Asset based approaches and health economics: What do we value and how can we capture it?

Event report

Thursday 12th February 2015, 9.30am – 1.30pm

The Lighthouse, Glasgow

Introduction: Why we held this event.
There is growing acceptance that asset based approaches have an important role in improving the health and social conditions of individuals and communities. This is particularly the case for complex problems, where causes are multiple and pathways to health and social inclusion can be highly individualised requiring tailored interventions that respond to particular contexts, needs, abilities and aspirations. The report of the Christie Commission has identified asset based approaches as being central to responding to the multiple challenges of an ageing population, reductions in public sector budgets and tackling continuing inequality.

Although asset based approaches are widely recognised as being successful in many cases they also pose challenges for existing evaluation methodologies. In a climate where projects and services are increasingly expected to demonstrate their value against competing priorities, the ability for successful approaches to demonstrate their economic worth is vital to their continued development and wider adoption.

This workshop brought together research in health economics and evaluation with practitioners, managers and resource allocators who shared an interest in developing and promoting asset based approaches. Our stimulus was a literature review commissioned by the Centre which highlighted the poor alignment currently between asset based approaches and health economists' frameworks of evaluation. This produced a challenge: if asset based approaches are vital in preventing some of the most persistent, long-standing and therefore expensive health and social challenges that face us, why has the evidence base for their economic effectiveness, which is powerful for making the case for further investment, not yet materialised?

This question was the reason for bringing the professional groupings together. We hoped to create a space where different approaches could begin to work together, to foster new relationships and potential collaborations and begin an on-going conversation around method and approaches which would support the development of an economic evidence base for asset based approaches.

Who attended?
Thirty-five people gathered at The Lighthouse in Glasgow with representatives from academia , public sector service delivery, voluntary sector service delivery , the Scottish Government and local councils, a large national charity funder and other practitioners in service related research and evaluation . The delegate list is provided in Appendix 1.

Structure of the day
This was a morning meeting chaired by Professor Cam Donaldson of Glasgow Caledonian University's Yunus Centre. The meeting took the form of two presentations each followed by table discussion around four question developed with each speaker. Plenary discussion was built across the morning with feedback provided by a panel of three perspectives towards the

end. Expert input was provided by Dr Emma McIntosh, Reader in Health Economics at the University of Glasgow and Dr Lisa Garnham who is part of the team evaluating a complex intervention, *Sistema* at Glasgow Centre for Population Health. The programme for the meeting is provided in Appendix 2.

The final plenary session discussed how we move this conversation forward and next steps so we could build on the momentum established by the meeting.

Scene setting

Cam introduced the meeting as a timely opportunity to explore perceptions, realities, overlaps and differences between asset based approaches (ABA) and health economics (HE). He highlighted the opportunity to explore what working together might look like and how we could develop methods which remained faithful to the ambitions of both approaches.

HE approaches are concerned with evaluating and quantifying the costs and benefits that arise from a particular intervention and to ascertain what would have happened in its absence. In the real world however, this becomes more challenging as interventions become more complex and ABAs are on the extreme end of complexity. It is now conventional to conduct studies of economic benefit alongside other studies of impact and those who fund projects increasingly might ask for appraisals based on the methods of economic evaluation.

However, ABA are not necessarily interventions in the way understood by scientifically derived approaches to evaluation (such as those used in medical trials). They are based on the principle of 'doing with rather than doing to' and tend to be more integrated into communities rather than as actions which can be isolated to measure their effects. Even more fundamentally, ABA often involve resources, such as the input of people working in a project, which economists regard as a cost, but which participants regard as a benefit due to its impact on empowerment, self-esteem, self-efficacy or other outcomes important to health and well-being.[*] This is an interesting conflict to explore and try and resolve.

Cam then introduced the first expert speaker of the morning.

[*] Volunteering is an example of this. Whereas a health economist may see volunteer time as an opportunity cost (i.e. the benefits that could have been generated by other potential uses of a volunteer's time), the opportunity to volunteer is valuable in itself because of the benefits for the volunteer of being involved in productive, communitarian activity.

***A Review of the Economic Evidence of Asset Based Approaches for Health Improvement* - Dr Emma McIntosh**

Emma contextualised herself as someone who has a background in economic evaluation alongside clinical and now working in the public health arena. She told the room that her natural instinct is to try and fit everything within a HE framework but said that today she would argue that although there is much value in HE frameworks, for its application to ABA, there would also need to be some adaptations.

