Yunus Centre for Social Business & Health

researching the relationship between poverty alleviation and health

Conceptualising Social Enterprise as a Health and Wellbeing 'Intervention'

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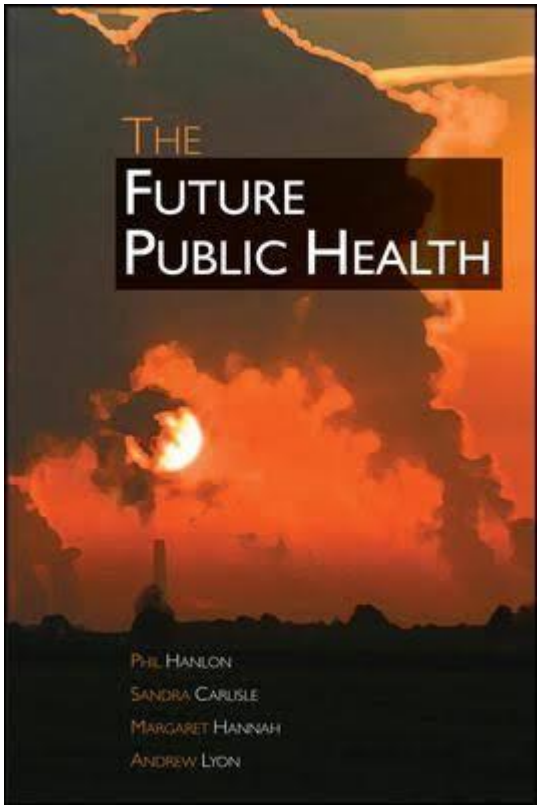
“Non-obvious” public health actors



“Non-obvious” because they are not part of formal health systems. Unrecognised – or under-recognised – by health service funders, researchers and policymakers. Indeed, the actors *themselves* may not recognise the impact of their work in public health terms:

“…many of the key players [in the future public health] may not consider themselves to be involved formally in public health at all: their influence on health will be a product of their primary intent” (Hanlon et al., 2012: 169).

What is health?

