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An organisational approach to understanding how social enterprises address health inequities: A scoping review

Researchers are turning greater attention to the role of social enterprise in addressing health inequities. However, few studies explicate the organisational features through which social enterprise may improve health equities. This article reports on a scoping study (Arksey and O’Malley 2005) that finds researchers are focusing on understanding the perspectives of target beneficiaries, thus examining the ‘transactional’ organisational features that are most apparent in daily life—including interpersonal relationships and the allocation of tasks. The role of ‘transformational’ features—including organisational strategy and leadership—remain relatively unexamined. Given that the transactional and transformational features of organisations are intertwined, future research should develop holistic analyses of organisations that show how social enterprises improve health equities and health equity outcomes.

Keywords: social enterprise, health equity, wellbeing, organisational features, scoping review

Introduction

Health inequities—or systematic differences in health outcomes associated with geographic and demographic factors—are a global social problem with significant social and economic consequences (World Health Organisation 2013). In efforts to address health inequities, governments are giving increasing attention to the role of social enterprise in supporting marginalised social groups to access social determinants of health such as housing, employment, income, social networks and to reduce stigma (Farmer et al 2016; Macaulay et al 2018; Roy et al 2013). The European Union launched its Social Business Initiative in 2011 with the aim of creating an action plan that supports the development of social enterprises and key stakeholders in the social economy. The Scottish Government is widely recognised as making the strongest commitment to developing its social enterprise sector, with the launch of its 10-year
Social Enterprise Strategy in 2016. The UK government has led the way with social finance policy interventions, largely by establishing the independent Big Society Capital investment fund in 2012 and through the work of its former Office of the Third Sector. Australian governments have not been far behind, with the launch of a nation-wide Social Enterprise Development and Investment Fund in 2011, and by recently launching a Social Enterprise Strategy (2017) and Social Procurement Framework (2018) in the state of Victoria. While social enterprises are attracting investment from governments, scholars warn that there is still inconclusive evidence of whether and how social enterprises produce positive social impacts, including whether and how they alleviate health inequities (Agafonow 2018; Calo et al 2018; Garnett et al 2018; Roy et al 2018).

While emerging evidence is starting to ‘lend weight’ to some of the positive social impacts of social enterprise, scholars argue that we need to better understand the causal mechanisms through which social enterprises create these impacts (Agafonow 2018; Roy et al 2017). It is through hybrid business models that are characterised by the innovative design and arrangement of organisational features that social enterprises aim to facilitate, for example, a more inclusive workforce, community participation, improved service design and accessibility, or redistribution of wealth (Mason et al 2015; Roy et al 2017). Improved understandings of how social enterprises address health inequities will help determine how to allocate resources. This is particularly relevant in contexts where governments are seeking to achieve policy goals by leveraging the local knowledge, resources and reach of community and market actors (Daughbjerg and Fawcett 2017; Defourny and Nyssens 2010; Klijn 2008; Roy et al 2015; Teasdale 2012).

This article makes two key contributions to the conversation about how organisational features enable social enterprises to create positive social impacts, with
flow-on effects on health equities. First, the article offers new theoretical insight via a process model that theorises the causal links between organisational features of social enterprise, health inequities and health equity outcomes. Second, the article draws on this process model to present findings from a scoping study (Arksey and O’Malley 2005; Levac et al 2010) that reviewed existing evidence of the causal links between organisational features and shifts in health equity. This informs the article’s conclusions about areas for future research.

Because this field of research is international, interdisciplinary and growing, it is susceptible to fragmentation and potentially divergent conclusions. Literature reviews can progress the field by drawing links between separate threads of conversation and by identifying the research questions that will make the evidence base more comprehensive. Our analysis shows that scholars who research the causal links between organisational features of social enterprises and health equities tend to focus on the views, experiences and meaning-making of target beneficiaries, and so examine organisational features that are most apparent in day-to-day life—including interpersonal relationships within the work unit team or the allocation of tasks relative to individuals’ skills. The effects of higher-level organisational features of social enterprise such as organisational strategy, culture and leadership remain relatively unexamined. The significance of systems of power that structure operating contexts and give meaning to social enterprise activities also remains relatively unexamined. Given that different levels of organisational features are necessarily intertwined, future research should develop more holistic analyses of organisational features to support deeper understandings of how social enterprises are associated with health equity outcomes.
Improving health equities: a role for social enterprises

Health inequities are differences in the health interventions and outcomes for social, demographic, economic or geographic groups that come about because of unfair social systems and structures (Solar and Irwin 2010; World Health Organisation 2013). Social systems and structures are institutionalised through values and policies in socio-economic and political contexts, and permeate daily living conditions through factors such as one’s income, level of education or training, occupation, housing situation and type and reach of social networks (Bambra et al 2010; Marmot et al 2008; Raphael 2011; Solar and Irwin 2010). In the context of health equities research, these socio-economic factors are often referred to as social determinants of health (SDOH).

