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How do social enterprises impact upon health and wellbeing? Some lessons from *CommonHealth*

Gillian Murray, Michael J. Roy, Rachel Baker and Cam Donaldson

Abstract

Considering that new thinking was required to address longstanding and ever-deepening health inequalities in Scotland, we explored the potential of social enterprises to address the factors in the social environment that we know favour or harm health: the so-called 'social determinants of health'. In this chapter we outline the key findings of a major five-year programme of research (2014-2019) undertaken in Scotland. Working with academic and practitioner partners, we sought to conceptualise and improve knowledge of the health and wellbeing impacts of social enterprises in various contexts and working with different beneficiary groups. We provide an overview of each of the component projects of *CommonHealth* and their key findings and implications. In our view, and reflecting the nature of social enterprise, research frameworks are required to account not only for the contexts in which they operate but also the consistent outcomes which emerge from such contexts and thus reflect the pervasiveness of social enterprise as a driver of wellbeing.

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Introduction

Despite the existence of world-class health and social care provision in Scotland, health inequalities – the preventable and unfair differences in health status between social groups, populations and individuals (Whitehead, 1992) – continue to widen and deepen. This challenge is by no means unique to Scotland, but support the premise that new thinking was required to address this longstanding issue from a different direction (Donaldson et al., 2011; Roy et al., 2013). This underpinned the geographical focus for a major five-year programme of research (2014-2019) undertaken to develop methods to evaluate the health and wellbeing impacts of social enterprises. Many of the factors that social enterprises aim to address are those that we know influence the health and wellbeing status of individuals and communities. These are otherwise known as the 'social determinants of health' (Wilkinson & Marmot, 2003): the conditions in which people are born, grow, live, work and age, which are shaped by the distribution of money, power and resources at global, national and local levels. The project team were keen to establish whether social enterprises can be thought about (and thus studied as) a form of health and well-being 'intervention' through acting on these social determinants. The basic thinking was that even social enterprises that do not explicitly mention 'health' and/or 'wellbeing' in their mission statements, or trade in health-related services with public funders such as the National Health Service (NHS) (see, for example, Hall et al., 2015; Roy et al., 2013; Vickers et al., 2017), they are likely to have health and well-being impacts, irrespective of whether this is their primary intention. We use the term 'non-obvious' public health intervention in this context because social enterprises exist outside of what we normally think about as formal health systems such as the NHS – see Roy et al (2017) in particular.

The programme of research 'Developing methods for evidencing social enterprise as a public health intervention', which was quickly shortened to *CommonHealth,* was jointly funded by the UK's Medical Research Council and the Economic and Social Research Council. It

involved a partnership of five universities around Scotland; Glasgow Caledonian University, the University of Glasgow, Robert Gordon University, the University of the Highlands and Islands and the University of Stirling. The Scottish social enterprise sector was involved in the research programme in a variety of ways. Thirty-seven social enterprises actively participated in the CommonHealth research projects, featuring as case studies, or providing access to their staff, members of their board or other stakeholders, and/or beneficiaries (at times these roles overlapped) as interviewees. Advice on facilitating these relationships came from membership- and government-funded Scottish social enterprise support bodies such as SENScot, Social Firms Scotland, Social Enterprise Scotland and CEiS.

The research programme drew in expertise from across a range of disciplines, including history, sociology, economics, geography, political science and public health, and adopted a wide range of methodological approaches. The contexts in which the research was undertaken were also wide-ranging, not just geographically, but in the variety of activities that the social enterprises were involved in: from women's self-reliant groups in inner-city communities, to interventions focusing on addressing homelessness; from addressing the social exclusion of elderly people, to working to address isolation in fragile rural communities. In this chapter we outline the programme of research and provide a brief overview of the key findings of the CommonHealth projects. We will follow this with an outline of what the programme taught us about the effects that social enterprises have in relation to health and wellbeing and the implications for evaluation and measurement. We close the chapter with a brief discussion of where our research may be heading in future.