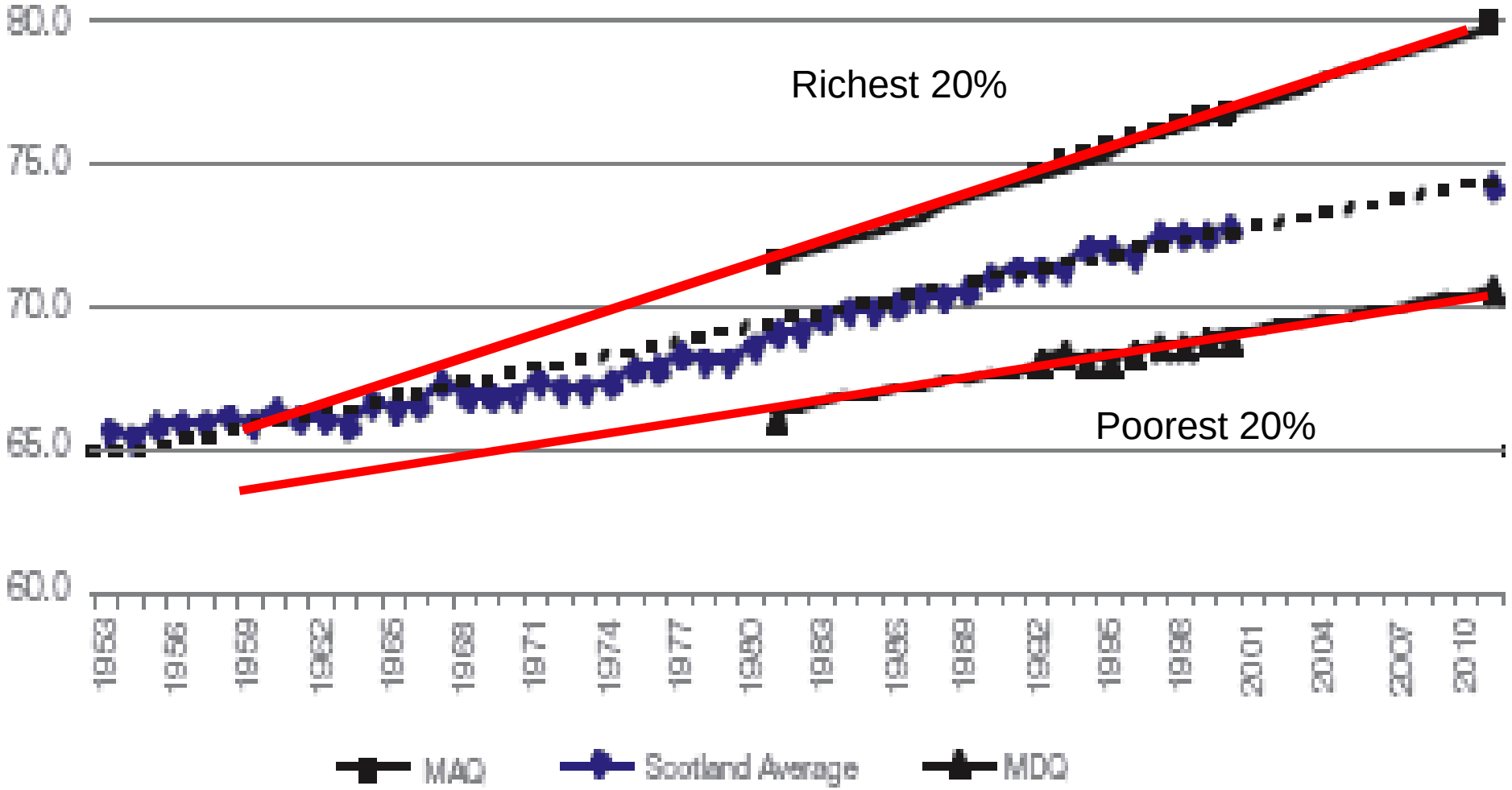
- The Constitution of WHO (1946) states that good health is a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity.
- Health is a resource for everyday life, not the object of living, and is a positive concept emphasizing social and personal resources as well as physical capabilities.
- Health is a fundamental human right, recognized in the Universal Declaration of Human Rights (1948). It is also an essential component of development, vital to a nation's economic growth and internal stability: better health outcomes play a crucial role in reducing poverty, key to issues of of social justice.