Emma began by telling the audience that economic evaluation is the comparative analysis of costs and outcomes. Emma highlighted an existing definition of ABA, encompassing outcomes such as control, mutual support, cooperation and care. Such outcomes pose challenges for economists because of the difficulties inherent in measuring them and of incorporating them within standard economic evaluation frameworks. The HE analysis of ABA hinges upon the additional benefit gained or benefits forgone if that same investment had been used on something else - the health opportunity cost.

Emma continued to describe a review of the literature that she and colleague, Kenny Lawson, undertook looking for health economic evidence on ABA. At the time of research it found that no evaluations had been conducted to collect economic evidence of community ABAs. Further, none of the projects from *Assets in Action* (a key GCPH publication illustrating the approach in community settings) included economic evaluation, although one (*Routes Out of Prison*) did include analysis of Social Return on Investment (SROI) and showed, through modelling, that the intervention had the potential to be cost saving.

The headline of this research is that as health economic benefits of ABAs are not well evidenced this will not support and encourage commissioners to change the way services are delivered and provided.

Dr McIntosh therefore suggested there is a need to

- Conduct outcome evaluations of ABA to establish their effectiveness in promoting health and wellbeing
- Use this evidence of effectiveness to generate evidence of cost effectiveness ABA interventions using standard methods of economic evaluation
- Discover why AB services do not currently collect the data required to carry out economic evaluation. Their preliminary evidence suggests that it is because it is not requirement of funding

Some potential ways forward around establishing causality were also proposed. This included layering ABA logic models with HE logic models to allow process evaluation. Scales for both ’hard’ and ‘soft’ outcomes are already developed and available and reference cases also exist.

Highlights of questions and comments in response to Dr McIntosh's presentation:

Q. What about the time period involved in the production of some of the outcomes?

A. Inside the lifetime of a particular project, we may need to think carefully about what is measureable. In terms of longer term outcomes, we can use modelling to predict what might happen in future based on what we already know about the relationship between shorter and longer term outcomes. We might not yet have hard evidence from a particular intervention but we may have early indications of change.

Comment

A central strand of your argument is that 'economic evidence provides credibility' but on whose terms is this credibility? There's a clash of world views; (the health economist world of) inputs, processes and outputs but what about systems thinking and complexity? It's also difficult to put a value of life. There are many projects out there that people in communities know do work but the evidence is not considered robust enough. Scarcity is created by inequality.

A. HEs agree with that. Who gains and who loses is a question that animates economists and in that there is no conflict. (But) If you do not accept that there are limited resources to go around then you do not accept the need for HE. If you do accept that there are more claims on societal resources than there are resources to go around, then the question becomes how do we reconcile the problem of scarcity?

Comment

What I'm looking for out of this, is that I find myself in a resource constricted world where I believe I should invest more in this kind of area (ABA) but the hard reality is that I'm competing with people who have hard data (on the cost effectiveness, waiting times, GP visits etc). I think personally that much of that world is inverted and what we should look at first and foremost is health and benefit but I have to compete in the world I live in and this can help me argue for resources and describe the types of outcomes that we might reasonably see.

Comment

Often when we present findings we glibly provide a statement such as "no evidence of cost effectiveness was found" which is sometimes misinterpreted as "there is evidence of cost ineffectiveness".

A. That's a really good point and hopefully in the second part we will see an example of how HE can be flexible to accommodate ABA within their frameworks, perhaps looking at 'softer' outcomes, for example trying to look at the ICECAP[1] capabilities score, we've got to be

[1] A quality of life measure developed for use in older populations and based on Sen's notion of capability. Flynn TN, Chan P, Coast J and Peters T (2011) Assessing quality of life among British older

creative in this environment. This is a difficult environment to be in so let's try and join them and try and find the evidence of the benefits. If it is there.

Comment

Should we be investing in things like smoking cessation or should we be investing in ABAs? When we are making decisions we have to be able demonstrate their value. So I would hope during the rest of the day we could find some common ground as it is everybody's interest, whether you are in a team delivering ABA or in a Government team prioritising resources, what we all want to do is invest resources where they will have the most value. The crux of today is in the title; "what we value and how we measure it?"