This article draws on a conceptualization of SDOH that Solar and Irwin (2010) developed to support the World Health Organisation to formulate policies that would promote health equities. Informed by social epidemiology, Solar and Irwin (2010) call for interventions that aim to improve health equities to change the distribution of power within societies, both at the level of individual households or workplaces and the structural conditions at the macro level of economic, social and political institutions. While Solar and Irwin focus on the responsibility of states in catalysing systemic change, governments and researchers are increasingly considering the role and capacity of other actors—including social enterprise—in altering or remediating the unfair social systems and structures that affect the SDOH (Mason and Barraket 2017; Roy et al 2013; Roy et al 2015; Teasdale 2010, 2012).

Research into the impacts of social enterprise on health inequities is building (Roy et al 2014, 2017). Whereas studies initially focused on illustrating the outcomes of social enterprise, researchers are increasingly curious about how social enterprises are designed and resourced to produce these outcomes (Agafonow 2018; Roy et al 2018). The effects of ‘causal chains’ that are built into the design of social enterprises should
be understood relative to the formal and informal institutions that structure operating contexts, and cause social, demographic, economic or geographic groups to have unequal access to health interventions and outcomes (Calo et al 2018). This allows for analysis of unintended consequences of organisational factors.

**Theorising the organisational features that affect health equities**

Informed by an established model of organisational performance (Burke and Litwin 1992; Burke 2017), this article distinguishes between two levels of organisational features: transformational and transactional. Transformational organisational features such as leadership, mission, strategy and organisational culture guide whole-of-organisation responses to social issues that structure operating contexts (whether on a local, national or global scale). Transactional organisational features, by comparison, are the organisation’s relational, structural and policy mechanisms that shape day-to-day interaction among people within and between organisations’ teams. As illustrated in Figure 1, this conceptual distinction is fruitful when examining *how* social enterprises impact health inequities. It facilitates a separate analysis of the organisational features that engage with the economic, social and political institutions that create health inequities, compared with the organisational features that can alleviate the outcomes of health inequity that internal staff and stakeholders may experience in the shorter-term. In line with Krieger (2008), the article accepts that transformational and transactional organisational features co-exist, and that change (whether at the macro institutional or micro individual levels) occurs through the interplay between these levels of organisational features.

*[insert Figure 1 here]*
Studies of social entrepreneurship illustrate the significant influence that leaders of social enterprises have on the missions and strategies that determine how social enterprises aim to address social and health inequities. Zahra et al (2009) distinguish between leaders who focus on resolving local issues via innovative use of existing resources (social bricoleurs), leaders who focus on developing scalable solutions that can be applied to various situations (social constructionists) and leaders who focus on challenging the social structures that underpin large-scale social issues (social engineers; see also Wulleman and Hudon 2016). The ambitions of social entrepreneurs can affect whether they create social enterprises to pursue missions that aim to improve society by ‘compensating’ shortfalls, or missions that are orientated towards radically disrupting and transforming the system (Newey 2018). Roy and Hackett (2017) argue that the latter are rare because social and economic structures steer social enterprise sectors to align with the philosophical direction that underpins the narrative of social policy.

Alongside the vision and ambition of social entrepreneurs, their access to resources in operating contexts also affects the strategies through which social enterprises create change. In particular, research shows that the social capital of entrepreneurs and their approach to stakeholder inclusion and deliberation affects how social enterprises engage in social innovation (Lubberink et al 2018) and in some contexts, what progress leaders can make towards creating the desired social impact (Khare and Joshi 2018). Different types of partner organisations, for example, tend to offer different types of support and resources. Researching social enterprises in Korea, Choi (2015) finds that while all types of partner organisations can provide financial support, social enterprises are more likely to receive support around marketing from partner organisations in the social or public sectors. Marketing can be an effective
strategy through which social enterprises employ language to challenge social norms—whether through problematising, empowering, marketising, mobilising resources or publicising issues (Chandra 2017).