***CommonHealth*: an overview**

CommonHealth comprised eight distinct projects organised into three broad areas of research activity; conceptual, empirical, and evaluative in nature. There was also a transversal theme

that ran throughout the project relating to knowledge exchange, with regular 'knowledge exchange forums' involving representatives from across the third and public sectors with an interest in the intersections between social enterprise, health and wellbeing. In the last project – 'Project 8' – we attempted to gather all of the findings and discussions together, highlight overarching themes and lessons, and to lay the groundwork for synthesis across the programme post-project, when all the projects had completed their research. Projects 1-7, the research projects relevant to this chapter, are outlined in turn.

Project 1: the 'history project'

Project 1 set out to explore the modern history of social enterprise with a particular interest in the 'community business' movement, an important forerunner of social enterprise in Scotland. Forms of trading that prioritise social good have existed in many forms at a variety of often turbulent historical junctures (Roy, McHugh, et al., 2015). The acceleration of deindustrialisation in Scotland from the late 1970s compounded economic and social challenges, providing a key impetus for the emergence of Scotland's community business movement (Murray, 2019). As well as charting the development of social enterprise in Scotland, the historical research also sought to consider the movement's relationship to the developments in thinking in public health that were happening in parallel.

This project was based on archival research, making use of a number of regional and national archives and the Social Enterprise Collection (Scotland) held by the Glasgow Caledonian University Archive Centre. The Collection was created in 2011 when social enterprise pioneer John Pearce (see, for example, Pearce 1993; 2003) donated his personal archive of papers and literature to the Centre. The archival research also informed the development of an oral history project. Running in parallel to the archival research, 10 oral histories were recorded with community development workers and community business pioneers across Scotland. Thus, the project drew upon a rich range of documents and audio recordings for interpretive analysis.

The historical research found that the community development skills and values of community business pioneers were of great significance to the development of social enterprise in Scotland. Their legacy remains visible in the infrastructure of Scottish social enterprise today, where an asset lock on the redistribution of profits remains a central part of the Voluntary Code of Practice, to which a significant number of social enterprises in Scotland subscribe. However, the project found only scant evidence of community business pioneers working with public health practitioners in a formal capacity. Where their paths did overlap, it was through community health projects, often working at the 'radical edges' of public health that arose in response to the attempted suppression of the findings of the Black Report by the Thatcher Government in the early 1980s, which starkly revealed the extent to which such inequalities were socially determined (Townsend & Davidson, 1982). While the concerns of community business practitioners, and the skills and capacities they supported communities to develop, are highly comparable to those within community health projects, their learning remained in silos of knowledge, that are perhaps only now beginning to come together.

Since the 1970s, pluralism in health and welfare has frequently been associated with a reaction to the imposition of neoliberal policies from above and their effects on the structural composition of health systems. However, reflecting on the history of social enterprise in Scotland reveals how organisations in Scotland's developing social economy supported communities in comparable ways to community health projects. The acceptance of the discourse of socially determined health over the late twentieth and early twenty-first century provides an example of the historically contingency in how we conceptualise 'health'. . However, there has not been a comparable reconceptualisation of health actors who support the 'social determinants' arguments. Hence, the view that the contribution of civil society actors to health and wellbeing, from a systems perspective, has been limited to their role as organisations that have filled gaps caused by the rollback of state services. They have been

characterised as service providers of last resort, rather than service innovators supporting a broad range of individual and community needs. Relating this historical insight to projects 2-7 on the *CommonHealth* programme, the resonance between the parallel development of the social economy and increasing acceptance of, and knowledge of, the social determinants of health opens up a new perspective on pluralism from below. It is this 'non-obvious' space that *CommonHealth* sought to research and articulate.

Project 2: The 'contemporary' project

Project 2 was focused on conceptual development, complementing Project 1 by studying contemporary social enterprise practice. The project had three aims to: map and describe the activities of social enterprises; gather insight into how they report their social impact, and; analyse the extent to which they considered their impact in health and wellbeing terms.