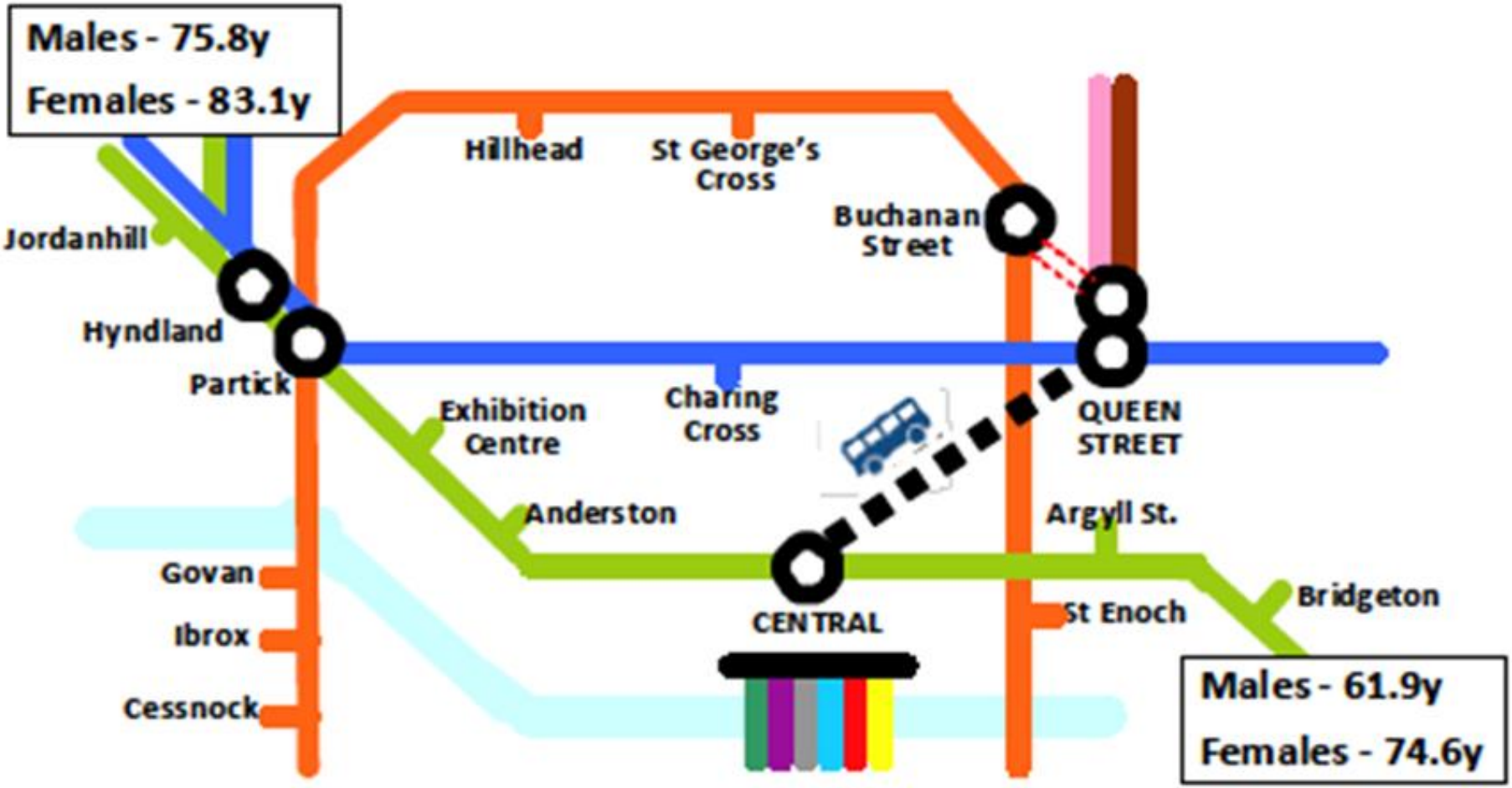
What are health inequalities?

- The ‘preventable and unfair’ differences in health status between social groups, populations and individuals (Whitehead et al. 2001)
- The ‘scandal of our times’ (Dorling 2013) since “the right to life itself is at stake” (McCartney et al. 2013, p. 222

Trends in male life expectancy: Scotland

Source: Chief Medical Officer for Scotland (2012)





Life expectancy data refers to 2001-05 and was extracted from the Glasgow Centre for Population Health community health and wellbeing profiles. Adapted from the Strathclyde Partnership for Transport travel map by Gerry McCartney.

(Source: McCartney, 2012)

It’s not just deprivation!