Transformational organisational features co-exist with the transactional features that aim to shape day-to-day interaction among people within and between organisations’ teams (Burke 2017). The relational, structural and policy mechanisms of individual social enterprises are determined in part, by how the social enterprise balances the tension between commercial and social goals. For Gidron (2017), this tension informs recruitment or selection of target beneficiaries, remuneration and human resources policies, the expectations that are placed on participants (regarding performance versus improvement on social indicators), and how results are measured. Specifically, human resources policies will affect the extent to which a social enterprise uses alternative recruitment channels, on-the-job training, and intrinsic rather than extrinsic rewards (Napathorn 2018), with implications for how staff participate in the social enterprise; and their sense of motivation, commitment and belonging.

Research of social entrepreneurship and social enterprise thus illustrates the types and combinations of organisational features through which social enterprises innovate; enabling or limiting progress towards commercial and social goals. Rarely, however, do these studies examine how interlinked organisational features affect the general social impacts of social enterprises, and health equity and health equity outcomes in particular. This is the focus of the scoping review that follows.

Method

This article presents a scoping study of empirical research that focuses on the intersection between social enterprise, SDOH (as indicators of health equities) and health equity outcomes. Distinct from systematic review methodologies such as
PRISMA and Cochrane that examine narrower research questions that are addressed by studies that use similar research methods, scoping studies aim to map the key concepts and evidence underpinning a broad research area (Arksey and O’Malley 2005; Levac et al 2010). In a recent systematic review that examines what evidence exists for social enterprises providing improved outcomes relative to usual care in health and social care systems, Calo et al (2018) found that ‘no two papers explored the same research questions… studies utilized different methodological approaches… [and that studies] examined evidence across very different social and health care systems situated within very different public policy contexts… at different points in time.’ (2018: 1803). They acknowledge that this limited the efficacy of the systematic review, which is an approach best suited to reviewing the effects of relatively homogenous forms of public policy interventions with clearly defined outcome measurements. Given that the research topic of this article is informed by numerous disciplinary orientations (including public policy, social science, public health and organisation studies) with different research questions and methods, the scoping study was deemed the most appropriate approach for examining the extent, range and nature of research activity (Arksey and O’Malley 2005).

This scoping study followed the five steps proposed by Arksey and O’Malley (2005): (1) identify the research question; (2) identify relevant studies; (3) select studies; (4) chart the data; and (5) collate, summarise and report the results.

To devise a search strategy that would encompass broad research fields, the scoping study adopted the following research question: What does contemporary scholarly literature tell us about how organisational features affect the impacts of social enterprise on health equities and health equity outcomes?
To identify relevant studies, the scoping study searched databases, reviewed reference lists of key articles and reviewed publication lists of key authors. Books, book chapters, dissertations and proceedings were excluded because of difficulty in ascertaining the quality of peer review. Academic databases were first searched for peer-reviewed articles that made reference to the following three concepts in the title or abstract: social enterprise, SDOH and health equity outcomes. Table 1 lists the search terms that operationalised each concept. To ensure validity of results, these search terms were collated by a multidisciplinary research team with expertise in public health and social enterprise to best reflect the key terms that are used in the relevant areas of research. Although the concept of ‘organisational features’ is central to the research question, it was omitted from the list of key concepts to capture studies that look at the impact of social enterprise on health equity and health equity outcomes, without explicitly attributing this impact to organisational features.

[insert Table 1 here]

The following seven databases were searched: Discovery; EBSCOHost; Expanded Academic ASAP; ProQuest Central; Scopus; Science Direct; and Web of Science. Only peer-reviewed articles that were published in English between January 2000 and June 2018 were selected. This yielded 443 hits for consideration. Adopting an iterative approach, the scoping study then reviewed the reference lists of articles and publication lists of key authors to identify any relevant texts that had not yet been captured by the initial search of databases. This yielded an additional 49 articles for consideration.

To support reliability, two researchers assessed the titles and abstracts of the initial database search results to select articles that presented original empirical
research, were written in English and examined the intersection of social enterprise, SDOH and health equity outcomes. Articles progressed to full-text review if both researchers independently assessed them as ‘somewhat’ or ‘definitely’ relevant. If both researchers assessed an article as ‘not at all’ relevant, it was excluded from the scoping study. Mindful of reliability, a third researcher adjudicated opposing assessments by independently reviewing the title and abstract of articles in question.