The project combined desk research with qualitative data collection to develop insight giving a 'macro' perspective on social enterprise in Scotland, as well as producing detailed case studies. The desk-based research involved analysing social impact reports in the public domain that had utilised either of two popular forms of impact measurement method presently in use in Scotland: 'Social Return on Investment' and 'Social Accounting and Audit' (Arvidson et al., 2013; Pearce & Kay, 2008). Through analysing evaluative reports of the work of social enterprises in Scotland utilising a 'process coding' method, Macaulay et al. (2017) describe both the self-reported impacts (measured or not) of the work of social enterprises and the mechanisms by which these are said to be derived. The method of coding allowed the identification of various processes and outcomes, which could be said to operate at the level of the individual, community and/or the 'systems level.'

The case study phase, meanwhile, involved in-depth semi-structured interviews and a focus group with board members, staff and beneficiaries from three social enterprises in different

regions of Scotland. Macaulay et al. (2018) found that rather than social enterprise being a homogenous group of organisations with homogenous effects, different types of social enterprise, in different sectors, impact on dimensions of health in ways that are contextually and contingently dependent. They can: engender a feeling of ownership and control; improve environmental conditions (both physical and social); and provide or facilitate meaningful employment. Crucially, the project also provided insights into how those who participated in the study understood the causal mechanisms through which their activities may impact health and wellbeing, even when these activities are not explicitly 'health focused'.

Project 3: Growth at the Edge

'Growth at the Edge', the title of Project 3, explored the health and wellbeing effects of rural social enterprise activity on individuals and communities in the Highlands and Islands of Scotland. Over three years, 68 in-depth interviews were undertaken with stakeholders from a variety of roles, including rural social enterprise board members, staff, volunteers and service users. These stakeholders were drawn from seven different organisations and, in addition to the interviews, were visited for extended periods to allow for ethnographic research on the rural communities and contexts in which they were operating.

Kelly et al. (2019) explain that social enterprises have a significant role in addressing social isolation and loneliness, which is a major public health concern because of the associated implications for both physical and mental health. Factors identified as contributing to social isolation, such as isolated people feeling like they have 'nothing to do', and/or having poor social connections, can be compounded by living in a remote or rural area (Farmer et al., 2008). For example: access to transport can be challenging and being viewed as 'an incomer' can be difficult to socially navigate (Farmer et al., 2012).

The project also explored instances where social enterprises were addressing challenges created by the reduction in public budgets and withdrawal of public services. The organisations studied worked to counteract factors contributing to social isolation and loneliness, especially those exacerbated by rural contexts. The most significant among this range of activities involved providing spaces and opportunities for people to meet and interact with others, and the means to access these spaces. Over time, the increased sense of purpose that arose from interactions with the activities and spaces provided by social enterprises led to perceived improvements in health and wellbeing.

There were also cautionary findings from the project, particularly relating to the need to consider more widely the resources, capacity, and resilience of communities to be able to continue to respond to public health issues such as social isolation and loneliness. The study found that, in rural areas, the burden of maintaining social enterprise tends to fall on a relatively small number of community members. Feelings of stress or even ‘burn out’ were reported across all the social enterprises studied. There is often a small pool of rural volunteers to draw upon, especially people with skills such as business and accounting skills, and even holding driving licenses. These factors contributed to the social enterprises studied often seeming fragile and precarious, as has been noted in other rural studies (e.g. in rural Ireland – see O’Shaughnessy, 2008; O’Shaughnessy et al., 2011). This reinforces the idea that policy interventions supporting social enterprises in rural areas require to be tailored effectively to take into account specific contextual needs and requirements (Steiner & Teasdale, 2019; van Twuijver et al., 2020).

Project 4: ‘Passage from India’

In January 2011, 13 women from seven different communities in Glasgow were supported by the Church of Scotland to travel to India to study women’s self-help groups, a model that has been used there to address social and financial exclusion. Inspired by what they saw, the women

returned to Scotland to explore how they could apply their learning to their own community contexts. The groups that were established as a result of the visit to India came to be known as 'Self-Reliant Groups' (SRGs) and Project 4 was based on five years of ethnographic research, where the researcher observed and participated in SRG activities and conducted in-depth interviews with SRG members.