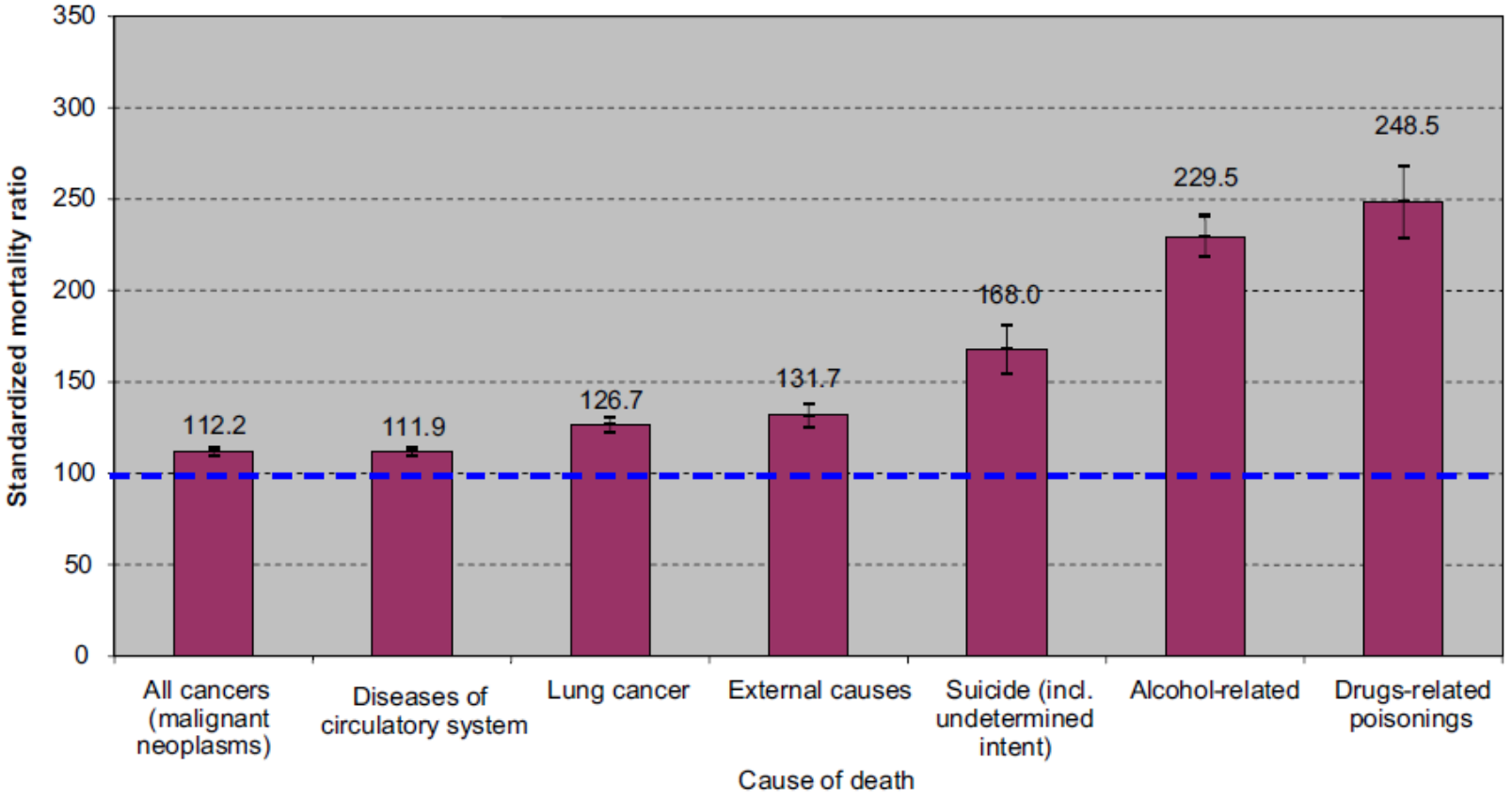