Based on a review of titles and abstracts, 63 articles were assessed as somewhat or definitely relevant to the research question. These articles were reviewed in full to verify that they presented original empirical research, were in English, and examined the intersection of social enterprise, SDOH and health equity outcomes. Through this process of verification, 38 articles were assessed to be ‘definitely’ relevant to understanding the intersection between social enterprise, health equities and health equity outcomes. The process of selecting studies is summarised in Figure 2.

The full text review found that only 10 articles critically examine the causal links between organisational features, health inequities and health equity outcomes, with remaining studies describing organisational features, but not framing them as causal mechanisms. The scoping study drew on two analytic tools to collate and synthesise the evidence provided in the 10 articles. First, the CIMO framework (Context, Intervention type, Mechanisms, Outcomes; Denyer et al 2008), which is used in organisation and management research to formulate practice-derived evidence through the logic: ‘in this class of problematic Contexts, use this Intervention type to deliver these Outcomes, through these generative Mechanisms’. While the CIMO
framework serves to collate the findings of the 10 articles (see Table 2), the article draws on the SPIDER framework (Cooke et al 2012) to position the findings within their research contexts (see Table 3). The SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) framework maps the primary dimensions of research designs that involve qualitative or mixed research methods. Two researchers independently analysed the 10 articles according to the CIMO and SPIDER nodes, and then collaboratively identified patterns in the emerging themes.

This article now charts the research field by examining the distribution of the 38 studies over time, journal of publication and the extent to which scholars examine organisational features as the causal mechanisms through which social enterprises impact on SDOH and health equity outcomes. The article then synthesises and discusses the findings of the 10 articles that examine how particular organisational features enable social enterprises to work on health equity and health equity outcomes.

Results

*Charting the studies*

The scoping study identified 38 peer-reviewed scholarly articles that were published between January 2000 and June 2018 on the topic of social enterprise impacts on SDOH (including employment, income and social networks) and flow-on health equity outcomes (such as wellbeing and quality of life). Suggesting growing interest, almost two thirds of articles (63%) were published in the last six years (2012-2018), compared to only a quarter (26%) and one in ten (11%) published in the six-year periods prior to that (i.e. 2006-2011 and 2000-2005, respectively). While research interest may be growing, a community of scholars engaged in sharing questions and insights has not yet emerged, with the 38 articles having been published in 34 scholarly
journals. Fragmentation may be in part due to multi-disciplinarity—with concepts of social enterprise, SDOH and health equity outcomes speaking to organisational, social policy and health research agendas.

The full text review showed that only 10 of these 38 articles examine organisational features as factors that impact organisational performance on health equity through SDOH. By comparison, 25 articles (66%) summarise organisational features only when providing context for the study, and 3 articles (8%) offer no substantial description of organisational features. Therefore, while the 38 articles generally examine the impacts of social enterprise on health equity (in line with Roy et al 2014), the field of research provides limited insight into how organisational features create these impacts in different social and political contexts.

**Collating and summarising existing evidence**

To synthesise current evidence about how social enterprises affect issues of health equity, the article now turns to the nine studies (reported on in 10 articles) that examine organisational features as mechanisms through which social enterprise work on health inequities to improve outcomes such as wellbeing and improved quality of life. The research contexts of the nine studies reflect the profile of the broader group of 38 articles described above. Seven of the nine studies were published in the last six years, with the remaining two published between 2006-2011. All the articles were published in different journals. Eight of the nine studies were carried out by health or social and political scientists. Eight of the nine studies also have a qualitative component—with five studies drawing on qualitative methods exclusively and three studies employing mixed methods.

Aligning with findings from the systematic review conducted by Roy et al (2014), all nine studies find social enterprise interventions to have positive outcomes for
at least one SDOH (e.g. education, income, housing or social networks) and the related health factors of wellbeing or quality of life. Target beneficiaries describe the lived experience of these health equity outcomes as a sense of competence (Lanctôt et al 2012), strengthened confidence, hope and purpose (Svanberg et al 2010), viewing oneself as experienced and capable with a desire to participate in meaningful occupation (Williams et al 2010), reduced anxiety, alongside greater confidence and self-efficacy (Chan 2015), confidence, optimism, control, independence and pride (Bertram and McDonald 2015), or the power to make decisions (Macaulay 2018). These health equity outcomes can be categorised in terms of individuals’ sense of self-worth, sense of the future, sense of capacity, sense of self-determination and general sense of wellbeing. Figure 3, shows these outcomes to be created primarily by transactional organisational features (including relational, structural and policy mechanisms).