SRGs are usually small groups of 5-10 people who come from a shared economic and social background and aim to meet regularly to support each other. At their meetings they agree to start a collective savings fund; a typical contribution is £1 per person, per meeting. These savings, along with any other income generated by the group, can be lent to SRG members in times of need or crisis. The SRGs in this study were all supported by WEvolution, an independent organisation established in 2014 to act as a facilitator to emerging groups, provide key training opportunities, and offer loans. As the SRGs began to scale up, they often started small businesses to generate income (Hill O'Connor, 2013; Roy et al., 2014; Roy, Hill O'Connor, et al., 2015) such as running a weekly lunch club, opening a laundrette, and making craft products for sale in the local church and craft markets.

Hill O'Connor et al. (2020) identify two key characteristics of the SRGs that made positive differences to the lives of the women involved. Firstly, the savings they generated could provide members with control over their finances in times of acute financial stress. This not only gave them the ability to avoid high-interest weekly payment retailers or 'loan sharks', but also to direct savings towards people in the group who had a specific need; the opportunity to take a teenage son with developing behavioural issues on a short break to a caravan, for example. Within their groups, SRG members set the interest rates and repayment periods for the loans and rotated the role of treasurer, offering the women a sense of belonging, ownership and trust that they did not necessarily experience in other areas of their lives.

Over time, their financial skills – which had often been a point of anxiety for members – accumulated to the point where they described a 'mastery experience', which strengthened their self-efficacy. Secondly, the SRGs provided opportunities for productive activity: the activities associated with the small businesses the groups ran became a source of pride for the members, who learned new skills and felt they were contributing to their communities. The SRG women also reported increased confidence as a result of participating in the group. This meant they were able to socialise more easily with people outside their immediate family, and in a few cases even talk to large public audiences and the media about their SRG activities. Engaging with people in new and different ways had an impact on how the women engaged with figures of authority.

Connecting these findings to health and wellbeing, the external validation SRG members received through their engagement with the group, increased their sense of voice and ability to use it: an important precursor to agency and the ability to create change and pursue their own life choices (Hill O'Connor & Baker, 2017). The analysis identified how group members used the SRG activities to negotiate active citizenship, providing insight into how members could navigate the political economy of participating in the SRG. In liberal active citizenship terms, participation in the SRG allowed members to demonstrate (for example, to the Jobcentre – the UK government-funded employment service) that they were 'responsible' and readying themselves for work. Membership in the SRG also provided space for negotiated 'active citizenship' (Jansen et al., 2006), where the women were able to make strategic decisions about balancing streams of income with their roles as carers (Hill O'Connor, 2016).

Project 5: Focus 50+

The aim of Project 5, Focus 50+, was to understand the impact of social enterprise activities on the health and wellbeing of participants aged 50 and over, and how that impact was generated. Harnessing the European Union (EU) active aging policy definition that older age

begins at 50 years (Davies, 2014), Scottish social enterprise networks and support agencies helped us to recruit three partner organisations that all delivered activities at least once a week to supported older people in community spaces. The selection of organisations was based on the willingness of management/board to participate, their delivery of recurrent activities to study, and the availability and cognitive capacity of potential interviewees. Importantly, the study aimed to explore the health and wellbeing impacts of involvement in social enterprise activities on all older participants regardless of their role. Therefore, staff, clients, carers and volunteers were included in interviews. In total, 43 interviews were conducted using an open-ended topic guide developed by the research team following a review of existing measures of subjective wellbeing, quality of life and sense of coherence. Data was collected over one year and included social enterprise reports and observations.

Henderson et al. (2019) explain that all participants reported a greater sense of purpose. Staff and volunteers valued the opportunity to support other people, while clients emphasised the importance of the social enterprises providing 'somewhere to go' each week. By creating these opportunities, the social enterprises united people who otherwise would not have met and facilitated the formation of new social groups and connections. In this way, participating in the social enterprises directly benefitted their health and wellbeing, through a reduction in social isolation and an increase in social connectedness, both of which are known to be key determinants of health and wellbeing (Ottman et al., 2006).

The 'accessible informality' afforded by the social enterprise enabled participants to shift roles and adopt strategies to enhance their own self-perceptions of identity and capabilities, increasing self-worth and self-confidence. Traits of what could be described as 'downward social comparison' (Festinger, 1954) could be identified among the older people participating in the study. This has been identified as a protective function where older people distance themselves from others who are the same chronological age (Chopik et al., 2018), hence

reducing self-internalised ageism which could threaten their wellbeing (Weiss & Freund, 2012).