The introduction of the 'clash of world views' perception was welcomed by many in the room and it became a hot topic of discussion. If ABA and HE represent two fundamentally different two conceptions of value they were not fully resolved in the discussion so far, yet it felt by and large a healthy sign that the poor alignment had been raised.

people using the ICEPOP CAPability (ICECAP-O) measure. Applied Health Economics and Health Policy 9: 317-329

Table discussions- Session 1 – summary of feedback

Time, resources and that HE is not a cost neutral exercise
Many commented on the idea that evaluation requires time and expertise. There is currently limited capacity to conduct evaluations within services. There is an opportunity cost to conducting an economic evaluation, an even greater one if the tools are not sensitive enough to demonstrate change.

Are HE evaluation frameworks appropriate for application to ABAs?
Related to this, there were risks considered to be associated with the application of HE frameworks as they currently stand. What if the evaluation does not adequately capture the benefit of a service? Would the HE evidence be considered superior to other evidence and lead to a funding cut?

This echoes a common concern about the sensitivity of HE frameworks. Measuring the processes and outcomes we might expect to see from ABA (e.g. trust, relationships, connections) and their contribution to other outcomes will often be more difficult than measuring 'more traditional' and 'harder' outcomes (like employment). There was concern that decision-making, and therefore programmes and interventions, are informed only by what evaluations find easier to measure. This could hinder the innovation required for tackling intractable problems. Would HE evaluations always unfairly advantage programmes which fit the model in providing clear data on costs and benefits and will more complex programmes always look 'second best under such an approach?

There was concern that a two tier view of outcomes was present in the language being used, for example 'hard' and 'soft, 'tangible' and 'intangible'. Change in people's lives is never 'soft' or 'intangible' to those who experience it.

There was also a concern that although qualitative work is often better at capturing particular processes of change in AB services, it would not have the authority of quantitative data. Could HE approaches use qualitative data to capture the complexity? Many did not know the status of qualitative data in HE evaluation and assumed it at best peripheral to the business of identifying cost/ benefit or enumerating effectiveness.

Language
How could the world views of the academic economist and the community-based worker be reconciled? The language and terminology were widely felt to be a barrier in their technicality and the sense of finality of judgement conveyed. However, it was also suggested both perspectives could be characterised as reluctant to accommodate or recognise the validity of each other.

The need for evidence to support development and investment
Participants recognised the need for decision-makers to be able to make comparisons about the effectiveness of different interventions given scarce resources. However, many felt economic evaluation methods need to

continue their evolution. It was hoped that ABA could help shape the development of new methods for HE evaluation. How do we develop an approach which captures the fundamental differences between projects in the scope and aims?

It was suggested evaluators would benefit from first hand knowledge of the projects or services they are evaluating otherwise there will be disconnection form the aims and intentions of service users and providers. There was fear that what health economist's value might not match what users and communities value.

It also might not be appropriate for ABA to have a tightly defined set of outputs and outcomes established too early in the life-course of intervention. This contradicted the complaint that often HE evaluation data collection is considered too late in a project, perhaps missing the opportunity to collect baseline data. In ABA, flexibility is required as to what kinds of outcomes a project may orientate towards as it evolves. Participatory methods provide different sorts of data. Could they be adapted to HE evaluation in a manner which makes them appropriate to the evolving nature of outcomes but also helps overcome the technical barriers to conducting HE evaluation?

The second expert speaker was then introduced.

***A worked example: Evaluating Sistema Scotland (Big Noise)* - Dr Lisa Garnham**

Lisa's presentation offered an insight into the complexities of a real world intervention (Sistema's Big Noise project) and posed a number of questions for the application of evaluation frameworks, both economic and general.

Identifying rewards and costs

The nature of rewards in Big Noise are varied- from being able to perform a piece of music in front of your family to developing social skills, resilience and self esteem. These can lead to better educational and employment opportunities and health outcomes in the longer term.

There are challenges however around establishing measurable costs. It was highlighted that a number of aspects of the projects that you would expect to be easily measurable are actually quite difficult and finding complete data is challenging, for example numbers of children in the programme, cost of the programme, number of hours of delivery. This is reported to be due to the programme being fluid, dynamic and fast-paced.

Big Noise is delivered in school and after school in community settings. The project is heavily integrated into other resources producing lots of in-kind contributions; resources such as teacher time which are also hard to pin down. The counterfactual of "what would you do with this time if Big Noise did not exist?" becomes difficult to answer. People don't know, because they value it, they *found* the time.

Comparability of outcomes; which have greater value?

