if the initial measurements become dated and new and better ways of measuring (e.g., new proxy sources) become available. The amount of a social impact that is due to the organization's activities (i.e., attribution) is something that is best measured over time, through tracking and perhaps more sophisticated evaluation methods.

NETHERLANDS CASE STUDY – VITALHEALTH SOFTWARE



Background

VitalHealth is an eHealth solutions enterprise with a focus on social impact. The company's view is that for-profit companies look at the financial bottom line for investors and employees, while nonprofits look at societal impact. On that spectrum, it is a social-enterprise corporation, valuing social impact more than profit but keeping profit in mind. Its sales and development processes include taking account of societal impact as well as financial impact. The company also reports societal-impact indicators in management reporting and uses them to determine bonuses for its employees.

VitalHealth was founded through a collaboration between Mayo Clinic and Noaber, and has 120 employees. It is active in the Netherlands, the United States, India, and Germany. Its products revolve around personalized Collaborative Health Management (CHM) systems that can integrate with other systems and are accessible to both professionals and the patient. VitalHealth's CHM systems provide professionals with comprehensive support that is knowledge-based and patient-centric. Patients can also actively participate in their own health care through individualized patient portals in primary care and mental health, eHealth in areas such as diabetes to assist in education and self-regulation, and clinical pathways.

Primary care in the Netherlands requires that general practitioners (GPs) for chronic diseases act as care brokers for their patients. GPs receive a form of lump-sum financing, called Diagnosis Treatment Combinations, which means that a GP will get a certain amount of money for, say, a diabetes patient, and will need to provide all the care for that patient. For example, if a GP's patient needs a dietician, the GP will pay that dietician.

In the Netherlands, patients need a referral from their GP to see a specialist. Most (98 percent) of GPs in the Netherlands have electronic health records, but they use different systems that are not usually accessible to patients. This leads to several challenges identified by VitalHealth:

- Information is not shared among medical professionals.
- Data management and referrals are poorly handled.
- Compliance with protocols is limited.

- Integrating new protocols, standards, and knowledge into the daily practice of medical professionals has a time lag.
- The patient has insufficient involvement and empowerment.
- Emphasis is on treatment instead of prevention.

VitalHealth Software operates on the belief that proactive health management, tailored to the needs of individuals and delivered through seamless health networks that are accessible to all people involved in giving care as well as the patient, addresses these challenges.

Staff of VitalHealth Software and shaerpa (a spinoff of Noaber that provides consulting services) were interviewed to obtain background on the process they used to determine their SROI and how SROI is integrated into their business.

SROI Process at VitalHealth

VitalHealth worked with shaerpa to develop its SROI, eventually conducting each step in the process and using the Social E-valuator software. To provide input, VitalHealth asked for volunteers from different parts of the company. It held workshops where 10 employees met to provide input to shaerpa before and after it developed the SROI. At the first workshop, the employees discussed the theory of change of their company – a framework for attributing causes to their desired social goals. They also compared individual projects within the company with the overall theory of change. They determined that the solutions delivered by VitalHealth Software can reduce the incidence and severity of complications (mainly for people with chronic diseases) as well as the number and time of consultations or (re)admittances (which includes the avoidance of transfer to a next line of care). Ultimately, these led to an improvement in the quality of life and care and reduced the cost of treatment.

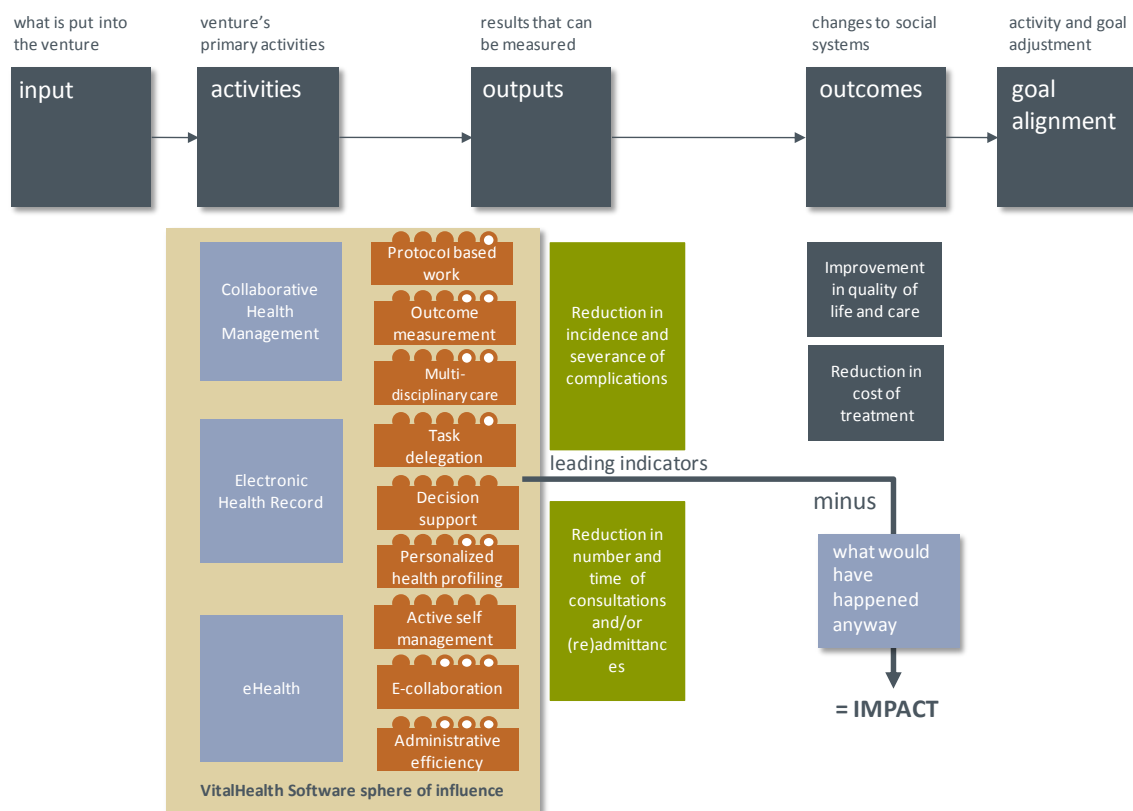
The first step in determining VitalHealth's theory of change was to describe the social problem it sought to address. The biggest social problem it identified was that task delegation was not sufficiently facilitated by the GP systems. In other words, the GP systems did not support good patient-care management. Additional social problems were poor communication between caregivers working according to the guidelines and bringing into the picture the risk profile of the patient.