The ‘fluidity’ and flexibility of the social enterprise activities enabled multiple sub-activities to emerge simultaneously. For example, a language class that became an unintended support group for carers, and a Men’s Group that helped with bereavement. Since such groups are often difficult (and expensive) to target through traditional forms of ‘intervention’, the findings from this project suggest that social enterprises could play an important role in addressing health and wellbeing service provision challenges, particularly for older people (see Farmer et al. 2010).

Project 6: Aberdeen Foyer

Project 6 investigated the challenges that employees in social enterprises encounter when engaging in social impact management tasks. Social enterprises consistently report that providing evidence of their organisation’s performance to funders is complex and challenging to plan and implement. Creating organisational capacity to identify tools and train staff to collect and record impact data is often difficult for small, often overstretched organisations to manage. Given the *CommonHealth* programme’s interest in elucidating the pathways and mechanisms between social enterprise activities and health and wellbeing outcomes, insight into how social enterprises tackle the issue of ‘social impact management’ is significant. Social impact management can be defined as processes of measuring and monitoring the impact of social enterprises, such as for organisational and funder reporting. Understanding the impact measurement tools and processes that social enterprises use was also of interest and this aspect was investigated from the perspective of managers considering the strategic future of organisations, as well as staff and volunteers collecting and recording impact data.

A process that supported such organisations to identify robust outcomes and indicators was co-created with Aberdeen Foyer; a social enterprise based in Aberdeen in the northeast of Scotland

that supports people towards independent living. The outcomes and indicators were then used to build an 'impact management process'. This was then tested with six further social enterprises engaged in delivering projects and interventions related to health and wellbeing. Their focus included: housing, substance misuse, learning, employability, early intervention, and family support. Across these organisations a total of 40 interviews was conducted with client-facing service delivery staff, focusing on the impact management activities in which they directly engaged. A further 20 interviews were conducted with operational and strategic-level management. The interviews were recorded, transcribed and coded, then analysed thematically.

Fulford and Liddell (2018a, 2018b) found that social impact measurement activities needed to maintain both internal and external relevance, meaning that as well as satisfying the requirements of funders, the processes created should facilitate organisational learning. The ability of an organisation to undertake a systematic analysis of available social impact measurement resources and select the right tools for their requirements was crucial. Often, the researchers found, there was a temptation for social enterprises to use tools that seem current or fashionable, even if they were a poor fit for the organisation's requirements. Making sure that all staff felt comfortable with their role in measuring social impact and the tools and language they were expected to use was significant for successful social impact measurement. Finally, the researchers concluded that processes implemented should be meaningful within the daily workflow of staff; aligning closely with their working environment so that the process of social impact management does not become burdensome.

Project 7: Housing through Social Enterprise

The research conducted through Project 7, 'Housing through social enterprise' aimed to test the *CommonHealth* hypothesis that social enterprises may deliver health and wellbeing impacts, with a focus on the varied roles of social enterprise in parts of the housing sector. A longitudinal, mixed methods study was completed over three phases. The research followed a

cohort of new tenants from each organisation over the first year of their tenancy, interviewing them at the start of their tenancy, after 2-4 months, and after 9-12 months. At each of the interviews, tenants were asked questions relating to their health and wellbeing. This included measures of wellbeing and perceived impacts on wellbeing and quality of life from the property and the social enterprise housing service. The interviews covered a discussion relating to the property itself, how tenants were coping financially, and community and social supports they received.

