Agenda

1. A statement of the problem
2. About social enterprise
3. Some hypotheses/theories of change
4. Development of ‘empirically informed’ conceptual models
5. So what?
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. Along with traditional and unequivocal arguments on social justice and the importance of health, it is now accepted that better health outcomes play a crucial role in reducing poverty.
What are ‘health inequalities’

• The ‘preventable and unfair’ differences in health status between social groups, populations and individuals (Whitehead et al. 2001)

• Described as 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)
In Iraq, life expectancy is 67. Minutes from Glasgow city centre, it's 54

In deprived inner city area of Calton, the chance of surviving to old age is lowest in UK

Life expectancy (male)
Andorra (highest): 80.6
United Kingdom: 75.9
Gaza Strip: 70.5
Calton, Glasgow: 53.9
Liberia: 38.9
Swaziland (lowest): 32.5

Source: Gillan (2006)
It’s not just deprivation!

- There is something else going on in Glasgow that cannot be explained ‘simply’ in terms of poverty alone, as the comparative studies of different cities show.
- There are countless theories as to what is causing this ‘Glasgow effect’: “likely to be a complex array of factors acting in concert” (Roy et al, 2013)

![Graph showing standardized mortality ratios for different causes of death in Glasgow compared to Liverpool and Manchester.](Source: Walsh et al, 2010)
Despite this...

- The medical model of health – that health is simply the absence of disease or disability, the responsibility of individuals is to minimise exposure to ‘risk factors’ – remains by far the dominant discourse.
Theory of causation of health inequalities

Source: Scottish Government (2014)
So what do I mean by social enterprise?
A social enterprise is a trading entity whose surpluses are reinvested for the benefit of social objectives rather than for distribution to shareholders or owners (Borzaga and Defourny, 2001; Nyssens, 2006)
Source: Defourny and Nyssens (2012); original based on Pestoff (1998, 2005)
Social enterprise is highly contested!

• Ridley-Duff and Bull (2011: 100): “social enterprises offer either a partial or a complete rejection of established rules of international capitalism”

• Aim to “create wealth in communities and keep it there. They trade on a ‘not-for-personal-profit’ basis, re-investing surplus back into their community...effecting social, economic and environmental...outcomes” (Teasdale, 2012: 105-106).

• A (potential) means of exploring ‘alternative economic spaces’ (Leyshon et al., 2003; Lionais, 2010)

• Unlocking the “social and economic capacities latent in even the most deprived communities” (Amin et al., 2003: 27)
"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 their social mission is their primary 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 any social enterprise, regardless of whether this is explicitly stated as part of their social mission
“…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)
How do they work?: A working hypothesis

Social Enterprise:
- social mission
- trading
- no share ownership

Engagement

Assets and ‘Deficits’

Community

Individual

Improved health and well-being

Social cohesion

Connectedness
How do they work?: A working hypothesis

SOCIAL ENTERPRISE:
- social mission
- trading
- no share ownership

ENGAGEMENT

ASSETS AND ‘DEFICITS’

COMMUNITY

INCOME

Improved health and well-being

Social cohesion
Connectedness
How do they work?: A working hypothesis

SOCIAL ENTERPRISE:
- social mission
- trading
- no share ownership

ENGAGEMENT

ASSETS AND ‘DEFICITS’

SAFETY/TRUST

CONFIDENCE

Improved health and well-being

Social cohesion

Connectedness
Hypothetical model (Roy et al., 2014)
Building an empirical 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.
  – Can we ‘map’ this somehow? That is, the ‘causal pathways’ to produce an empirically informed conceptual model?
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**
“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
“...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, forthcoming)
So what?

• Not intended to be the “truth” by any means, merely as a plausible starting point for future research
• In other words: a platform for future empirical enquiry
• Hopefully encourages a broader and more imaginative consideration of what actually constitutes a public health ‘intervention’
• Also implies that the Third Sector and other ‘non-obvious’ actors have an important role to play in addressing contemporary and future public health challenges
In summary: key messages

- New field of scientific enquiry at the interface between social enterprise and public health has started to emerge internationally, presenting significant scope for future research activity.
- Evidence of CIHR:IPPH being interested in this agenda (workshop in Toronto Feb 2015).
- Major (£1.96m / $CAN 3.8m) five year programme grant co-funded by the UK’s Medical Research Council and Economic and Social Research Council, commenced in early 2014: Developing Methods for Evidencing Social Enterprise as a Public Health Intervention (see www.commonhealth.uk).
Thank you!

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