'"It makes me really happy when I play the violin and I feel really proud when I play in front of my mum." How do you quantify that?'

How do you compare the happiness a child feels when they play a violin to the happiness they may feel when playing football? Are they comparable?

Funding for Big Noise comes from a number of different sources. So the question as to whether the money would be more effective if spent elsewhere becomes moot from the perspective of those involved in delivery, because they cannot spend it elsewhere. Big Noise has the ability to draw on different pots of money to produce something greater than what each of those pots could produce alone.

Lisa showed a logic model of the children's outcomes to highlight the complexity of the outcomes and processes which lead to them. After ten years, outcomes have to be extrapolated based on qualitative evidence with lots of assumptions of causal pathways following on from each other (of course, every child will not follow this assumed pathway).

Outcomes from the project are so diverse and interrelated that it is difficult to deal with them in one evaluation. Different funding agencies are interested in

different outcomes that Big Noise can produce. Illustrative examples of outcomes include: improved engagement at school leading to the improved uptake of exams, leading to improved school outcomes and attainment, leading to improved employability and life chances. Involvement in diversionary activities can reduce anti-social behaviour, drug and alcohol use as children become young adults. Others outcomes we may value include pride and social cohesion.

This raises the question of which outcomes and which funders' interests should be measured? Furthermore, due to the mix of funders, range of funding arrangements in place and the complex nature of the project it is not easy to say which funders finance which parts of the programme and can therefore be said to be fiscally responsible for an outcome of interest.

Another issue with attribution is that Big Noise works in a context of lots of innovative projects and interventions in the wider community as well as what is happening in the schools. It doesn't just affect the children involved, it affects and is affected by, the community in which it is based.

Rethinking 'evidence'

Another challenge is 'robustness' of evidence. Just because something has a number on it, doesn't make it more robust than other forms of evidence. A picture a child drew, or a film they made is robust in their context. Can we have a diversity of evidence from a range of different sources as 'robust' evidence? If so, what would it look like? What kinds of evidence are we going to need to gather to do that?

Diversity and complexity of interventions? If you strip away the complexity for comparison. Is there value in doing that? Do you lose the essence of what the intervention aimed to do and how it did it?

Highlights of questions and comments in response to Dr Garnham's presentation

Comment

There was discussion around the value attached to different forms of evidence. On a practical level, can evidence such as drawings and insights into lived experience bridge some of the gaps between ABA and HE discussed earlier in the morning? Can they be incorporated?

The idea of logic modelling was also raised. What about unintended consequences? The Sistema evaluation team can't map all the things that might happen. The wider evaluation it was hoped would maintain the holism against reduction.

A. How much does the Sistema evaluation cost?

Q. As with the project more generally, there have been a number of in kind contributions to support the project and the evaluation. The figure quoted was £50k per year for two years.

Table discussions- Session 2 – summary of feedback

Should funders of ABA include resources for economic evaluation? Should demonstration of value in economic terms be a condition of funding?

One table highlighted that evaluation is importantly also about learning and not just for satisfying funders. Otherwise, it reinforces the view that ABA are short term and pilots rather than long term ways of delivering services. Information and monitoring for funding or governance purposes are not the same as full economic evaluation and it is important not to confuse the two. The purpose needs to be clear. Is it about demonstrating the value of a project to argue the case for continuation or about generating a wider evidence base on effectiveness of approaches? We know a lot about what is effective but it is still a challenge to get funding for these types of approaches. Most budgets are committed to other things and funding for ABAs often comes from discretionary budgets. Lack of evidence is still a major issue alongside an ability to demonstrate impact of working this way. It was also highlighted that funders are not the only audience for evaluation and it is important to demonstrate to participants and local communities what benefits projects are having and to seek their views.

There was also discussion about the appropriateness of fitting ABA into 'recognised' evaluation approaches. Perhaps we need to be asking other types of questions - not 'what works' but for who, why and in what circumstances?

It was also raised that we should not be thinking about ABA as discrete interventions or programmes but be focused on considering how the values and principles of this way of working can underpin how all services are provided. When conceived in this way, the need to provide robust economic evaluations on a project by project basis becomes less important. This point further reinforces the idea that 'people change lives' not interventions or approaches. We need to put a value on the quality of the relationship between a worker and client. This was seen to be unquantifiable.