Garnham and Rolfe (2019) found that many of the mechanisms linking housing to health and wellbeing operate through tenants' ability to establish a sense of 'home' in their new tenancy: recognising that housing is not just a physical shelter, but a foundation for social, psychological and cultural wellbeing. They found that tenants' health and wellbeing generally improved over the first year of their tenancy. A strong relationship with a named member of staff, who respected them and understood their particular needs, history and situation, was found to be important to tenants. Furthermore, a good quality property was one that was efficient and free from obvious physical defects, but also well decorated, comfortable and 'homely' with the condition on move-in day especially important. Although tenants had varying ideas about how much they wanted to improve or customise a property to their own tastes, their ability to influence this was dependent upon whether they had the capacity, permission or resources to do so. Financial challenges were particularly acute at the start of a new tenancy, with some tenants struggling to recover from this because of ongoing high or unexpected expenses, many of which were related to their properties or tenancies. While tenants valued a sense of safety, friendliness and amenities, and having social support networks in their local area, their neighbourhood priorities depended on their personal circumstances, characteristics and prior experience. Ultimately, having a choice of where they would live was the most important issue for tenants.

Tenants of the 'hybrid' housing organisation (Rolfe et al., 2019) organised as a social enterprise showed relatively greater health and wellbeing improvements and satisfaction with their letting agency compared to the Housing Association and private landlord tenants. Considering the implications of these findings, therefore, social enterprises may have a significant role to play in relieving pressure on social housing and providing better outcomes for vulnerable tenants compared with the mainstream, for-profit sector. Moreover, the data suggested that it was precisely the blurring of the conventionally established boundaries between the social housing and private rental sector that led to improved tenant wellbeing and satisfaction since they were able to bring different principles (or 'logics' – see (Pache & Santos, 2013) to bear: rather than simply focusing on extracting maximum profit, their activities were guided by the principle that "vulnerable people get access to quality housing and are treated well" (Rolfe et al 2019: 9).

Discussion

The groundwork for synthesising findings across the various *CommonHealth* projects began during the final two years of the research programme. Through 'Project 8' researchers ran a series of events that were designed to generate discussion between the project teams on their emerging findings, as well as with policymakers and sector representatives. Further synthesis has taken place since the teams started to publish their individual project findings and formal synthesis will continue for some time yet. As described above, the research conducted by various projects was generally exploratory and mostly utilised qualitative methods, albeit with tailored approaches per project. Although often beginning from different methodological foundations, the projects have permitted development of rich descriptions based on lived accounts of people involved in and with social enterprises, whether as board members, staff, volunteers, or beneficiaries. The projects (generally speaking) did not seek to measure outcomes or impacts on large participant samples but sought to reveal the *plausible*

mechanisms by which impacts on health and well-being were achieved, which can then serve as the basis for identifying some overarching findings about pathways between social enterprise, health and wellbeing. Although articulated in slightly different terms in each project, taken together the qualitative findings point to a common set of intermediate determinants of longer-term health outcomes in relation to: social inclusion; social capital; connectedness and sense of belonging; empowerment and control; confidence and self-worth; and sense of meaning or purpose in life. Figure 1 brings together some of the high-level insights from the qualitative studies on the impact of social enterprises on health and wellbeing across different geographical and demographic contexts. While the diagram shows how 'sense of purpose' can be described as a shared impact, this is just one example provided for the purposes of this chapter, and further synthesis will begin to illuminate further shared outcomes in future publications.