[insert Figure 3 here]

**Transactional relational mechanisms**

Six of the nine studies discuss team morale as the organisational feature that has the strongest influence on improved health equity outcomes. Team morale is a relational experience that is created through team members’ perceptions and feelings towards one another. Accordingly, Bertram and McDonald (2015) find that in their case study, the trusting, empathetic and respectful relationships among employees and warm, friendly, safe and comfortable physical spaces enabled social enterprise to improve personal and community wellbeing. Similarly, Chan (2015) attributes improved wellbeing to interpersonal relationships that nurture and include, Lanctôt et al (2012) to interpersonal relationships that are based on harmony, mutual respect and good communication,

The seventh study that examined a social enterprise in a liberal welfare state (Fergusson 2012, 2017) hypothesized that the peer and team-oriented context of a social enterprise intervention would bring about improved health and wellbeing outcomes. Ferguson found that, while the social enterprise intervention improved the wellbeing of target beneficiaries, the outcomes did not fare significantly better than an Individual Placement and Support approach. The specific type of intervention, Ferguson concludes, may not be as important as integrating employment programs with clinical and case-management services, frequent contact with peers and ongoing support. This prompts questions about how relational and policy features of social enterprises should intersect, to improve health equity outcomes.

**Transactional structural mechanisms**

The studies find that the structure of social enterprise and the tasks individuals are allocated affect health equity and health equity outcomes in two ways: by affecting the extent to which individuals can choose their own ‘recovery path’ (particularly in regards to mental health), and by affecting the extent to which individuals can influence local decision-making.

Chan (2015), Svanberg et al (2010) and Williams et al (2010), who examine WISE in Canada, Scotland and Australia respectively, find that flexibility in the allocation of roles and tasks tends to alleviate stress, and enhance one’s sense of control, security, self-efficacy and motivation. In this context, target beneficiaries have an
overarching routine coupled with choice in types of tasks, number of work hours, schedule, workload, and flexibility around when to receive therapeutic support. In their case study, flexibility around task allocation enabled beneficiaries to feel that their treatment or recovery path was not prescribed and standardised, but rather, that the social enterprise accepted that recovery did not occur via a linear or standard path. These outcomes stem from how transactions are structured between individuals within the organisations.

By comparison, studies that examine cooperative social enterprises bring into view the transformative organisational features that may help address issues of health inequities in broader social structures. Galloway (2016) and Maguirre et al (2016) examined community enterprises focused on conservation and economic development in developing contexts. Both Galloway (2016) and Maguirre et al (2016) focused on the involvement of women in decision-making and found that this not only contributed to the empowerment of women as individuals, but also placed greater value on knowledge that is traditionally owned and used by women. They found that this contributed to shifts in cultural norms that support more equitable gender roles. Comparing three types of social enterprise in Scotland, Macaulay et al (2018) find that cooperatives in liberal welfare states can improve health equity by placing community members in decision-making roles. For Macaulay et al (2018), the cooperative organisational structure enabled target beneficiaries to experience a sense of ownership and control.

**Transactional policy mechanisms**

The nine studies give relatively little attention to how policies within social enterprises affect transactions between individuals, with implications for health equity outcomes. Macaulay et al (2018), Lanctôt et al (2012) and Williams et al (2010) loosely consider organisational policies by examining the role of remuneration in improving health
equity outcomes. In these studies, target beneficiaries did not consider income to be as significant as the interpersonal or relational dimensions of social enterprise (i.e. the work unit climate). For example, examining WISE in Canada that engage people living with disability who are unable to work under standard conditions, Lanctôt et al (2012) find that while target beneficiaries are engaged in mundane tasks the WISE improved wellbeing partly by providing a good salary but mainly by treating employees with respect in the work environment. However, Macaulay et al (2018) note that in the social enterprises they examined, informants tended to prioritise interpersonal relationships only when they perceived their income as secure. Informants who had insecure employment were more likely to emphasise the importance of income to their sense of wellbeing. This finding again prompts questions about how different types of organisational features (e.g. relational and policy features) need to intersect to improve health equity outcomes.