It then described the urgency of the problem, which it tried to make concrete. For example, VitalHealth noted that there is a higher risk of complications with cardiovascular diseases because caregivers are not sufficiently facilitated to communicate about patients methodically with other caregivers. It also determined the scale of the problem. It found that there were 6,500 diabetes patients in a given year in Almelo and surrounding areas and noted that 40 percent to 50 percent of those patients had high risk of cardiovascular diseases. Given such high risk of complications, it determined that about 56 percent of the GPs were not fully working according to the standards. VitalHealth hypothesized that this risk will decrease when people are working according to the guidelines.

In order to solve this problem it introduced a CHM system to facilitate communication between caregivers and working according to the guidelines, keeping account of the risk profiles of patients, and facilitating task delegation. The specific goals of the project were for all diabetes patients in the GP practices in Almelo and surrounding areas to include the CHM system, whereby task delegation is possible and caregivers can work according to the guidelines and to facilitate communication between caregivers. The timeline was between 2006 and 2010. The VitalHealth SROI measurement team then generated a list of outcomes and rated them in order of importance from 1 to 5. It held several more workshops over 18 months where, with shaerpa's assistance, it identified other pieces of the SROI analysis and obtained research on the health of patients and the effect on primary care for hospitals.

Figure 1 represents VitalHealth's summary of how it analyzed social returns in the context of its theory of change, using information gathered from the workshops with shaerpa, VitalHealth's interviews with caregivers, and other data collected. Notice how "active self-management" is rated with five dark circles, while "administrative efficiency" is rated with only two. According to the framework, these ratings suggest that active self-management has a higher social return on investment than administrative efficiency. The rationale for this, the summary notes, is that higher administrative efficiency would save maybe one day of a bookkeeper's time a year, which is much less important than the time saved for a health care professional through active self-management.

Figure 1: SROI Analysis of VitalHealth using Social E-valuator



Inputs were identified as investments as well as time for each stakeholder: patients, their caregivers, doctors, administrators, etc. For loans, only the part of the loan that was below market rate was included. To determine outcomes and impact, literature was examined on complications from diabetes and it was determined that 40 percent to 50 percent of patients developed complications, while patients using VitalHealth software had 22.5 percent. To estimate impact, the reduction in complications was attributed to the program. A 50 percent deadweight was assigned in deliberation with the customer, aiming to stay on the safe side regarding the impact of the VitalHealth software. The resulting SROI calculation was then revised in an iterative process. After the initial calculations, shaerpa recalibrated the measurements after further input from workshop participants and further research on specific outcomes.

Challenges to Implementing SROI at VitalHealth

The VitalHealth SROI process was intensive, iterative, and highly informed both by primary data from stakeholders and direct measurements and by secondary data from other literature. Even this careful SROI process, however, was highly sensitive to small changes in assumptions used in the calculation model, and to small areas of uncertainty or missing information. A small change in impact measurements or deadweight percentage made a big difference in the eventual SROI ratio calculation. Shaerpa has done SROIs for many companies like VitalHealth, and it has concluded that the general tendency is to overestimate the contribution and impact percentages, skewing the SROI ratios upward. This is something that SROI analysts should always be keenly aware of when doing analysis, especially when information is particularly scarce.

VitalHealth staff also noted that considerable expertise is needed to conduct SROI, whether using Social E-valuator or another tool. Expertise is important, for instance, in calculating deadweight attribution so that activities are not double counted. They also indicated that the most difficult part of the process was to estimate value. Estimating value retrospectively has many advantages, however, such as being able to determine if there were unintended consequences. And estimating it prospectively helps with data collection because systems can be put in place to collect data, which is easier than going back and trying to collect data retrospectively. So while valuation is particularly difficult, it is an essential part of the SROI calculation process. Knowing this, the VitalHealth team indicated that it was important to be transparent about the many assumptions used when estimating value, and changing calculations when new information required prior assumptions to change.

Interviewees stressed that adopting an SROI approach to a project also requires significant resources, especially in terms of time and level of commitment of participants. Estimating the amount of time needed to implement SROI can be difficult, as this depends on factors such as the availability of the required data and the skills of those involved in the process.

Lessons Learned

Through this SROI calculation process, VitalHealth learned about what it values and contributes as a social enterprise, and some of its assumptions about how it achieves these contributions had to be reconsidered. For instance, one activity that VitalHealth staff originally thought would have the greatest impact was increased administrative efficiency, but as shown above this did not lead to as large an impact as predicted, relative to other activities.

Moreover, calculating SROI is now an integral part of VitalHealth's organizational processes, including prospective planning processes, and in this way SROI is kept salient as a valued organizational priority and learning tool. VitalHealth staff perform at least two full SROI calculations a year, discuss social impact in staff meetings and strategy documents, and define targets for impact indicators in communication with stakeholders. They report impact indicators within their management and board reports. They focus on six ratios, and two are social indicators. Perhaps most significant, a part of VitalHealth's employee bonus system is based on SROI performance. If VitalHealth has two opportunities, it considers social impact in the decision to proceed with the opportunity. It has meetings, called VitalColleges, of all employees four times a year, and through these everyone in the company is made aware of the importance of SROI.

As noted earlier, the VitalHealth case shows how adopting an SROI measurement process requires considerable resources – especially time and organizational commitments – and considerable expertise. For one thing, this case shows how some kind of consultant or outside partner is likely needed for an SROI process as extensive (and useful) as VitalHealth's, at least for the first time such an SROI process is conducted.

