The Ethics of Pay for Success

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Every application of Pay for Success (PFS) financing (e.g., recidivism, health care utilization, special education) must meet clear, measurable goals to obtain "payout" funding. Much of this journal focuses on how to structure contracts to achieve these goals. But larger questions remain. What is the ethical framework for choosing specific goals or setting programmatic priorities? How is one metric of success chosen over others? Insofar as the PFS interventions considered in this issue are presumed to be meeting societal goals, it is necessary to prioritize projects according to the priorities of society.

An inquiry into the process of selecting which PFS projects to prioritize may seem superfluous because any project that meets a social aim more efficiently than the status quo appears in itself to be sufficiently ethical. That is, finding a way to improve any outcome while spending less would seem to represent a good choice, given government's economic constraints. Thus, no inquiry into the ethical basis of these decisions would seem necessary.

However, the idea that efficiency in and of itself will properly inform the ranking of goals already presupposes a particular ethical approach, that of utilitarianism. The utilitarian framework is often the default approach for policymakers, particularly those influenced by economists. As a result, absent explicit attention to values, PFS applications are likely to be implicitly utilitarian.

Utilitarian approaches set priorities according to the standard of efficiency. The norm or ideal of a utilitarian ethic is to maximize the ratio of benefit to cost. This approach to ranking social programs makes the most sense when all relevant outcomes can be measured according to a homogenous unit of "benefit." It makes the least sense when the outcomes have disparate social value and there is no single type of "benefit." In such cases, simply seeking to get more of any given benefit does not ensure the value of that benefit vis-à-vis other potential goals. In commonsense terms, doing relatively less important things at a bargain rate is poor policy when it leaves more important things undone.

Efficiency itself has no normative or ethical value. Of course it is morally preferable to do "more good" overall by doing each thing efficiently, but what counts as "more good" still has to be established in some way. Rather than treating efficiency as a noun—seeking to create "efficiencies"—we ought to treat it as an adverb—seeking to reduce, for example, illiteracy or obesity efficiently. While this may seem obvious, it entails something less apparent: we need to decide what problems to address and how to design PFS approaches according to societal values that are *independent of the dollars a project might offset*. Lacking this perspective, a PFS approach regresses into taking efficiency itself as its fundamental value.

The error of attributing ethical value to efficiency itself is made repeatedly in social policy. The most common error is to equate equity or justice with the most efficient use of a limited resource, but to do so without any independent ethical rationale. For example, during the early stages of managed health care, an influential health policy leader, David Eddy, made this error in an important article in *Journal of the American Medical Association* on how to ration health care.[1] He literally defined equity in terms of efficiency, stating:

> In the context of health care, a preferable definition of equitable is that services should be used in such a way that the services received by each individual should provide them with approximately equal amounts of benefit per unit of resource consumed. Thus, an equitable distribution means equal yield or, more colloquially, equal "bang for the buck."

We disagree with this definition of equitable. Eddy's approach does not necessarily consider people or their needs equally; instead, it treats the benefits per dollar equally. People vary in the complexity of their health problems. Thus, they will vary in which medical interventions they need, and how much cost is involved, to address their medical conditions. Consider, for example, two people with cardiac disease who are both good candidates for treatment that can return them to equally productive lives and good health. However, while one can be treated with an inexpensive, noninvasive catheterization, the other–because of a quirk in blood vessel anatomy–will require expensive open-heart surgery. Using an "equal benefit per dollar spent" approach would prioritize the inexpensive treatment, yet this may not be equitable. What if the person needing the more expensive treatment was 20 years old and the other person was 70? Perhaps the fact that the 20-year-old would likely gain many more life years from the surgery could be factored into a more complex measure of efficiency. But what of the ethical consideration that the 20-year-old has experienced less than a fair share of his life? Even if both were likely to live just ten more years, this scenario poses questions of equity or fairness that an "equal benefit per dollar spent" approach alone cannot resolve.

Other influential thinkers, including Amartya Sen[2] and Norman Daniels,[3] have also pointed out difficult policy dilemmas that can arise between equity and efficiency. Often, helping people who are already disadvantaged requires using more resources to get the same outcome as helping more advantaged people. For example, in the case of microcredit loans in developing countries, it was more difficult for loan recipients who were worse off to begin with to achieve the same benefits as others who started with more resources.[4] Note that there is no inherent reason that maximizing efficiency should disadvantage those most in need–the point is just that efficiency and equity or justice can conflict.