In response to the question 'should HE be a condition of funding' - others came up with 'a highly qualified yes', with a concern around what kinds of final outcomes would be lost if not. There were also concerns around the resource implications of HE evaluations - another opportunity cost (while others talked of 'overwhelming project staff' with additional work to do, data to collect, skills and capacity). The Humankind Index was highlighted as a tool which takes into account broader issues and that we measure ourselves against societal outcomes and not just economic value.

A point was raised about 'having funders *here* and service providers *there.'* This dynamic needs to be reframed as we're not always talking about funding one or two year projects but about mainstreaming good practice. It was also proposed that economists should go out and see projects with the aim of understanding what it looks and feels like to work in an AB way and the value of this to staff and local people.

Invited perspectives in response to discussion

Neil Craig, Principal Public Health Advisor, NHS Health Scotland
I was slightly worried at the start that there were two world views that are irreconcilable but through the course of the discussion I'm more confident that that there is common ground and that this is encapsulated in the question:

Can we agree that we are all here to maximise value from available resources? If we are then we need the measurement tools to help us do that.

About value, what is of value and to whom? There's nothing inherent in HE that prevents us from adopting a societal perspective or getting the views of service users to get a handle on what they believe is valuable and then working out ways of measuring it. This includes things like building up people's self esteem, empowerment, process utility, finding a job as well as physical and mental health. If that is what people value then as economists we would want to try and measure it. I suspect that is something we share with people who deliver the services.

Economics has a set of tools that can do that - but my view as an economist is that the discipline has painted itself into a corner by becoming focused on methods that allow comparison of programme outcomes measured in the same units. This has led us down the route of cost utility analysis and cost benefit analysis. However, when you look at Sistema approaches like SROI have advantages. It allows a range of benefits to be measured but it doesn't impose on evaluators and those delivering programmes the difficult task of measuring these things in the same units.

The downside is that this will mean we have to compare programmes in terms of different outcomes measured in different units rather than having one metric, and this will make less certain which programmes generate the most value. However, decision makers constantly make decisions in a context of uncertainty. The Holy Grail of evaluation should not be to try and tell decision makers what to do based on one piece of certain evidence. Rather, it should be to help them make the right decision as to whether we should fund something or not by providing *"forms of evaluation that give us insight into the balance of value and cost that we can use to justify funding a particular programme. That means we might have to rely on imprecise evaluations, underpowered evaluations but at least evaluations that correctly identify all the things that are of value and make some attempt to value them".*

Arguably, it's better to imprecisely measure the right things than precisely measure the wrong things.

Finally, there are big methodological challenges in measuring cost. From what I understand about ABA, the very process of giving people a say in developing a service is of value in and of itself. It can build self-esteem, empower people, and help people get back on the right track. *There's value in just getting involved but the time in doing so would traditionally be measured by economists as a cost rather than a benefit.*

Prof Antony Morgan, Associate Director, Centre for Public Health, NICE and Glasgow Caledonian University

Firstly - language, AB terminology is very popular these days and the reason why it gets difficult is because people hang on to their own terminology and they can't understand what the core principles of something are. This might prevent people understanding the similarities between approaches.

ABA is useful because it might if we can get the evaluation question right, economic or other, it might help us to make the case for sustained approaches and it goes mainstream and not just something that goes on in the voluntary sector.

"*It should be part and parcel of everybody's principles of working. That's why we need evaluation to make the case to bring different worlds together".*

This event has been useful in people from different perspectives starting to talk about what matters to them. Part of that dialogue is about building the mutual perspectives and trust and that ABAs are all about.

Dispelling the myth around what it is we are trying to answer here and sometimes speak in plain language. My experience of working at NICE in terms of *the health economists is that they are trying to place their methods onto a different phenomenon and so the methods become more important than the thing they are actually talking about*. Connecting with those who don't feel comfortable with evaluation and the language of evaluation is part of this process of dialogue.

We also spoke about not needing to evaluate everything but we do need some bigger evaluations to demonstrate why we need to continue to work in this way. This will involve in changing the mindsets of funders in terms of what's important in terms of outcomes. So when we talk about 'softer' outcomes, some of the intermediate outcomes that are the aims of asset-based approaches, bringing communities together to solve things at the time, *things like building social networks and self esteem, these should be as important as the health outcomes.*

Lastly, if you can build a multi-method approach to evaluation, there's lots of methods out there, what we're not so good at is making sense of what we already know and seeing how the whole is greater than the sum of the parts-synthesis, the added value.

