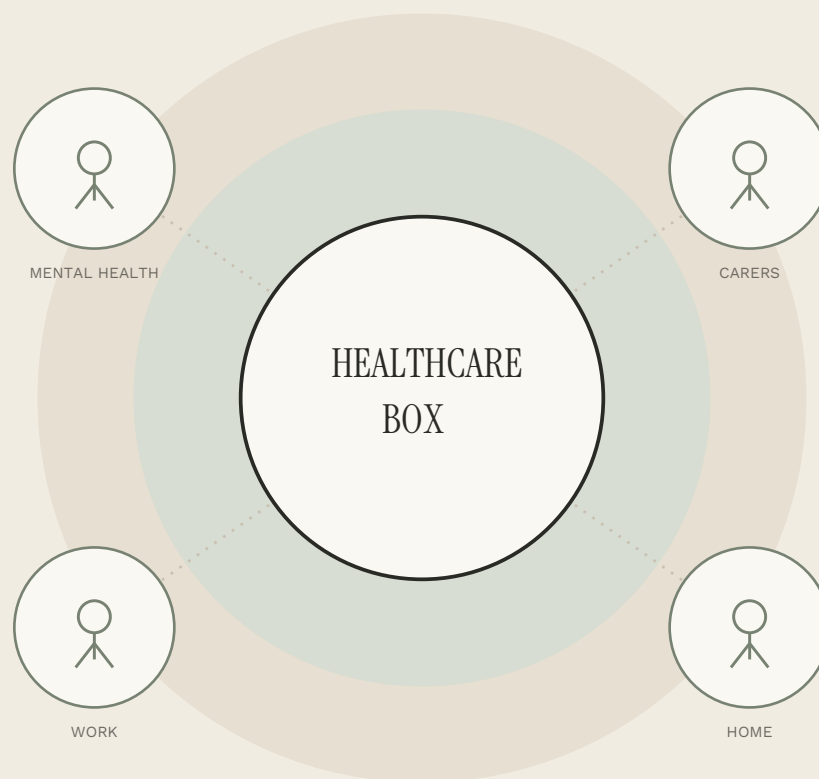




Beyond the healthcare box

What should an SROI study actually capture?

A broader value lens for a healthcare system that increasingly asks us to understand the patient journey – not just the clinical endpoint.





There is no single 'value' method

There are different questions – and different evidence designed to answer them.

☐	CLINICAL	RCTs · indirect comparisons · meta-analysis	<i>Does it work?</i>
☐	PATIENT	PROs · PROMs · preferences	<i>What changes for patients?</i>
☐	REAL WORLD	RWE · registries · utilisation	<i>What happens in practice?</i>
☐	ECONOMIC	CEA · CUA · CBA · CCA	<i>Is it value for money?</i>
☐	AFFORDABILITY	Budget impact analysis	<i>Can the system afford uptake?</i>
☐	IMPLEMENTATION	pathway · workforce · capacity	<i>Can the value be realised?</i>
☒	SOCIAL VALUE	SROI	<i>What sits outside the conventional box?</i>