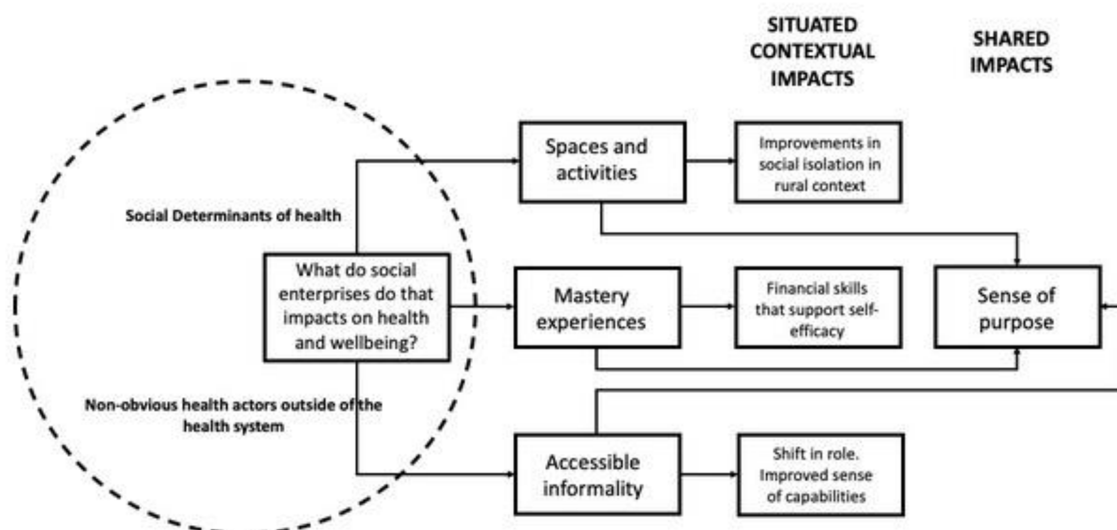

Figure 1: Pathways to Impact - 'Sense of purpose' example

The diagram illustrates several of the experiences provided by social enterprises discussed, which we have identified as 'spaces and activities' (particularly project 3), 'mastery

experiences' (project 4), and 'accessible informality' (project 5). The diagram also illustrates the observation that, whilst 'sense of purpose' or 'sense of worth' are very strong themes running throughout the separate analyses, across geographical context and different groups of beneficiaries, that other (intermediate) impacts are contextually dependent. This combination of context and shared impacts is key, not only for drawing lessons from *CommonHealth*, but also going forward, so addressing dual requirements for evidence of individual (often-small) social enterprises as well as of the sector as a whole.

Historically, social enterprise in Scotland developed from a community base, with a patchwork of support from local authorities, government bodies, national regeneration funds, and, more recently, a tailored policy framework for social enterprise which has culminated in a ten-year (2016-2026) social enterprise strategy co-produced between government and the sector. The most striking change over the longer term is how the professional dialogues that inform social enterprise and public health have gravitated towards each other over several decades; from the Ottawa Charter (WHO, 1986) and full recognition of the importance of the social determinants of health (Commission on Social Determinants of Health, 2008), to the more recent and emergent discourse around the 'wellbeing economy' (Coscieme et al., 2019; Costanza et al., 2018). There are structural forces at play that have undoubtedly informed the parameters of this convergence, particularly since the Great Financial Crisis of 2008, which precipitated a decade of austerity policies, the profound effects of which on health and wellbeing are just starting to be understood (Marmot, 2020). Gains, to this point, in life expectancy have stalled, or even fallen in places, for the first time in a century (Boseley, 2020). The immediate after-effects of the COVID-19 pandemic of 2020 in both health and economic terms have also barely begun to be understood. Project 1 revealed how a focus on how neoliberal policies has shifted health and welfare provision from a systems perspective, neglecting to reconfigure understandings of health actors from a community perspective. This alternative narrative

around the ‘service innovation’ (Farmer et al., 2018; Osborne & Brown, 2011) that social enterprises provide in the spaces they create, which has been far more difficult to articulate and make heard, has been taken up by projects 2-7 exploring the ability of social enterprises to address a wide variety of needs.

Project 2 identified the diverse and complex relationship between social enterprise processes and intermediate health outcomes. The relationship between these processes and outcomes was examined in closer contextual detail in projects 3-5. What appear to be consistently important across the insights from these projects are the positive impacts that arise from the interaction between people, space and activities that community-based social enterprises provide. Effectively this means that social enterprises provide space for a ‘dialogic’ experience (Bakhtin, 1982) supporting opportunities for personal and collective growth and transformation, since “every human being likes to resist, confront and make personal meaning out of social interactions” (Nesari, 2015, p. 643). This resonates with the idea of social enterprise as an ‘alternative’ economic space, and an opportunity to “reject the values and identities associated with the mainstream, instead choosing to operate differently and being concerned with different values” (McHugh et al., 2019, p. 81).