It is curious to note that the VitalHealth staff and consultants who have worked so extensively on their SROI process often remarked how the *process* (staff meetings to discuss social impacts, stakeholder conversations, and so on) has turned out to be more important than the *product* (the actual ratio). Through this process, the organization learned about its priorities and programs by determining the stakeholders, inputs, outcomes, and how much a program contributed to those outcomes. It identified and engaged stakeholders in a new way, which has benefits beyond a mere SROI number, and identified the main drivers of social value, which helps to refine its programs to maximize those values.

The VitalHealth case also reveals a few other cautions about SROI calculations. First, analysts should be careful not to overstate the role of the program's activities in directly creating impacts. Attempting to attribute 100 percent of benefits or unrelated benefits to the activities of any organization can undermine the credibility of the SROI analysis. It is also important to be transparent about the assumptions being made. One suggestion is to conduct sensitivity analyses to test how much certain assumptions matter in the calculations (e.g., What would be our return on investment if we assumed different attribution or deadweight levels?). Recognizing that SROI is not an exact science and presenting varying scenarios can deflect criticisms of the process.

AMERICAN CASE STUDY – WELLNESS CENTER AT PAN AMERICAN ACADEMY



Background

Pan American Academy is a K-8 charter school in a heavily Latino and relatively underprivileged urban neighborhood in northeastern Philadelphia. Like other charter schools in the United States, Pan American receives some per-pupil government funding, but is privately organized and operated, with part of the budget covered by private charitable funds. Also like other charter schools, it has a particular educational focus. For Pan American Academy, this focus is intercultural understanding and awareness, which is infused into all aspects of the curriculum.

The school-based wellness center at Pan American Academy is one of about 1,900 such centers across the United States. It serves children who live in medically underserved areas and who face the chronic health problems, such as allergies and asthma, usually associated with poverty and lack of access to medical care. The wellness center provides primary and preventive medical care to these children in the charter school, as well as an Asthma Home Assessment program in which nurse practitioners visit students' homes to assess environmental and health risks (e.g., dust-collection spots) that could trigger asthma attacks. It is hoped that this sort of early intervention and prevention will help the children miss fewer school days due to illness, have fewer visits to the emergency room for health care, and avoid the consequences of undertreated chronic illnesses.

The school-based wellness center is operated by five partner organizations. In addition to the academy itself, the organizations are Congreso de Latinos Unidos Inc., the National Nursing Center Consortium, Education-Plus Inc., and Temple University's Department of Nursing. The partners perform various roles and coordinate various activities as stakeholders in the wellness center, such as staffing and funding.

Staffing of the wellness center comes mainly from Temple University's nurse practitioner program. Five or six nursing students volunteer one day per week at the center during the four years of their program at the university, and they work with four staff nurse practitioners (also from Temple) who rotate time at the center. Health educators from the other partner organizations also help with certain staff functions. Funding comes from money raised or contributed by the other stakeholders, especially Education-Plus Inc., as well as other

contributions and some payments from Medicaid and other health insurance programs. The governance structure of the wellness center is relatively informal, with representatives of partner organizations working closely with Pan American Academy staff on planning and fundraising.

Characteristics that stand out in Pan American's center, compared to other school-based wellness centers across the country, relate to the unique role of the nurse practitioner. The nurse practitioner has advanced assessment skills and prescribing powers. The authority of nurse practitioners to prescribe medication at school-based wellness centers, while it varies by state, is found to be a key tool in certain areas for preventing illnesses that might otherwise require emergency care. In the zip code surrounding the Pan American Academy, for example, there is a higher rate of children with asthma-related health problems (33 percent) than found in children from surrounding zip codes (Woods, 2011). Nurse practitioners in a school-based wellness center who are able to prescribe medication for asthma are particularly beneficial for this population of children.

SROI Process at the Wellness Center

An SROI evaluation of the Pan American Academy wellness center was conducted in 2011 by a master's degree student at the University of Pennsylvania (Woods, 2011). The evaluation focused on one specific intended outcome of the center's work: the cost savings from the decrease in emergency room (ER) visits that is an intended result of the center's Asthma Home Assessment program. (Note that this "ER diversion" is but one impact of one particular service of the center.)

The student collected data for the assessment through interviews with staff and stakeholders as well as background research on health outcomes from home health care, average costs of ER visits, and other topics. She interviewed the center's nurse practitioners about how many home assessments they had done in the previous year, and asked them to estimate how much they thought such a home visit cost the center and its staff. She found the nurse practitioners of the wellness center had, over the course of a year, conducted 20 home assessments. The cost estimates the nurses provided were all close to \$50 per home assessment, so she used this figure in the SROI calculation.

The nurse practitioners said they safely assume that each child receiving a home assessment would have had to visit the ER at some point during that year – most likely due to an acute asthma attack – if they had not received the assessment to identify and correct some of the risks in the home. So one home visit was seen as preventing one visit to the ER. The researcher then estimated the average cost of one ER visit at \$600, which is a conservative estimate taken from Aetna Health, an American health insurance company. (Note that this number does not include the cost of hospitalization, which may be at least 10 times higher.)

The final SROI calculation tallied the amount that would have been spent on ER visits without the home assessments for those 20 children (\$12,000), minus the cost of conducting the home

assessments (\$1,000). Therefore, the SROI of this one aspect of the wellness center's work, for that one year, was determined to be \$11,000 in cost savings from ER diversion.

The student researcher also gathered some informal evidence of other social impacts from the work of the wellness center at Pan American. She found that absentee rates at the school went down over time, while the center's services expanded. The stakeholders interviewed for this project said they believed that those two trends were connected because attendance by those students receiving services had improved, but they did not have the data to quantify a correlation. If so, this would certainly result in benefits for the children, who would not fall behind academically, and for parents, who would not have to take time off work to take their children home or to another medical center for care.