1 David Eddy, "The Individual vs Society: Resolving the Conflict," JAMA 265 (18) (1991): 2399-2401, 2405-2406.
2 Amartya Sen, "Why Health Equity?" *Health Economics* 11 (8) (2002): 659-666.
3 Norman Daniels, Just Health, Meeting Health Needs Fairly (New York: Cambridge University Press, 2008); Norman Daniels, "Four Unsolved Rationing Problems: A Challenge," *Hastings Center Report* 24 (4) (1994): 27-29.
4 Paul Mosley and David Hulme, "Microenterprise Finance: Is There a Conflict between Growth and Poverty Alleviation?" *World Development* 26 (5) (1998): 783-790.

Ethical Considerations for Evaluating Pay for Success

So how are ethical considerations, such as equity, relevant to PFS models? PFS requires a focus on outcomes and efficiency. However, delineating which outcomes to prioritize and which interventions to implement raises additional ethical questions regarding societal priorities and the equal treatment of individuals and communities.

In addition to considerations of efficiency, then, we suggest that PFS policies raise the following ethical questions: (1) Is there a hidden human toll? (2) Are we taking the easy money rather than doing what is more important? and (3) Are we using problematic means to achieve a given end?

Is There a Hidden Human Toll?

Financially rewarding a select outcome can ignore other noxious side effects or hidden costs. In the case of health care, abundant evidence demonstrates that for-profit organizations targeting efficiencies for measured outcomes may provide lower-quality care for unmeasured outcomes. This result could even extend to avoiding or providing no care to more vulnerable or expensive patients.

For example, while health maintenance organizations (HMOs) originally claimed that they would improve care for entire populations by eliminating inappropriate care, studies show that many HMOs have actually excluded sicker and/or vulnerable patients to contain costs. They may be providing more efficient care to their selected patients, but at what cost to the population as a whole? In "Health Care and Profits: A Poor Mix,"[5] *New York Times* reporter Eduardo Porter gives multiple examples of for-profit health organizations that routinely underserve vulnerable populations. He writes:

> Our track record suggests that handing over responsibility for social goals to private enterprise is providing us with social goods of lower quality, distributed more inequitably and at a higher cost than if government delivered or paid for them directly.

We do not believe that there is an intrinsic conflict between seeking profit and seeking quality, but our point is that the incentives need to reflect both aims.

Are We Taking the Easy Money Rather Than Doing What Is More Important?

Selecting a certain social goal and a specific intervention always entails opportunity costs. What goals or approaches were not selected? Attention is needed to ensure that more ethically important endeavors are not passed over because they may not save as much money or result in savings as quickly. Since we can never meet all human needs, perhaps the best way to address this issue is to turn the question inside out, and instead of asking what we are neglecting, ask if we are doing what has a higher priority. Again, saving societal dollars can be a goal in and of itself, but then that goal should be explicit and not cloaked as benefiting

5 Eduardo Porter, "Health Care and Profits: A Poor Mix," *New York Times,* January 8, 2013.

society in other ways. If the goal is to provide important health and social benefits, then those proposing an intervention should consider whether the project addresses a fundamental human need.

Again, while this may seem obvious, we have seen health policies shipwreck over this issue. When policymakers sought to set priorities to ration Medicaid in Oregon, they faced such a problem. Through a democratic process they established rankings for health care treatments by calculating the number of quality-adjusted life years (QALYs) gained from a treatment divided by the cost. They then set population priorities according to the resulting aggregate value. This utilitarian approach resulted in ranking vasectomies higher than mobility-preserving hip repair surgeries and placing tooth capping higher on the list than lifesaving appendectomies. This "aggregation problem" arises whenever an intervention provides an inexpensive but relatively less important benefit for a large number of people.[6] We suggest that those designing PFS interventions keep this issue in mind. The most valuable or most important outcome may not be the one that saves the most money or benefits the largest number of individuals.

Are We Using Problematic Means to Produce a Given End?

Finally, another risk of the focus on outcomes in PFS financing is the possibility of ignoring morally unsatisfactory means of producing an outcome. In an elementary school setting, a PFS outcome of value might be reducing the cost of expensive special education classes. Improving preschool quality or initiating earlier screening for developmental delays or reading disabilities could potentially accomplish that goal. Blocking children with educational difficulties from enrolling in the school or hiring cheaper, less qualified teachers would also reduce expenses, but at what moral cost?

In another example from the health care setting, Porter reports that when nursing homes transition from not-for-profit to for-profit status, their quality of care plummets. For example, one study showed that patients were given four times the dosage of sedatives in the for-profit condition as they were given in the not-for-profit condition. Porter quotes economist Burton Weisbrod, who states that sedatives are "less expensive than, say, giving special attention to more active patients who need to be kept busy."[7] Efficiency-focused child care facilities could use equally problematic means–such as television for children rather than stimulating, interactive play–to "succeed" at cost reduction.