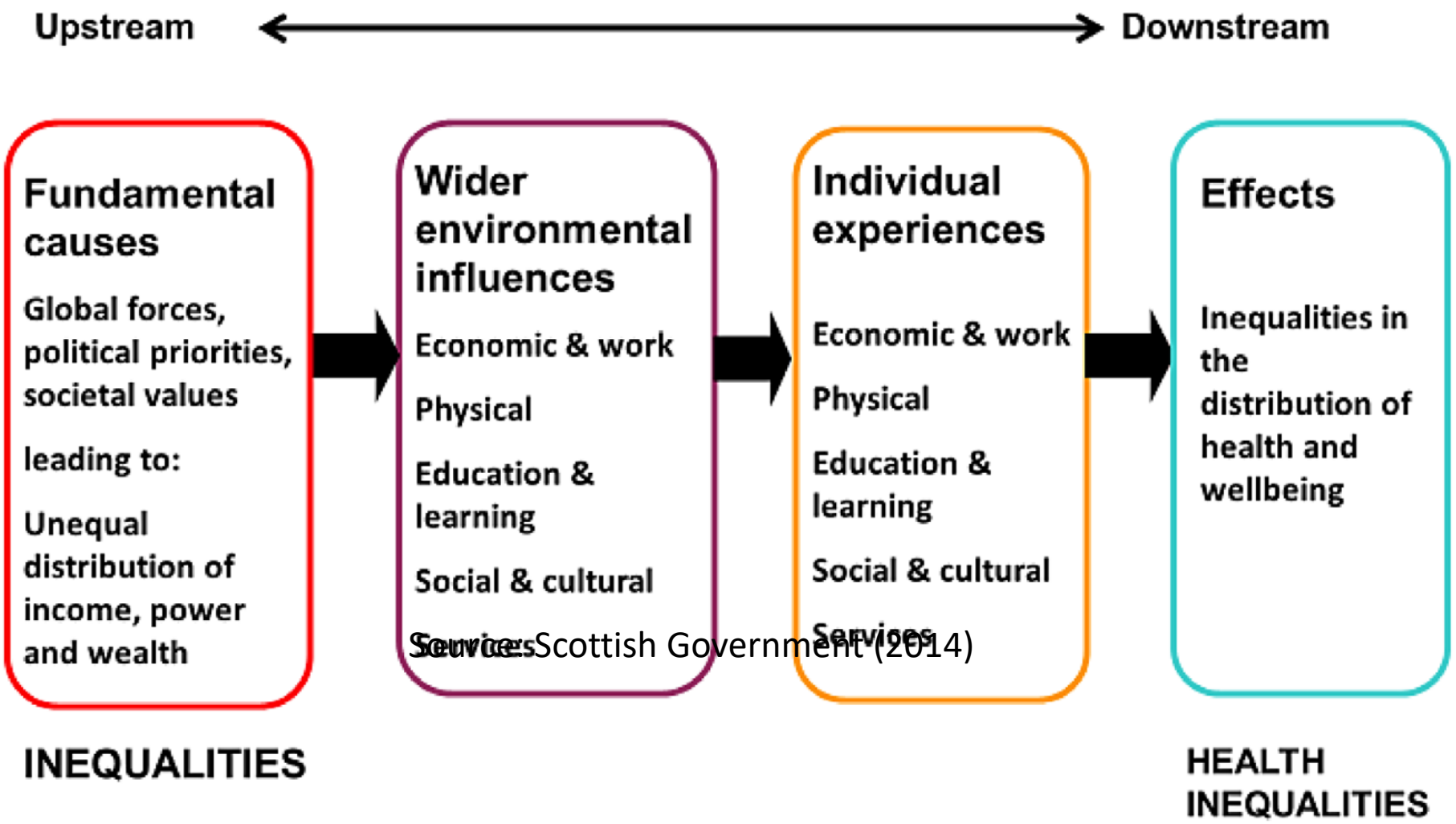