Feedback from stakeholder organizations and center staff who experienced the SROI calculation process was positive. They said they were not surprised by the result of the calculation, because it suggested strengths and weaknesses of the program that they had already acknowledged. The student researcher noted in an interview how the SROI process was positive overall because it reminded everyone of the bigger picture of the center's work and brought attention to the specific goals and the theory of change behind it. In discussing her analysis with various center partners, she also suggested what the organizations might do to maximize their social returns. But it appears that the wellness center and Pan American Academy staff have not made much explicit use of the findings of this SROI analysis to date.

Challenges to Implementing SROI at the Wellness Center

The scope of the SROI analysis of the wellness center at Pan American Academy was clearly very limited. The primary challenge to note, then, is the difficulty of addressing the many possible social impacts of a preventive and early-intervention health care initiative such as this one, particularly among children who could benefit from such care for many years after.

There are a number of other social returns that could be included in an SROI assessment of the center, such as the benefits of providing immunizations, allergy treatments, or other primary care; the cost savings of those other treatments; the long-term benefits of asthma home assessments in addition to the short-term ER diversions; and, of course, the many positive social and familial outcomes that result from healthier children. Also, this SROI calculation focused just on the direct health care cost savings as the return, and not on any of the other social impacts or indirect cost savings of this one aspect of the program (or the other outcomes of the center).

The process of calculating the SROI of the wellness center presented challenges as well, including getting access to the full range of stakeholders to interview for data collection (e.g., parents, health care officials, busy nursing students) and asking them the right questions, which was a particular challenge noted by the student researcher. This goes to the broader challenge of having the professional evaluation and technical expertise necessary to collect SROI information and do calculations. Stakeholders are sometimes unaware of the full extent of

potential social impacts of their work, so the researcher needs to ask the right questions to get a comprehensive assessment.

Finally, this SROI assessment was a one-time analysis. The underlying issue of all these challenges is acquiring the resources necessary to conduct a comprehensive and sophisticated SROI analysis. In this case, many more resources would be needed to gather the necessary data to measure the range of social benefits of wellness center care, to track those over time, and to integrate the findings into the center's programs, marketing, or other processes.

Lessons Learned

Compared to the European cases that go through the comprehensive Social E-valuator steps, the process used for calculating SROI in the Pan American wellness center was more limited in scope and deviated from the Social E-valuator steps in important ways. This analysis focused on only one outcome, it identified the outcome at an early stage of the process and other steps followed from that, and it quantified that outcome in terms of cost savings only.

While this case again points to the ideal scenario of a comprehensive, longitudinal, professional SROI assessment – even if that ideal is hard to achieve and to support – it can provide a good lesson for other situations with a limited scope from the beginning, in which that more sophisticated SROI analysis is not possible. The decision to focus on just one specific piece of the programming and one specific outcome led to a more useful result from the analysis – better to focus intently on one small social return than to collect bits of information about a range of possible social returns.

The student researcher and stakeholders noted in interviews that conducting this sort of SROI assessment annually, either by stakeholders or by third parties, would be ideal to track the benefits for children, families, the neighborhood, and the health care system. If they are able to find support for this sort of tracking, they can then make use of the findings to improve the center's services and clarify their theory of change. The first step toward this ideal would be to improve their data-collection systems, matching them to the stated goals and outcome framework for the center.

There is an opportunity in this case to do more longitudinal tracking of the health and other outcomes for the children treated because they are a relatively small and easily observed local population, one that will be in contact with the institution for a few years at least. It is out of the question for moral reasons to do a formal random-assigned experimental comparison with a control group because that would require denying care to children. But some indication of the impact of wellness center treatment, and therefore some measure of attribution, could be arrived at through longitudinal tracking.

This case of a one-time, limited-scope SROI analysis also shows the importance of an agreed-upon plan for the use of the assessment in place before conducting the assessment. This is the central principle of the noted utilization-focused approach to evaluation in general (Patton, 2011), and it applies to SROI analysis as well. Having the uses planned avoids having the analysis

quickly shelved despite its acknowledged benefits, as it was in this case, and allows the analysts and stakeholders to shape the assessment in a way that is most useful. When there is a need to focus on one or two primary outcomes, as in this case, they can be chosen in part based on what feedback the organization needs most.

Interviewees also expressed their belief that SROI assessments such as this one can have considerable external value, particularly in the health care field. The SROI calculations can be presented to potential funders and investors to make them aware of the activities of the wellness center and the projected (monetized) social impact of these activities. Again, if this external use can be discussed ahead of time, the specific measurements of most interest to external funders – government, philanthropic, or otherwise – can be prioritized in the analysis.

AMERICAN CASE STUDY – PENNSYLVANIA FRESH FOOD FINANCING INITIATIVE



Background

Access to affordable, healthy food is significantly more difficult for low-income and poor people. Many who face food insecurity in the United States live in what have come to be called “food deserts” – low-income areas where a significant number of households have limited access (e.g., more than one mile away) to a supermarket or a large grocery store. The predominant food retailers in low-income communities are fringe food outlets such as liquor stores and convenience stores. These retailers have limited selections of healthy food on their shelves to compete with the abundant, cheaper, processed foods that are high in fat content and calories.

Food insecurity and food deserts have negative consequences for community health; an unhealthy diet is linked to obesity and an increased risk of obesity-related chronic diseases, such as diabetes, hypertension, and heart disease.

The Food Trust, a nonprofit organization founded in 1992 and located in Philadelphia, seeks to ensure access to healthy, affordable food for all people. To achieve that, the organization focuses on implementing both school-based programs – including nutrition education, policy reform, early childhood initiatives, and farm-to-school programs, and community-based programs – including nutrition education, farmers markets, and a variety of grocery store initiatives.

The Food Trust helped launch and coordinate one program, the Pennsylvania Fresh Food Financing Initiative (PFFFI), which has come to be celebrated and replicated nationally as a model program and best practice ideal. The initiative is a public-private partnership designed to foster the development of supermarkets and other fresh-food retail outlets in low-income neighborhoods.

PFFFI was the direct result of the Food Trust’s research, advocacy, and policy work. Allison Karpyn, director of research and evaluation for the Food Trust, explained how research showed that the lowest-income neighborhoods not only lacked sufficient access to outlets for nutritious food, but also had the highest diet-related death rates.