*Transformational organisational features*

Finally, the nine studies give little attention to transformational organisational features (including organisational culture, leadership, and mission and strategy) that challenge or reproduce the formal and informal institutions that structure operating contexts. Lanctôt et al (2012) briefly note that ‘professionalism’ in the organisational culture can help reduce the effects of stigma that come about when social norms are not accepting of people with disability who are unable to work under standard conditions. As noted above, both Galloway (2016) and Maguirre et al (2016) found that involving women in leadership positions enabled social enterprises to challenge cultural norms in developing countries around inequitable gender roles. While existing studies have linked the missions and business models of social enterprises with improved opportunities for accessing social determinants of health such as education, housing, employment,
income and social networks (Roy et al 2017), this part of the causal chain needs greater clarity via further investigation.

[insert Table 2 here]

When synthesising these findings, it is significant that research samples in seven of the nine studies are either target beneficiaries exclusively (Bertram and McDonald 2015; Ferguson 2012, 2018; Lanctôt et al 2012; Williams et al 2010) or target beneficiaries primarily, with supplementary insights provided by project leaders or representatives from other stakeholders (Galloway et al 2016; Maguirre et al 2016; Svanberg et al 2010). In line with the research objectives, these samples enable the studies to investigate the views, perspectives, meaning-making and experiences of target beneficiaries (see Table 3). While target beneficiaries are best placed to describe their own lived experience of health equity outcomes, they provide insight into only some of the causal chains within social enterprise that impact health equity and health equity outcomes.

Discussion and conclusion
This scoping study shows that few articles aim to develop organisational and systemic approaches that comprehensively investigate how social enterprise affect health equity and health equity outcomes. For Agafonow (2018), making sense of the complex causal mechanisms that give rise to the visible ‘symptoms’ of social enterprise activities will help elucidate the uniqueness of the effects of social enterprise. Roy et al (2018) argue that evidence of the effects of social enterprise is building, however evidence of the uniqueness of these effects is still inconclusive. Understanding the mechanisms and causal chains that are embedded within social enterprise can support practitioners and
policy makers to be more strategic and deliberate when deciding how to design and resource these diverse hybrid organisations for desired individual and social outcomes. This holds implications for the effectiveness of social enterprise and the efficient use of public resources, particularly in policy contexts where governments are increasing investment in the social enterprise sector.

This article makes two substantive contributions to this growing area of research. First, the article offers new theoretical insight by drawing a conceptual distinction between transformational and transactional organisational features. Transformational organisational features are best positioned to challenge the economic, social and political institutions that create health inequities, while transactional organisational features that are better suited to alleviating the outcomes of health inequity that internal staff and stakeholders may experience in the shorter-term. The article makes its second contribution by charting existing evidence against the theoretical model. This scoping study shows that although there is growing interest in this field of research, most studies do not critically examine the effects of organisational features. Of those that do, most focus on the link between transactional organisational features and alleviating the outcomes of health inequity. This places some limitations on the trajectory of the field of research, as discussed here.

First, the nine studies that critically examine how organisational features affect issues of health inequity focus on segments of organisations’ causal chains that are most apparent from the perspectives of target beneficiaries—transactional, relational mechanisms. The premise of ‘causal chains’ however, is that these organisational mechanisms are created and reinforced by other mechanisms of the organisation—including structural and policy mechanisms. Future research should give greater attention to the effects of organisations’ structures and policies on the primarily
relational organisational features that have clearer, more experiential impacts on individual wellbeing (from the perspectives of target beneficiaries).

For example, current research loosely considers the effect of organisations’ remuneration policies on the wellbeing of target beneficiaries (Macaulay et al 2018; Lanctôt et al 2012; Williams et al 2010). Organisations’ policies and procedures would also prescribe the terms of involvement in the organisation (e.g. employment) and the social support or other benefits that social enterprises offer to target beneficiaries. Existing research also considers the effect of organisational structure on the wellbeing of target beneficiaries through, for example, what tasks are allocated to individuals and how (Chan 2015; Svanberg et al 2010; Williams et al 2010). By determining what activities individuals are involved in, and with whom, the structure of social enterprise may also affect the social networks or the skills and experiences that beneficiaries develop.