Thus, using an appropriate ethical framework–beyond just efficiency–to identify the "true" societal goals of an intervention should be an important component of any PFS model. And the measures of success should incorporate these goals in addition to assessing the efficiencies gained as a result of a successful intervention.

6 Daniels, "Four Unsolved Rationing Problems."
7 Weisbrod, *The Nonprofit Economy* (1988), quoted in Porter, "Health Care and Profits."

Case Discussion

Consider, for example, the first social impact bond intervention, at Peterborough Prison (Peterborough) in the United Kingdom. In this example of PFS financing, the local community desired to reduce the rate of re-incarceration among short-term prisoners held at Peterborough, 60 percent of whom re-offended within a year of release. With a control group as comparison, the Ministry of Justice signed a contract agreeing to repay investors in full if the recidivism rate was lowered by 7.5 percent over a six-year period as well as pay out an additional percentage of the cost savings for any reduction beyond 7.5 percent. While we lack firsthand knowledge of how the project actually changed the lives of those involved (we base our discussion on a summary description)[8], we might apply the three ethical questions to assessing such a project as follows.

Is There a Hidden Human Toll?

It is easy to imagine how a recidivism intervention whose singular aim is to keep former inmates out of prison might have other noxious effects. Imagine, for example, an intervention that instructed police to make fewer arrests, just as a for-profit HMO might limit access to health care. This could lead to worse crime rates in the community. Or an intervention might reduce social services for prisoners and families (decreased scrutiny might lead to decreased arrests), resulting in increased domestic violence and strife.

In the actual case of Peterborough, the interventions appear to have been designed to improve the individual and family well-being of the people released from prison, not just to cut costs. At the early formative stages of the project, the input of prisoners, their families, and community social workers was elicited regarding their needs for a successful transition out of prison. These needs appear to have guided the design of the intervention:

> Experienced social sector organisations, such as St Giles Trust and Ormiston Children and Families Trust, provide intensive support to prisoners and their families, both inside prison and after release, to help them resettle into the community.[9]

Are We Taking the Easy Money Rather Than Doing What Is More Important?

The Peterborough intervention appears to be meeting an important societal goal. The targeted population–prisoners serving short-term sentences–lacked social services to assist them in returning to their families and communities. The released individuals and their families have important unmet needs, so this does not appear to be a case of simply taking the easy money.

However, to fully address the question of importance involves learning more about the other social ills present in this community. Is preventing recidivism as important for this community as, say, improving the local schools or increasing the availability of well-paying jobs? This intervention has an easily monetized marker of success–dollars not spent on re-incarcerated former inmates. Were other important opportunities for which the outcomes were more complicated, yet still possible to measure, passed over?

8 Social Finance, "Peterborough Social Impact Bond," 2011, available at www.socialfinance.org.uk/sites/default/files/SF_Peterborough_SIB.pdf.

9 Ibid.

Are We Using Problematic Means to Produce a Given End?

In the case of Peterborough, the means of preventing recidivism involved addressing the unmet needs of the released inmates and their families through the use of experienced social service agencies. This is hardly problematic. Consider if, instead, recidivism were kept down by giving sedatives to former inmates to make them too weak to commit crimes. That may sound implausible, but it is not too far a stretch from prescribing four times the dosage of sedatives to elders in nursing homes to cut costs.

Conclusion

PFS models use financial instruments to incentivize finding an efficient means to produce a measurable outcome. This utilitarian approach to reaching societal goals is practical but not necessarily ethical. To assess the ethics of a proposed project, we need to consider its hidden ethical costs, its relative human importance, and the appropriateness of the means used to achieve the given outcome.

The positive example of the Peterborough project provides an inspiring model for addressing these ethical concerns in future interventions. However, it is notable that the PFS model of Peterborough was funded by philanthropic donors who were already committed to meeting community needs. We are concerned that investors whose overriding aims are financial might not address such concerns unless an explicit ethical standard is developed. The basis for this concern is some observations regarding the early history of HMOs. Policymakers initially conceived of HMOs as improving efficiency by eliminating excessive treatment previously incentivized by the fee-for-service system. In particular, health leaders argued that patient care would improve as costs were reduced. Because of this expectation, little attention was paid to developing explicit safeguards for threats to quality posed by cost containment. In retrospect, those threats are now all too clear. We recommend that the social finance field learn from the shortsightedness of the health services sector and get ahead of such ethical challenges.

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