As a result, in 2001 a task force including key stakeholders from the supermarket industry, government, and nonprofit sector was convened to improve access to healthy, affordable food in Philadelphia's low-income neighborhoods. One of the task force's recommendations was a fund to subsidize startup costs for new supermarkets and grocery stores. The PFFFI was created in 2004 in response to this recommendation, eventually becoming active in counties across Pennsylvania. The initiative operated until funds were depleted in 2010.

The objectives of PFFFI were to

- reduce the high incidence of diet-related diseases by providing healthy food,
- stimulate investment of private capital in low-wealth communities,
- remove financing obstacles and lower operating barriers for supermarkets in poor communities,
- create living wage jobs, and
- prepare and retain a qualified workforce. (Reinvestment Fund, 2012, p. 1)

The PFFFI was a financing resource for food retailers looking to renovate an existing structure or to build in a distressed area. The state of Pennsylvania provided \$30 million over three years to establish and maintain the PFFFI. That money was used to leverage additional private investments totaling \$145 million through the efforts of a financial intermediary, the Reinvestment Fund, a socially conscious community investment group that finances neighborhood revitalization projects at the point of impact in distressed areas.

Loans and grants were provided to developers of fresh-food retail projects to support acquisition, construction, and startup costs such as employee recruitment and training. This funding encouraged food retailers to enter distressed communities by reducing risk, lowering development costs, promoting confidence among residents, and helping stores be good neighbors. The Food Trust played was an intermediary between the financing partnership and the community. The trust also conducted market analysis to uncover expansion opportunities, marketed the program statewide, and monitored the healthy-food provisions in grocery stores once an investment was made. A third PFFFI partner was the Urban Affairs Council, a nonprofit devoted to job creation for disadvantaged people, minorities, and women-owned businesses. The Pennsylvania Department of Community and Economic Development was also heavily involved.

The success of the PFFFI drew national attention and led the Food Trust to diversify its services to include consulting on FFFI initiatives in New York City, New Orleans, and other parts of the country. The FFFI concept is being replicated across the country with encouragement from national policymakers.

SROI Process at PFFFI

The public and private partners involved in PFFFI conducted studies to assess the program's economic impacts. These analyses showed how new supermarket development improved the overall real estate market by lifting home values or, in some instances, stemming the decline of property values; increased tax revenue, and created jobs. Of the 206 applicants vetted as of June 2010, the PFFFI funded 88 fresh-food retail projects in 34 counties. These projects created or preserved an estimated 5,023 jobs and added 1.66 million square feet of commercial space, providing access to healthy food for more than half a million people (The Reinvestment Fund, 2012).

But there were no similar analyses conducted by PFFFI partners of the social impacts of their efforts. This was despite that fact that health outcomes, such as reducing the high incidence of diet-related diseases in distressed communities, were among the primary objectives of the initiative.

A group of graduate students from University of Pennsylvania did conduct an SROI assessment of the PFFFI, which included estimated health outcomes alongside economic impacts (Chirouze, Atlas, & Rajyaguru, 2010). They interviewed staff at the Food Trust and searched research data on medical costs and declines in productivity related to obesity and obesity-related diseases such as heart disease, diabetes, and hypertension.

The students included in their SROI estimate three categories of social and financial outcomes from the PFFFI intervention in low-income communities: reduction in chronic-disease expenditures, increased worker productivity, and job creation. They projected that government-borne medical costs associated with chronic disease would decrease by 10 percent over the six-year initiative as a result of lowered obesity rates in the distressed communities, once the population had access to fruits and vegetables (total = \$430,000). They also extrapolated from research to estimate that access to fresh food would reduce by 10 percent the decline in worker productivity associated with chronic obesity-related diseases (total = \$1.7 million). Finally, they calculated the economic value of the 5,000 additional jobs created by the program by multiplying those by an average annual salary of \$20,000 (total = \$100 million).

Adding these cost savings yielded a total SROI over six years for the PFFFI of \$2.23 billion. When compared to the \$175 million total investment in PFFFI, this SROI is quite substantial. The majority of the SROI valuation came from worker productivity increases – or rather, the decline in lost productivity due to illness. And the monetization of the job creation benefit was in terms of salary rather than the other social benefits of being employed and receiving a salary, which could be “worth” more to an employed person than the money earned.

Challenges to Implementing SROI at PFFFI

Evaluation of the social returns from the PFFFI efforts was hindered, first, by a lack of available funding for this sort of assessment. Allison Karpyn of the Food Trust noted how allocation of funding by the state and private investors rarely includes funding for evaluation, except for tracking of basic economic outputs such as “number of stores opened, number of stores that remain open, loan repayment, number of employees, numbers of jobs, and other basic economic data.” She also explained that assessment of health outcomes from a program such as PFFFI is limited by the lack of an integrated system of “public health surveillance” in the United States, and by the expense required to adequately collect and track data. Individual studies and data-collection efforts are disconnected, and obtaining the data necessary for meaningful measurement of neighborhood health outcomes requires collecting it at the city block level. In the United States, most chronic-disease data are captured (if at all) at the local or county level, primarily at hospitals.

In addition, a collaborative social and health intervention like PFFFI involves multiple stakeholders, with differing “stakes” in the initiative. For some the financial returns from the investment are paramount, while others are focused on the social or health returns for food-desert neighborhoods. For example, tackling obesity was not a primary concern for food retailers who received funding from PFFFI, according to those involved. Rather, profitability and dollars generated per square foot seemed to be the preferred metrics of success. On the other hand, the financial intermediaries might be focused on loan repayment and store sustainability, while the local nonprofit partner may prioritize a decline in obesity and city planners might be chiefly concerned with economic revitalization and housing values. Neighborhood residents could be concerned with all of these and other social and financial benefits.