As is widely discussed in the literature on social entrepreneurship, many of the transactional mechanisms of social enterprises tend to be shaped by how transformational mechanisms (including leadership and mission) balance the tension between commercial and social goals (Gidron 2017). A similar logic underpins the concept of health equity. The quality of life and wellbeing that shape the day-to-day lives of individuals are affected by the mutually reinforcing socio-economic structures that create inequitable access to income, housing, training and social networks (Bambra et al 2010; Marmot et al 2008; Raphael 2011; Solar and Irwin 2010). It is therefore important to examine how transformational organisational features of leadership, organisational culture, mission and strategy affect the design of structural and policy mechanisms.
To uncover the layers of causal mechanisms that affect whether and how social enterprises alleviate health inequities to deliver improved health equity outcomes, future research should examine a broader range of sources, including organisational documents and the perspectives of multiple stakeholders. This approach will help bring into view the structures and policies through which social enterprises organize to affect income, education and training, housing, social networks and other social determinants of health. While some studies have moved in this direction (e.g. Chan 2015; Macaulay et al 2018; Maguirre et al 2016; Roy et al 2017), there is still a stronger focus on the perspectives and experiences of target beneficiaries.

Second, despite significant research in the social enterprise and social entrepreneurship literature into the diversity of social missions and business models of social enterprise (e.g. Barraket et al 2017; Defourny and Nyssens 2016; Kerlin 2013) this scoping study shows that empirical research at the intersection of social enterprise and health equity tends to focus on WISE that are operating in liberal welfare states. Rather than aiming to radically disrupt and transform the system, these social enterprises are poised to align with the philosophical direction that underpins the narrative of social policy, aiming to improve society by ‘compensating’ shortfalls in structural conditions (Newey 2018; Roy and Hackett 2017).

If the research field continues to focus on certain types of social enterprise in certain social and political contexts, it risks ignoring the causal chains that enable other types of social enterprise to address health inequities in novel ways. This limitation has previously been noted by Macaulay et al, who find that researchers ‘tend to reduce and simplify a complex and heterogeneous set of organisations to a relatively homogenous social enterprise concept’ (2018: 11). Both Roy et al (2017) and Macaulay et al (2018) have recently sought to address this via comparative analysis of the public health roles
of various types of social enterprise. However, articles that report on a greater diversity of qualitative case studies, are not able to provide the same depth of insight into the causal chains at play. To broaden our understanding without compromising depth of insight, it is important for the field as a whole to examine a greater diversity of social enterprises.

Finally, the scoping study shows that contemporary empirical research rarely adopts a critical approach to understand the meaning and distinct roles of transformational organisational features relative to the formal and informal institutions that create health inequities in operating contexts. For example, all nine studies in this scoping review examine, to some extent, social enterprises that aim to affect employment for particular demographic groups. However, scholars that examine social enterprises in liberal welfare states tend to focus on employment through ‘work integration’, whereas scholars that examine social enterprise in developing countries focus on employment through ‘conservation and economic development’. Further, only the latter draw on a gender lens to understand the health equity outcomes of social enterprise activity. This comparison points to the differences between socio-political contexts, norms and meaning of particular social or economic activities such as employment. To support practitioners and policy makers in designing and resourcing social enterprise for improved health equities and health equity outcomes, studies should position the causal chains that exist within organisations as segments of the causal chains that affect health equity in organisations’ operating contexts.

While this article provides a thorough description and synthesis of the research field, the scoping review approach is bound by certain limitations. First, while the scoping review enables scholars to collate, synthesise and report on qualitative studies from disparate disciplines, it does not involve the adjudication of the quality of studies.
To mitigate this limitation, the review only includes studies that have been published following peer review. Second, scholars and practitioners in diverse social and political contexts use various concepts to refer to the practice of social enterprise. This scoping review operationalised key concepts via input from a multidisciplinary research team with expertise in public health and social enterprise. While this enabled the key concepts to be operationalised in a broad way, some studies may have been missed due to the international and interdisciplinary nature of social enterprise.

This scoping study provides theoretical and evidence-based direction to researchers who aim to sharpen understandings of how the causal mechanisms that are embedded in social enterprise organisations work to alleviate health inequities and improve health equity outcomes. This paper has argued that future research should develop this perspective through more holistic analyses of organisations in context. The theoretical and empirical insights that this article offers will support practitioners and policy makers to be more strategic and deliberate when deciding how to design and resource social enterprise for improved health equity and health equity outcomes.
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Full text included in quantitative synthesis (n = 38)

Full text included in qualitative synthesis (n = 10)

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Records excluded after full text screening (n = 25)

Figure 2. Process of article selection (Source: authors)
Figure 3. Synthesis of evidence of how organisational features affect health equities and health equity outcomes (Source: authors)
Table 1. Search terms to operationalise scoping study (Source: authors)