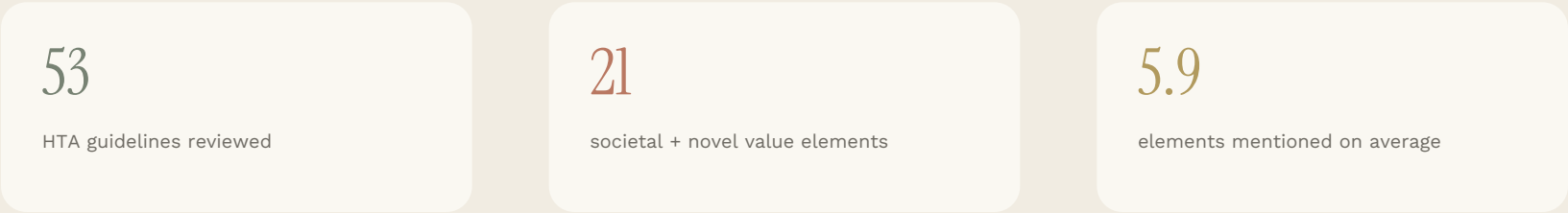
THE POINT OF SROI

Not a replacement for the toolkit — a way to fill a specific value gap

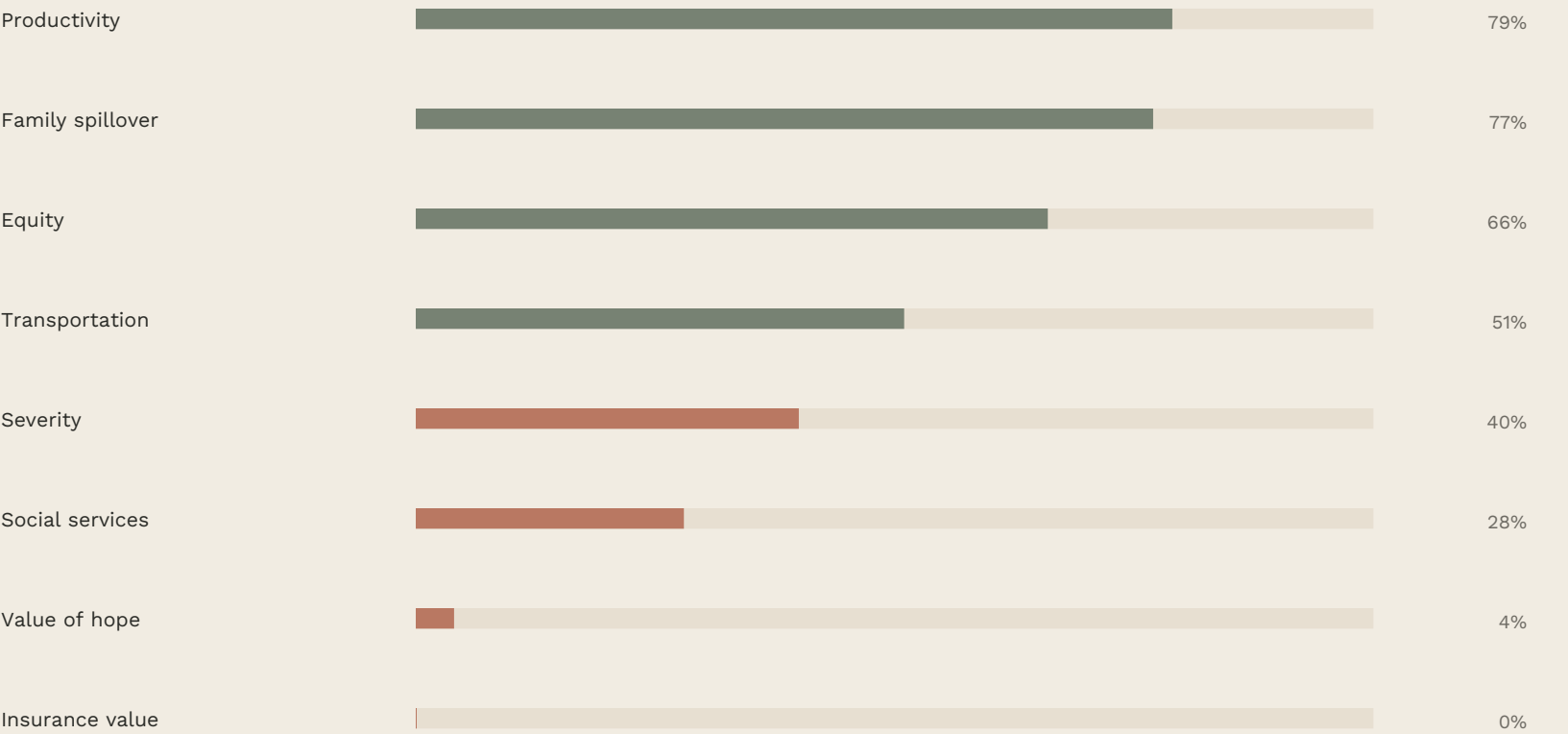


HTA does not ignore wider value

It is that many value elements are mentioned without being systematically built into the analysis.



WHAT GETS MENTIONED



THE CRUCIAL DISTINCTION

mention $\neq$ recommendation $\neq$ base-case inclusion

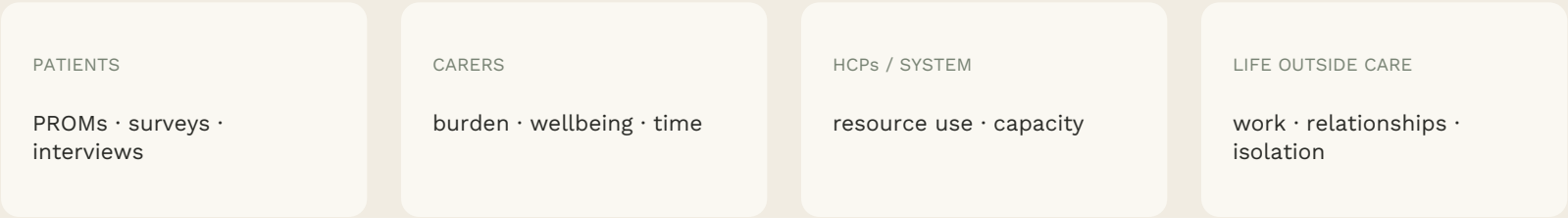
Across the 53 guidelines, base-case recommendation was uncommon for most elements.



SROI turns lived outcomes into a transparent value story



THE DATA DOES NOT COME FROM ONE SOURCE



SROI =
$$\frac{\text{present value of social benefits}}{\text{value of inputs}}$$

The ratio is the end of the reasoning – not the beginning



A Spanish example makes the argument concrete

€548m

first-year investment

€1.932bn

estimated social return

3.52:1

overall SROI

WHERE THE RETURN CAME FROM

General management	€232m	€1.164bn		5.01:1
Primary care	€180m	€515m		2.86:1
Emergency / hospital	€10m	€91m		9.05:1
Cardiology	€86m	€115m		1.33:1
Internal medicine	€40m	€46m		1.17:1

STAKEHOLDERS

patients · informal caregivers · Spanish National Health System

Autonomy · wellbeing · adherence · caregiver burden · hospitalisation · emergency care

WHY IT MATTERS FOR HEOR

It links a care-management change to value across multiple stakeholders — not just the payer line.