The point is that in a complicated case such as PFFFI, assessing the value placed on one or another of the myriad potential benefits of the initiative by each of the several stakeholders requires careful and comprehensive effort. An SROI analysis such as the one described above that only gathers information from one stakeholder – in this instance, the Food Trust – is limited, even if it attempts to assess both social/health and financial gains. The reasons for being limited in this way are understandable, as gathering information from multiple stakeholders with multiple perspectives would have complicated what was meant to be a targeted analysis yielding a straightforward cost-savings total. But the limitation also means the SROI valuation loses some legitimacy.

Lessons Learned

The Food Trust and other PFFFI partners are not the only ones who do not regularly employ SROI as a methodology for evaluation or decision-making. It is not a mainstream analytic tool used by healthy-food intervention programs across the country. However, particularly for programs such as PFFFI that are hailed as success stories, there is clear value in doing more to assess the complex SROI. It can help the replication efforts maximize those aspects of this sort of

program that yield the greatest return. It can also improve the understanding of the different values placed on different sorts of returns by different stakeholders, and can thereby increase the confidence of both social and financial investors that the venture will lead to the returns they seek. A multifaceted SROI analysis can be a means of consolidating disparate metrics into a common picture and story of impact. The SROI analysis conducted in this case did include both health and economic returns, but it was not clear that these were the returns considered most important by most stakeholders.

Still, it is unlikely that the United States will anytime soon create a public health surveillance system capable of tracking outcomes at the city block level, or even that funding will be forthcoming for a sophisticated, in-depth impact study on the range of health improvements from programs such as PFFFI. So a compromised, more limited approach is the most feasible. This might involve taking the necessary steps to create a system to track some health-impact indicators, those deemed most important by key stakeholders. With FFFIs growing across the country, this limited health-impact measurement and tracking could provide some targeted SROI measurements that might help inform decision-making about these developing FFFIs. In any scenario, expanded stakeholder engagement in the SROI measurement process would have clear benefits.

This case also provides further evidence of the importance of creating a sustained SROI measurement process, rather than a single assessment. While PFFFI was a time-limited initiative and this assessment was conducted post facto, meant to estimate the cumulative SROI, an ongoing assessment of social benefit accruing from the program could continue as the results of the program continue beyond the funding phase.

Finally, this case provides good evidence of the potential use of contingent valuation methods. These methods could be used to assess the full value of being employed (e.g., what having a job is “worth” to an employee beyond a paycheck). Measures such as QALY could also be used to monetize the value of the reduction in obesity-related diseases, beyond the government health-cost savings.

CONCLUSIONS AND LESSONS LEARNED

Grantmakers, social investors, and other donors are looking to be more strategic about their philanthropic or social-investment activities. To make these strategic decisions, they need good-quality information about the actual or potential social impact of their grants and investments, including the full, multifaceted value generated by those investments. One method for providing this sort of helpful information about social impact is to calculate the Social Return on Investment.

This collaborative research project sought to identify and describe state-of-the-art approaches to valuing social returns on social investments, review the organizational challenges to implementing an SROI measurement process, and examine in detail organizations in the Netherlands and the U.S. that have attempted to use SROI measurements. The focus of each piece of the project was SROI methods and valuation in the health care field, specifically.

The research here sought to advance scholarship about SROI techniques and organizational challenges, as well as contribute to our nascent understanding of the similarities and differences in social enterprises and nonprofits in Europe and the U.S. In addition, this project has clear benefits for practitioners by drawing a set of lessons learned and best practices for SROI measurement, which are presented in this conclusion.

Overall Benefits and Costs of SROI Use

While there are both proponents and opponents of SROI measures, our review shows that all sides agree that calculating something like an organization's full and accurate social return on investment in valid, reliable, and useful ways is difficult and time-consuming. And while emerging techniques for valuing social returns are being developed by scholars and practitioners alike – innovative “venture social investors,” health care economists, the consultants and scholars in the SROI Network – these techniques are not widely known or used in detail by organizations and social ventures.

Below are some of the benefits and the costs of instituting an SROI calculation process revealed by our review and case analyses:

- There are certainly benefits of a well-executed SROI calculation process, including clearer identification of the social impact and benefits created by a social investment – which can be useful for a number of reasons, not least of which is to see how social investments and grantmaking help create public goods – as well as the benefits for organizational learning and culture described below.

- One primary organizational benefit from implementing an SROI valuation process is a learning benefit. Through this process, even if the organization finds it very difficult to quantify a single SROI measure, organizations come to a better understanding of their own mission and how well they are achieving that mission. They gain new insight into their myriad social impacts, and in some cases they improve the mission-orientation as the focus of organizational culture by bringing stakeholders together to identify social returns. The SROI assessment process can then become a useful part of effective “learning organizations” (Senge, 1990), with systems of feedback on important outcomes that allow for continuous, real-time improvements in organizational practices.
- There are also clear costs to implementing an SROI measurement process for organizations, especially the time commitment required by multiple stakeholders both within and outside the organization staff, and the need for expertise that often requires help from outside consultants or the commitment of resources to build staff capacity. There is also the cost of possible misconceptions about the proper interpretation or use of this method for measuring the social good done by organizations – e.g., some observers might think the monetization of outcomes such as a child’s health is too crass a way to measure those human benefits, or that an organization’s use of SROI means the organization is primarily interested in more easily quantifiable outcomes instead of those that are more difficult to express in monetary terms.

Table 2 provides a general summary of the case studies and the SROI measurement methods and process used in each. It also connects to Table 1 in projecting how contingent valuation methods might have been used in each of the four case studies. The points from this table will be discussed in the lessons learned points below.