The project has also informed the impacts of social enterprises on intermediate outcomes that support longer-term health outcomes. Projects 3-5 found situated contextual impacts that were specific to the geographical and social context of their operation. For example, project 3 found that rural transport initiatives were vital to addressing the social isolation and loneliness experienced in rural communities; project 4 demonstrated the impact that the financial skills gained by women in urban SRGs to their feelings of self-efficacy; and project 5 found that older people participating in social enterprise activities made downward social comparisons which provide a protective function to their wellbeing. Thus, in all three of these examples, community-based social enterprises provided activities that fulfilled the needs of people in their

local areas and acted upon factors that can be connected to the social determinants of health. These findings are comparable to previous research which has depended on case studies to explore the impact of social enterprise in health and wellbeing. Indeed, the social enterprise research field, particularly in its early phase, was dominated by case studies generally. Where the *CommonHealth* research takes us further, though, is in the analysis of the shared impacts of community-based social enterprises, which appear to be consistent across contexts.

While projects 3-5 all identified and discussed the plausible mechanisms they observed differently – spaces and activities; mastery experiences; assessable informality – they all supported an increased 'sense of purpose' for those participating in the social enterprises studied. This suggests an element of consistency in the nature of social enterprise spaces in relation to people and activities that permits shared health and wellbeing outcomes (such as sense of purpose) to emerge. The comparative evaluation work completed in project 7 identified 'hybridity' (Doherty et al., 2014) as the potential element that amplified the health and wellbeing impacts of social enterprise housing associations in relation to both state and private sector housing providers. This insight provides a steer on directions for future research. The ability to identify some consistent findings is of crucial value to the social enterprise sector. Practitioners can describe in detail the complex impact that engaging with their organisation has on individuals and even their families, but the ability to begin to identify and articulate this impact beyond individual organisations and their clients is crucial to building knowledge on the connections between social enterprise, health and wellbeing.

Relating this back to the voice of social enterprises, Project 2 looked at how social enterprises understood their impact, and to what extent they expressed this in terms of health and wellbeing. This was examined in greater depth in project 6, which found that although social enterprises have a great deal of experienced-based knowledge about their activities and impacts, they can struggle to identify and make use of tools that allow them to express this

impact for impact-reporting activities. Connecting with the sector's perspective on evaluating their impact was (and will remain) essential in the endeavour of shifting the collective knowledge of the sector from the 'non-obvious' to evidenced and knowable. It is crucial not to overlook the importance of partnership working between the sector and academia, such as we saw during *CommonHealth*, as a means of attracting resources to start to grapple with such issues. Comparing these experiences with the findings of project 6, our research suggests that social enterprises themselves have an important role in articulating their health impacts and should be supported to strengthen their voices in this area. Moreover, reflecting on the findings of project 7, it is suggested that future investigations should consider the nature and dimensions of 'hybridity' of social enterprise (that is, their ability to draw on the logics of the state, market *and* civil society/community – see (Billis, 2010; Brandsen et al., 2005), and in what ways the nature of such hybridity supports the wellbeing impacts of community-based social enterprises.

Conclusion

There are several implications of the *CommonHealth* programme of research for understanding the impacts that social enterprises have in relation to health and wellbeing. This was (and still remains, in many ways) a previously understudied dimension of the contribution of civil society to individual and community health and wellbeing. The *CommonHealth* research projects have together illuminated and connected what social enterprises do to contribute to a variety of intermediate health outcomes that supports improved health and wellbeing by acting on the social determinants of health: social inclusion, social capital, connectedness and sense of belonging; empowerment and control; confidence and self-worth; and sense of meaning or purpose in life.

In relation to evaluation and measurement, in future research it is imperative that approaches to researching social enterprise, health and wellbeing do not 'flatten out' social enterprise into

a series of stable component elements and outcomes, but should look to employ methods that are able to capture the fluidity and plurality of social enterprise spaces and experiences. Although, as we have stated, the social enterprise experience is highly contingent and contextually specific – involving different places, spaces, beneficiary or target groups, and so on – this does not mean that some degree of consistency of outcome cannot be achieved. The level of consistency in the *nature* of the spaces in relation to people and activities and the interactions between them permits relatively common health and wellbeing outcomes to emerge.

The *CommonHealth* research has provided insights into health and wellbeing outcomes that map onto current understandings of the social determinants of health and has also supported the creation and development of new knowledge on the nature of social dynamics that support them across different community organisations and settings. There is a necessity to account for both context as well as commonality in order to evidence and articulate the potential pervasiveness of social enterprise as a driver of wellbeing.

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