How do we integrate different perspectives so that it becomes the evidence base for why we should invest in these approaches? So more work on that.

Working with people who work closest to local communities about building a narrative can be useful for that.

Dr Pete Seaman, Public Health Programme Manager, Glasgow Centre for Population Health

In speaking as the person who will be writing the event report of today's meetings - the title that has come to me of so far is "*Are we still friends*?" But I then perhaps it should be "*Can we be friends?"*- because in some ways we are in two camps that are strangers to each other.

I think that in some ways this confirms something that I thought about a year ago when Emma and Kenny gave us their report. I realised that some of the language of health economics would not sit well with practitioners of asset based approaches - with a lot of the discussion this morning being around finding common ground, about learning to trust one another, and about realising that we have the same aspirations but that these are perhaps positioned in different ways.

I think there is fear on behalf of people using ABAs that the application of health economics will not capture what they do, that they will be too reductionist and miss the holism. Today we have seen an example of a good evaluation approach that does keep the holism and does keep the complexity.

I think there was also an awareness that there was complexity/technical ability involved in evaluating projects, and that this was not a cost-neutral exercise for services.

So the question follows – who does it? Should the services themselves be responsible for capturing economic data? And are the skills that make you a good practitioner of ABAs necessarily the same ones that make a good evaluator? That's another fear/concern.

I think there have been some early solutions coming up. Our discussions have certainly identified a few. One was the idea of how we keep the holism and the integrity of ABAs when we are looking at very indicative headline indicators of their success (or not). I think the example given by Sistema, taking an outcome by outcome approach, rather than a project by project basis, is one way forward. So you might identify that a certain approach might work well for educational outcomes but might not necessarily work for other outcomes, such as wellbeing. But you're recognising, by segmenting in the first place, that you are not going to capture the holism and complexity of the project, but in some ways you then protect the project and its integrity.

I think there is another that has been raised a couple of times, and I have heard it using slightly different language around the room, and that is where do health economics approaches fit into things like complexity and systems approaches and the assumption that health economics comes from a concern that resources are scarce? I think that ABAs and a lot of innovative approaches are not about resources that are scarce and finite; they are about resources that are renewable, and quite often abundant.

So there was a great example of that in Sistema project around teachers' time. And you can perhaps not think about something more finite that 'time', but

actually time folds in on itself and if people are inspired, they can find time to do things. And I can think the other resources that ABAs use: inspiration, community, humour, social connectedness. These are not finite resources. So I'd be interested to learn more about how heath economics can capture these types of resources, not just those that are scarce, but also those that 'produce' extra resource such as the time, usually understood as a finite resource, that was created through inspiring and energising people around the *Big Noise* project.

Going forward, I think there is a lot of work to be done if the two paradigms are going to get together. But I think we've made a great start. I think we need to think where we want to be and find creative ways of engaging with each other. For example could health economists embed themselves in projects, in order for them to understand the projects better and for both sides to understand one another better, and to understand the different types of value that are being created by using ABAs?

I know that the remainder of the morning will be about looking at these ways forward. I think it's a bit too early to discuss a 'toolkit' but I think we can begin on the journey towards there.

Conclusions, reflections and next steps

From the many contributions and discussions at the event, attention has been drawn to a number of areas and overarching points, which we need to be aware of as we progress and support work in this area.

There are a diversity of asset based approaches, each operating within and responsive to, the individual assets and hopes of service users. There is a need to distinguish between the economic evaluation of *individual* projects and the assessment of value of the underlying approaches to support their wider application in mainstreaming the principles and practice learned from asset based approaches. How the demonstration of value from individual projects can be scaled up will require further thought.

The following suggestions were also made:

- Some were looking forward to there being more economic evaluations of ABAs and not letting the 'best become the enemy of the good'. It may be that the most benefit might come from one of two or three outcomes. And you don't need to evaluate every step in a complicated theory of change.

- To continue to ask who is economic evaluation for? Is it for funders or are we doing it for other reasons? What do we value about this intervention on which we wish to gather evidence?

- For both 'sides' to come out of their comfort zones to move forward. The economic and the other 'softer' measures can complement one another to produce an altogether more 'robust' evaluation framework

- To develop evaluations that help service providers mainstream approaches that work, not necessarily the interventions themselves but the approaches within them.

- Not to invent more toolkits! There are already lots of these - logic models, social return in investment etc. SROI for example allows the people involved in the intervention to identify what is important to them. Sometimes these things might then be quite rudimentary ways, but at least they are an attempt to measure the right things and a step in the right direction.