Table 2. Summary of Case Studies and Potential Use of Valuation Methods

	CareFarm Paradijs	VitalHealth Software	Wellness Center at Pan American Academy	Pennsylvania Fresh Food Financing Initiative
Location	Netherlands	Netherlands	United States	United States
Short description	Therapeutic farming enterprise serving seniors and youth with autism	e-Health solutions enterprise with social impact goals	School-based wellness center serving medically underserved children	Public-private partnership funding fresh food retail in low-income neighborhoods
Consultant? Who?	Yes, Noaber Foundation	Yes, shaerpa	No, U Penn graduate student analysis	No, U Penn graduate student analysis
SROI Software? Which?	Yes Social E-valuator	Yes Social E-valuator	No	No
SROI format	Ratio	Ratio	Cost savings	Cost savings and financial gains
Ongoing use of SROI?	Yes	Yes	No	No
Results used for programmatic decisions?	No	Yes	No	No
Valuation methods used?	Proxy cost measures from research literature on value of multiple social impacts	Proxy cost measures for reduced time/money for medical practitioners, and other cost savings	Estimated costs of prevented ER visits	Estimated percent of medical cost savings, percent decline in productivity avoided, and value of average job created
Valuation methods that could have been used	WTP/WTa, QALYs	WTP/WTa, QALYs	WTP/WTa, QALYs	WTP/WTa, QALYs
Example of valuation methods that could have been used	Surveying caregivers to determine WTP valuations for temporary break from caregiving	Measuring QALY tradeoff of living without complications for certain number of years	Surveying parents on WTP value of reduced ER visits over multiple years	Measuring QALY using health scales for improved health and self-esteem from reduced obesity

Lessons Learned About SROI Measurements

The specific conclusions and lessons learned from our review of the literature and our in-depth case-study comparisons can be separated into two categories: lessons about SROI measurements themselves and lessons about the process of organizational implementation of an SROI measurement. The first set of conclusions is below:

- The sophistication in the measurement methods that we identified in the scholarly literature far exceeds the sophistication of the methods used in practice, and certainly the methods used in the four case studies in this project. The nature of measurement innovation – in which the most sophisticated methods are developed in the academy where there are fewer constraints to such innovation – means that this imbalance will probably always be the case. But the lack of sophisticated valuation methods used regularly by organizations, even in the health care field where they are quite well developed by scholars, certainly keeps the field from assessing the best use and appropriate limits of such methods. The reasons for this lack of use are probably tied to the costs mentioned earlier and the specific limits described below, including the time, money, and expertise required; the lack of funding and other incentives for committing such scarce resources; the lack of processes for collecting the necessary data and the challenges of getting proper measurements of key outcomes; and the lack of standardization in models and measurements, making it difficult to learn from other practitioners or to compare measures across organizations. This divergence of innovation from actual practice is one found in the evaluation field generally, so it is not that surprising to find it in this very technically complex subfield.
- A major challenge to measuring SROI is specifying the wide range of social returns that are related in some way to the activities and intended outcomes of the organization. Any intervention or program – e.g., providing activity for autistic youngsters (and respite for caregivers) on a care farm, addressing asthma triggers identified through home visits – has social impacts that are both immediate and far reaching, individual and collective, short term and long term, easily identified and uncertain or merely possible. Capturing all of these social benefits that might be in the “ripple effect” of organizational activities is a nearly impossible measurement task. In the American cases, we saw how the analysts deal with this by choosing one or two key outcomes and measuring the SROI of those. But the more complex and comprehensive the analysis of diverse social returns, the more helpful and legitimate the SROI measurement is and the most likely it is to be taken seriously within and outside the organization. We see this in the comparison of how the relatively simple SROI measures in the American case studies were not taken as seriously as the more complex SROI measures in the Dutch cases.

- Another primary measurement challenge is assessing the extent of the myriad social impacts that can be attributed to the organizational activities in question, especially when we know that most social outcomes are “caused” by multiple factors. To determine attribution and deadweight, even the more technically sophisticated methods for calculating the SROI value, such as the Social E-valuator, rely on assumptions that are at best only partially informed by concrete information, and usually based on projections rather than specific relevant evidence. As the VitalHealth case showed, the eventual value of the SROI (a ratio in this case) was highly sensitive to these assumptions. Being transparent about the assumptions that are used for the calculation is essential, and getting better data to inform the assumptions is ideal – even if this means recalibrating the SROI measures as new information or tracking data becomes available. Ideally, attribution would be modified in an iterative fashion based on good outcomes tracking and perhaps even information that can determine net impact.
- As expected from the literature scan, the valuation process of quantifying and monetizing the social returns was another difficult component of the SROI measurements in the case studies. These calculations, too, were often informed by relatively simple proxy measures such as the cost of an emergency room visit. In the best cases, these monetary values were backed by good-quality scholarly research, but more often they are based on the values estimated by certain stakeholders. Again, it would be ideal if these valuations were revised based on new research or feedback from the measurement system (e.g., the actual monetary values of returns such as health care costs), but few organizations have the resources to search continually, or track and analyze, this better information. The literature review revealed a number of contingent valuation methods that could be used to help with this measurement challenge – these were shown in Table 1. But as noted, these methods were not used in the case studies. Table 2 describes some potential ways in which these methods could have been used in each of the four case studies. Of course, gathering the data for methods such as “willingness to pay” or “QALY” would require resources – and perhaps expertise – that these organizations likely do not have readily available. The people involved in each case study had varying levels of familiarity with contingent valuation methods, but none had deep knowledge or experience in using them.
- The literature review showed how even among experts there is disagreement over the best format for the SROI measurement. While a ratio has some advantages – especially in terms of being able to compare social investments in a straightforward way, either before or after the investment – there are also concerns about the validity of ratio measures. The case studies used both SROI ratios and SROI calculations in terms of total monetary value (not divided by inputs), and the choice of SROI format appears best driven by the intended use of the SROI calculation.

- The use of software such as Social E-valuator – with a careful, step-wise process for calculating SROI – was a helpful tool for making SROI calculations. It was particularly beneficial because it took into account the full range of inputs, stakeholders, outputs, and outcomes, and because it allowed for quick revisions to the full calculation when any one piece was modified. In fact, key parties involved in the two American cases – based out of the Public Health Management Corp. and the University of Pennsylvania – have started to use the Social E-valuator software in teaching students about SROI, and as those students do SROI analyses of other organizations.