Figure 3 – Standardized mortality ratios 2003–2007 (indirectly standardized by 5-year age band, gender and income deprivation decile) for Glasgow relative to Liverpool and Manchester (combined), for seven causes/groups of causes.

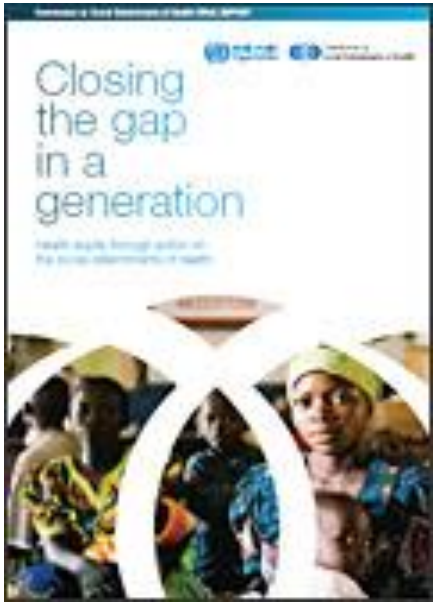
(Source: Walsh et al, 2010)



Source: Scottish Government (2014)

Despite this…

- The medical model of health remains by far the dominant discourse (i.e. that health is simply the absence of disease or disability, the responsibility of individuals is to minimise exposure to ‘risk factors’)



"This ends the debate decisively. Health care is an important determinant of health. Lifestyles are important determinants of health. But... it is **factors in the social environment** that determine access to health services and influence lifestyle choices in the first place."

Director-General Dr Margaret Chan, at the launch of the final report of the WHO Commission on Social Determinants of Health, 2008.

- Social enterprises act to remedy/ameliorate social conditions ("factors in the social environment"): addressing a social mission is their purpose!