One country — four cases — no universal benchmark

Different diseases, proposals and stakeholder mixes produce different value patterns.

HEART FAILURE	€548m → €1.932bn
3.52 : 1	patients + carers + SNHS

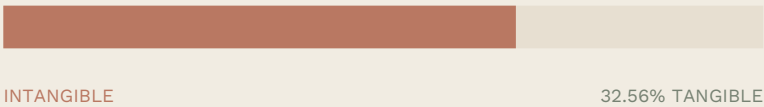
COPD	€668m → €2.079bn
3.11 : 1	15 proposals · 20 stakeholders

RHEUMATOID ARTHRITIS	€289m → €913m
3.16 : 1	22 proposals

PROMs / VBHC	Heart failure service
5.55 : 1	Epilepsy 0.85 · Parkinson's 1.29

COPD · THE DETAIL MATTERS

67.44% of return was intangible



Sources: Merino et al. 2020 (HF); Spanish COPD study 2022; Spanish RA study 2021; Crane et al. 2025 (PROMs/VBHC). Ratios are context-specific.



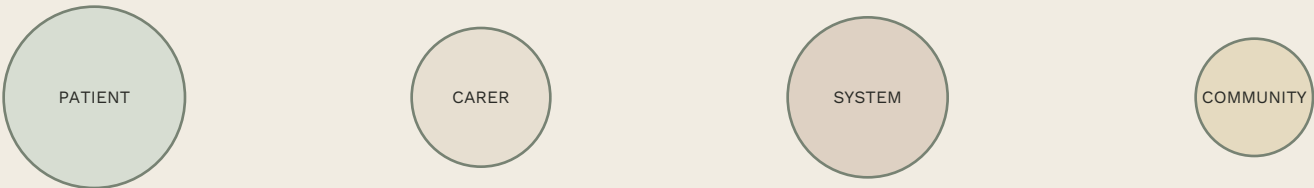
Newer evidence makes the case more interesting — not simpler



WHAT VARIED

- OUTCOME COLLECTION**
40% bespoke surveys · 38% validated surveys
- VALUATION**
47% assumed financial proxies · 37% direct costs
- SETTING**
9 system-wide · 7 community · 5 secondary care · 4 home

STAKEHOLDER INCLUSION



THE IMPLICATION FOR HEOR

SROI is not 'one method' — design must fit the decision question



A ratio is only as credible as its assumptions



CREDIBILITY CHECK

Pre-specify assumptions · test sensitivity and scenarios · avoid double counting · report stakeholder materiality · keep limitations visible



SROI works best as a value layer — not a replacement layer

JCA / CLINICAL

relative effectiveness · relative safety

EU-level clinical assessment

NATIONAL HTA

cost-effectiveness · local decision problem

payer / societal perspective varies

BUDGET IMPACT

uptake · affordability · time horizon

budget consequences

PATIENT / RWE

experience · adherence · utilisation

what happens in practice

SROI

caregiver · work · wellbeing · social spillovers

broader value outside the conventional model

THE STRATEGIC QUESTION

Where does the current evidence package leave decision-relevant value unmeasured?



Not every submission needs SROI

But some decisions are almost designed for a broader value lens.



MY RULE OF THUMB

If the decision is about more than incremental health gain inside the existing care model, ask whether the evidence should be broader too.



More evidence is not automatically better evidence

01

53 HTA GUIDELINES

21 societal + novel value elements assessed

02

EU HTAR / JCA LIVE

clinical evidence becomes more coordinated across Europe

03

29 SROI STUDIES

identified from 453 healthcare records / reports

04

PROMs + VBHC

HF 5.55:1 · Parkinson's 1.29:1 · Epilepsy 0.85:1

05

AGING IN PLACE

12 studies · median 5:1 · 8 high quality

THE QUESTION I WOULD TAKE INTO THE MARKET

Are we generating more evidence — or better evidence for the decision that actually needs to be made?



A QALY was never designed to count everything that matters

That does not make the QALY wrong. It makes the decision question bigger.

MY POSITION

SROI should not replace CEA, BIA, RWE, meta-analysis or clinical evidence. It should strengthen the value story when material outcomes sit outside the conventional frame.

I see its value in making consequences for patients, caregivers, the system and society explicit, testable and decision-relevant.

Used with discipline, it is not an alternative evidence story. It is a more complete and forward-looking one — connecting lived outcomes with the choices Market Access must shape.



ABOUT THE AUTHOR

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Cand.jur. and international Market Access professional with 13+ years across Pharma and MedTech, including six years in HEOR.

Experienced in HTA, reimbursement strategy and budget impact modelling — connecting evidence, public affairs and stakeholder insight to expand patient access across markets.

Known for bringing structure to complexity and translating evidence into decisions across leadership, affiliates and healthcare stakeholders.

THE QUESTION I KEEP COMING BACK TO

What evidence does the decision actually need?