Lessons Learned About Implementation of SROI Measurement Process

The findings of this project also lead to conclusions and lessons learned about the organizational process of implementing these complex SROI measurements, including:

- As mentioned, the process of implementing an SROI calculation has a number of clear benefits. And in fact, talking about, identifying, and specifying an organization's social returns is valuable in itself. In fact, the process in this case is probably more valuable than the product (i.e., the ratio or total cost-savings number). This process had a number of specific organizational benefits:
 - It helps the organization identify what it values, what it seeks to achieve in society, and how and what it contributes to these social benefits – and it forces a closer examination of the nature of the intended benefits and the organizational model for achieving those returns.
 - It helps integrate this knowledge of and focus on the intended social returns into the organizational culture, and to demonstrate the importance of achieving these returns to employees, stakeholders, funders, and others who would assess the organization's commitment to the public good. The best example of this was the VitalHealth case.
 - It helps establish systems of internal and external communication and feedback on the priority outcomes.
 - It helps identify and engage key stakeholders to the organization.
 - In general, then, conducting an SROI assessment can be a way for organizations to learn about themselves and reinforce a shared sense of purpose and organizational commitment among disparate stakeholders.
- The organizational costs associated with implementing an SROI measurement process have already been described, including the required resources of money, time, and expertise (often including the need for outside consulting assistance or software licensing). These costs not only apply to the calculation stage of the SROI measurement, but also to the process of gathering the data and setting up a process of information tracking – getting information on all phases related to the organization's theory of change, from inputs to impacts. The SROI measurement is only as good as the data collected for the measurement, and often the systems of data gathering for evaluation in organizations are not sophisticated or comprehensive enough to provide the data needed for an adequate SROI calculation. Ideally, as noted, this information

would be gathering in a continuous way, and the SROI measurement process would not be a “one-off” process. An ongoing SROI process is best because the iterative adjustments (based on actual values replacing estimated, for instance), and the longitudinal data lead to a more accurate and legitimate calculation. It also allows for an increase in the benefits of the SROI process, described above, as the learning and culture-building process within the organization is allowed to continue. Of course, an ongoing measurement process is much more expensive and time-consuming than a one-time process. Finally, it is best if the SROI data-collection process involves information gathering from a wide range of stakeholders with different sorts of inputs. The relatively fewer stakeholders consulted in the American cases versus the Dutch cases led to more incomplete and simplistic SROI measurements.

- There are few incentives for organizations to commit the resources needed to implement an SROI process. Most funders do not provide the additional funding or evaluative capacity that an organization would need. The Noaber Foundation is unusual in the assistance it provides for investee organizations to conduct SROI analyses, as those cases show. The experiences of the Pennsylvania Fresh Food Financing Initiative and the Wellness Center at Pan American Academy – where funders do not support much data gathering and staff time is limited for such activities – are much more common. This might change in the U.S. with the advent of the Affordable Care Act (so-called “Obamacare”), which requires some health care providers to track certain performance measures, and with the rise of interest by grantmakers and social investors in formal measurements. If more of the complex SROI methods in the literature were used in practice and encouraged by funders, we could make better judgments about the usefulness, and the limits, of SROI in various kinds of organizations or sectors.

Best Practice Suggestions

A number of the lessons learned and other specific findings from this research point to certain best practices for organizations and social investors who want to make most effective use of SROI techniques. Note that we are not here making a strong recommendation for or against the use of SROI as a measure of performance. Rather, we take the position that if an organization or funder wants to make use of this tool, these are some tips for maximizing its effectiveness. This is not meant to be a comprehensive list:

- Be transparent about assumptions in the model and data used.
- Acknowledge the sensitivity of final calculations to the decisions used in creating the calculation.
- Be inclusive in identifying stakeholders, and seek input from as many as possible – this is particularly important when using contingent valuation methods.

- Use the most sophisticated methods – especially for valuation and attribution/deadweight measures – that organizational resources will allow.
- Be clear about the limits of monetization and valuation techniques, and identify “softer” social returns that do not lend themselves easily to inclusion in monetary SROI.
- Avoid overstating social returns; err on the side of conservative estimates.
- Measure SROI in continual process, not “one-off.”
- Set up organizational systems to gather appropriate data and to track identified measures.
- Identify a team and influential “champion” of the process within the organization, preferably one with organizational respect and power.
- Recalculate and revise the SROI measures based on actual values and new research or data, in constant iterative process.
- Be realistic about the resources needed for a useful SROI analysis – time, people, money, expertise.
- As funder or organizational leader, support organizational capacity to commit the necessary resources for a valid and useful SROI measure.
- Frame SROI calculations in informative and easily understandable ways so that all stakeholders can grasp and support the use of the measure, and see their role in it.
- Make SROI calculations public, even if they reveal organizational shortcomings – this is particularly important when creating the organizational culture of learning and commitment to maximizing social returns.
- Be cautious in making claims and comparing SROI measures across organizations with different missions, services, products – SROI is most useful as a measure for assessing performance across time within one organization.

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APPENDIX: INDIVIDUALS INTERVIEWED FOR CASE RESEARCH

Netherlands

Geert-Jan Baan, Noaber Foundation
Stefan Bos, Noaber Foundation
Heleen De Boer, Social E-evaluator
Jorne Grollema, Mentalshare
Peter Haasjes, Noaber Foundation
Arjan Karens, VitalHealth Software
Wim Post, Noaber Foundation
Ijsbrand Snoeij, CareFarm Paradijs
Hero Torenbeck, VitalHealth Software
Saskia van Alphen, Noaber Foundation
Dave Van Dijk, VitalHealth Software

United States

Lisa Bond, Public Health Management Corporation
Vanessa Briggs, Health Promotion Council
Melissa Fox, Public Health Management Corporation
Tine Hansen-Turton, Public Health Management Corporation
Elizabeth Hayden, Public Health Management Corporation
Allison Karpyn, The Food Trust and PFFFI
Alex Lehr O'Connell, National Nursing Centers Consortium
Molly Porth, Education Plus and Pan American Charter School
Nancy Rothman, Department of Nursing, Temple University
Nicholas Torres, University of Pennsylvania and Pan American Charter School
Kaitlin Woods, University of Pennsylvania



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