- So if ALL social enterprises act on the social determinants of health then can ALL social enterprises be viewed as providers of public health?

Just to be clear…the ‘big idea’ is that…

- …by acting to address one or more aspects of social vulnerability
- …achieving the means to do so in some broader trading activity / hybrid ‘resource mix’
- Gains in health and well-being may be realised from (just about) *any* social enterprise, regardless of whether this is explicitly stated as part of their social mission

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The potential of social enterprise to enhance health and well-being: A model and systematic review

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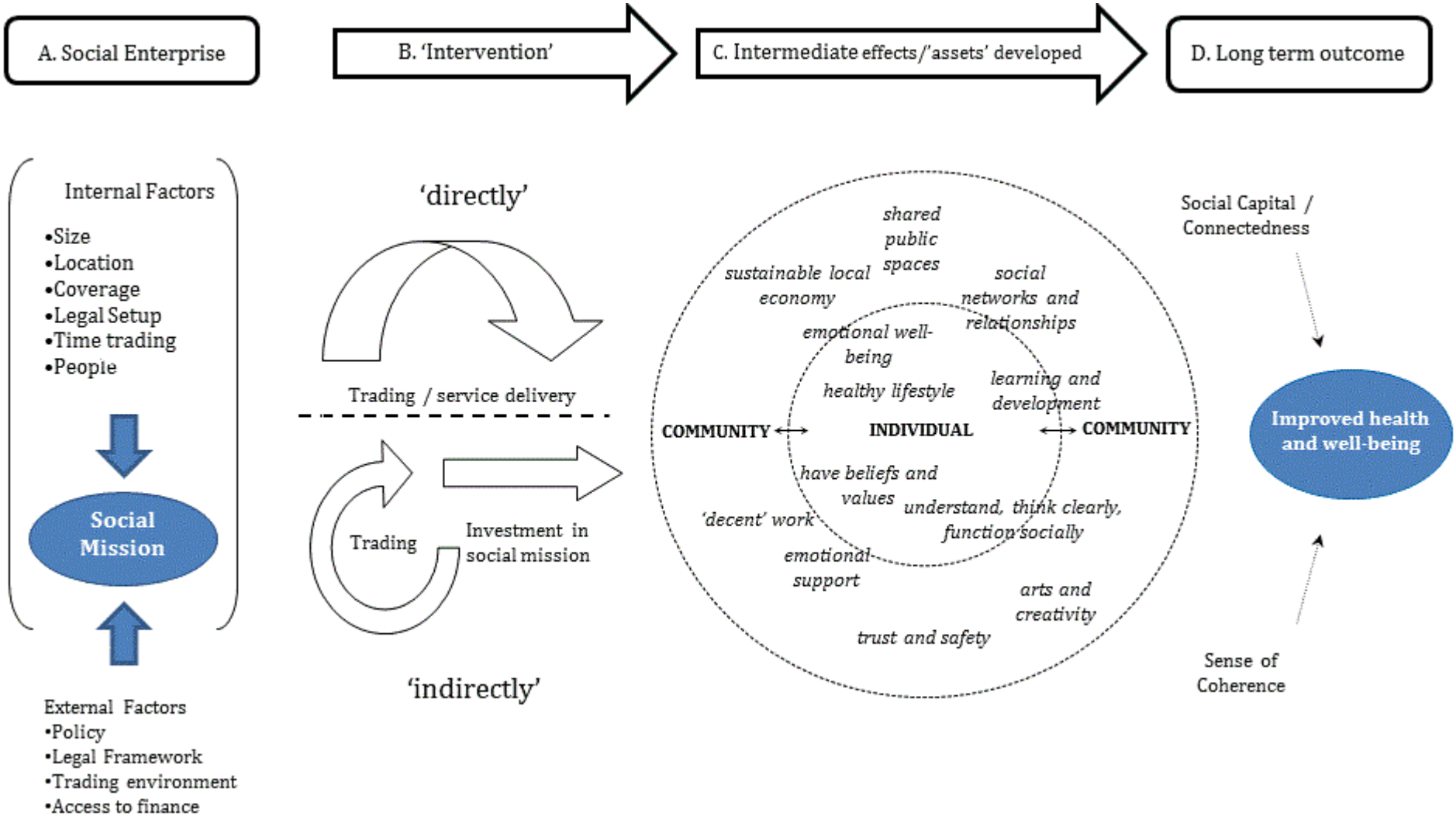
"…provide limited evidence that social enterprise activity can impact positively on mental health, self reliance/ esteem and health behaviours, reduce stigmatization and build social capital, all of which can contribute to overall health and well-being. No empirical research was identified that examined social enterprise as an alternative mode of healthcare delivery." (Roy et al, 2014:182)