- Develop collaborative agendas, it is important that the people involved in ABA are given a say in what is of value and that people who are part of these initiatives should be fully engaged in the evaluation in an 'assets-based' manner itself.

- There may be a need de-professionalise some of the evaluation language, terminology and methods so that it has wider meaning and can foster collaborative working. Could participatory approaches contribute to this?

GCPH will continue to work with the Yunus Centre and Glasgow University and the perspectives and guidance that emerged from the event will inform future work to align the two approaches. At GCPH, the development of the 2015/16 work plan offers opportunity to take forward the issues discussed in an action orientated manner. GCPH will also continue discussion with health economists in the Yunus Centre and University of Glasgow to explore joint working in response to the above encouragement and outlining of next steps.

Authors and acknowledgements

This report was produced by Pete Seaman and Jennifer McLean at Glasgow Centre for Population Health. We were aided by reviews and comments from Neil Craig (Health Scotland), Cam Donaldson (Yunus Centre, Glasgow Caledonian University), Lorna Kelly (GCPH), Lisa Garnham (GCPH) and Emma McIntosh (University of Glasgow).

Appendix 1 – Delegate list

Name		Organisation
Camilla	Baba	University of Glasgow
Nicki	Boyer	University of Glasgow
Angela	Campbell	Scottish Government
Anne	Clarke	NHS Ayrshire & Arran
Neil	Craig	NHS Health Scotland
Peter	Craig	MRC SPHSU
Lisa	Curtice	The Alliance
Cam	Donaldson	Yunus Centre
Ruth	Donnelly	NHS GG&C
Elinor	Finlay	Scottish Government
Lisa	Garnham	Glasgow Centre for Population Health
Cllr Emma	Gillan	Glasgow City Council
Chris	Harkins	Glasgow Centre for Population Health
Donald	Henderson	Scottish Government
Rikke	Iversholt	IRISS
Keith	Jack	Police Scotland
Amanda	Jubb	Social Marketing Gateway
Lorna	Kelly	Glasgow Centre for Population Health
Alison	Linyard	Glasgow Centre for Population Health
Andrew	MacGowan	Inspiring Scotland
Lisa	MacLean	Impact Arts
Gehan	MacLeod	GalGael Trust
Elspeth	Malony	NHS Health Scotland
Mike	McCarron	GalGael Trust
Kate	McHendry	SCDC
Emma	McIntosh	University of Glasgow
Julie	McKenzie	MusicALL
Jennifer	McLean	Glasgow Centre for Population Health
Rhiann	McLean	IRISS
Antony	Morgan	Glasgow Caledonian University/NICE
Neil	Orr	West of Scotland Housing Association
Bridget	Patterson	NHS Borders
Pete	Seaman	Glasgow Centre for Population Health
Nichola	Sewell	NHS Borders
Danny	Stuart	Police Scotland
Debby	Wason	NHS Ayrshire and Arran
Jane	White	NHS Health Scotland
Paul	White	SCVO

Appendix 2 – Programme

Asset based approaches and health economics:
What do we value and how can we capture it?

Thursday 12 February 2015
9.30am – 1.30pm
The Lighthouse, 11 Mitchell Lane, Glasgow G1 3NU

Programme

9.30 – 10.00	**Coffee and registration**
10.00 – 10.10	**Welcome and introduction from the Chair** *Professor Cam Donaldson, Yunus Chair in Social Business & Health, Glasgow Caledonian University*
10.10 – 10.40	**A review of the economic evidence of asset based approaches for health improvement** *Dr Emma McIntosh, Reader in Health Economics, University of Glasgow*
10.40 – 11.10	**Discussion groups**
11.10 – 11.20	Tea/coffee
11.20 – 11.50	**Evaluating Sistema Scotland: a worked example in capturing value and impact** *Dr Lisa Garnham, Researcher on Sistema Evaluation, GCPH*
11.50 – 12.30	**Discussion groups and plenary feedback**
12.30 – 12.45	**Response to presentations and discussion** *Neil Craig, Principal Public Health Advisor, NHS Health Scotland* *Prof Antony Morgan, Associate Director, Centre for Public Health, NICE* *Dr Pete Seaman, Public Health Programme Manager, GCPH*
12.45 – 1.00	**Summing up and next steps**
1.00-1.30	Close and lunch