Hypothetical model of social enterprise as a health and well-being 'intervention' (Roy et al , 2014)

Developing an empirical evidence base

To examine how social enterprise practitioners *think about* and *explain* their impact upon health and well-being, irrespective of whether they explicitly *intend* to impact upon health and well-being or not.

Methods

- In depth semi-structured interviews (and a focus group) with 13 social enterprise practitioners around Glasgow
- Four stage sampling process: purposive, maximum variation (Mason, 2002) sampling of social enterprises (on a range of variables e.g. size, age, location, type of business, geographical focus etc)
- Analysis: Critical Realist-inspired 'Causation Coding' method (Saldaña, 2013). Pictorial causal networks (Miles and Huberman 1994) employed to understand and demonstrate 'causal pathways' or 'generative mechanisms' contained in practitioner discourses. Abductive inference.
- **Antecedent variables > Mediating variables > Outcomes**

Physical Health

"there just wasn't anything positive for her to hook onto, she was just in a downward spiral… There has been real progression for her through gaining these skills…she now doesn't have a problem with alcohol, she looks after herself…she has become a volunteer…and is helping assist and lead other young people." (Fiona)

improving knowledge and skills > improved health behaviours/ decrease in illicit or dangerous behaviours

Mental Health

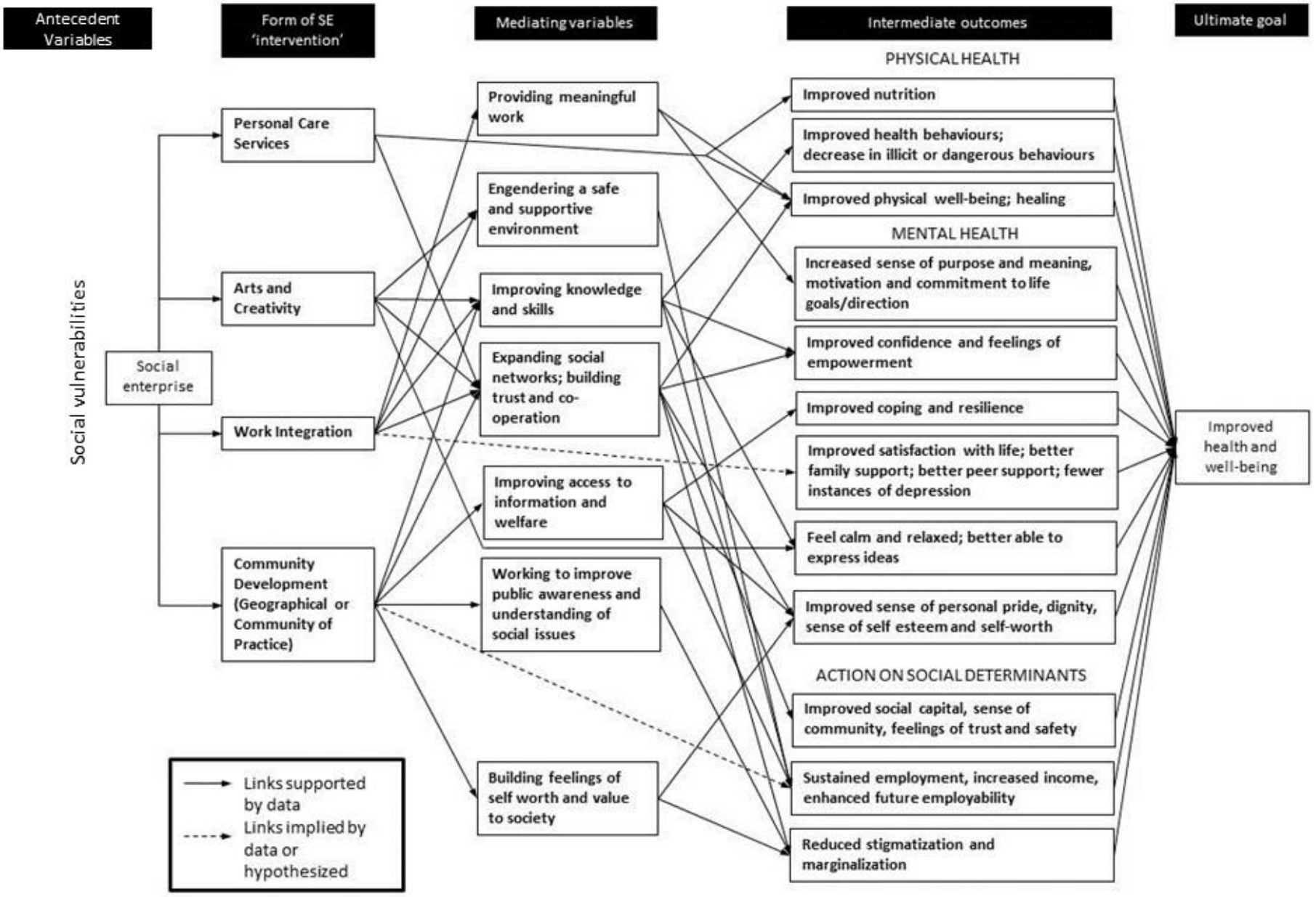
"…she now has a future. She's not sitting at home relying on grants, relying on benefits. She is now doing something for herself. I think it's giving somebody a future." (Doreen)

providing work that is meaningful > people have an improved sense of purpose and meaning

Social Determinants

“they actually have an interaction with a member of the public that they wouldn't normally get a chance to talk to…and the idea is that it empowers the person to kind of join back to society.”
(Christine)

facilitating, encouraging contact between people > vulnerable people (such as homeless people in this case) feel less marginalised



'empirically informed' conceptual model (Roy et al, 2017)

So what?

- Not intended to be ‘the truth’ by any means, merely as a plausible starting point for future research
- A platform for future empirical enquiry
- Broader and more imaginative consideration ?
- Implies that the Third Sector and other ‘non-obvious’ actors have an important role to play in addressing contemporary and future public health challenges
- But potentially raises moral dilemmas:
  - e.g. how can public policy recognise the (public health) work of non-public health actors?
  - how can SEs be supported without being destroyed (such as via assimilation into formal health systems?)

Thank you!

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