<table>
<thead>
<tr>
<th>Concept</th>
<th>Search terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social enterprise</td>
<td>‘social enterpris*’ or ‘community enterprise*’ or ‘community business*’ or ‘co#operative’</td>
</tr>
<tr>
<td>Social determinants of health</td>
<td>‘housing’ or ‘accommodation’ or ‘education’ or ‘training’ or ‘work?integration’ or ‘employment’ or ‘social network*’ or ‘social relationship*’ or ‘income’ or ‘stigma’ or ‘discrimination’ or ‘marginali*’</td>
</tr>
<tr>
<td>Health equity outcomes</td>
<td>‘well#being’ or ‘self#esteem’ or ‘quality of life’</td>
</tr>
</tbody>
</table>
Table 2. Summary of the organisational features that studies explicate as generative mechanisms that deliver outcomes for health equities and health equity outcomes (Source: authors)

<table>
<thead>
<tr>
<th>Study</th>
<th>Context</th>
<th>Intervention</th>
<th>Organisational features that function as Mechanisms</th>
<th>Outcomes for health equities and health equity outcomes</th>
</tr>
</thead>
</table>
| Bertram and | Country: UK                                                              | Type of social enterprise: User run information and support service with: work training project (contract with local council to clean carpets in library), partnerships with the voluntary sector that facilitate individual placement, and employment service | (i) Trusting interpersonal relationships  
(ii) Staff or peer supporters who are empathetic to services users and respect that change occurs at a pace that suits the service user  
(iii) Valued activities that provide a sense of purpose by integrating emotional, practical and financial support  
(iv) Warm, friendly, safe, comfortable spaces with good furniture and access to PCs and no CCTV | (i) Decreased use of health services  
(ii) Improved personal wellbeing, including sense of confidence, optimism, control, independence, pride and feeling valued  
(iii) Improved community wellbeing, including increased vocational activity, employment, and new or strengthened social networks |
| McDonald 2015 | Social: People in contact with mental health services are among the most excluded groups in society. Although employment rates are historically high, the majority of service users are unemployed.  
Policy: Intention of government is that: ‘More people will have good quality of life: greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, improved chances in education, better employment rates and a suitable and stable place to live.’ | Target beneficiaries: People in contact with mental health services |                                                                                                                                 |                                                                                                                                 |
| Chan 2015   | Country: Canada                                                          | Type of social enterprise: WISEs with variation in location, commercial activities, and focus on training, employment, or both | (i) Availability of instrumental support: e.g. flexibility around work hours, work load, schedule and time to develop skills; access to service providers; access to training | (i) Alleviation of stressors and anxiety that are work- and non-work related  
(ii) Improved sense of belonging, confidence and self-efficacy |
<p>|             | Social: Not specified                                                    |                                                                                                                                               |                                                                                                                                 |                                                                                                                                 |
|             | Policy: Not specified                                                    |                                                                                                                                               |                                                                                                                                 |                                                                                                                                 |</p>
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</table>
| Ferguson 2012, 2018    | **Country:** USA  
**Social:** Over 2 million youth experience homelessness each year in the USA. One quarter experience homelessness more than once in their lives. Homelessness intersects with low education, employment, and high rates of mental illness and substance abuse.  
**Policy:** Not specified | **Type of social enterprise:** WISE that provides vocational and business skills and mentorship (engaged in silk screening and photographic art)  
**Target beneficiaries:** Homeless youth (ages 16–24) who attend a drop-in centre in Los Angeles | (i) Peer-based and team-oriented context  
(ii) Asset-based approach to youth development (with commitment to learning, social competencies, identity and social context)  
(iii) Training and mentorship to develop vocational/technical and business skills  
(iv) Clinical support and case management | While social enterprise and competitive employment is associated with improvements in mental health, social support and life satisfaction, neither SEI nor IPS fared better or worse on mental health status or housing stability. |
| Galloway et al 2016    | **Country:** Namibia  
**Social:** Desertification is tied to poverty, migration, food security, and development. Communities in dry areas with marginal, | **Type of social enterprise:** Co-operatives owned by local indigenous communities that manage the commercialisation of a non-timber forest product, for | (i) Registration of harvesters  
(ii) Set price for kilogram of harvested resin, revenue split between Trust and harvester | (i) Supplementary income for food, education, healthcare, transport, personal items, livestock |
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<tr>
<td></td>
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<td>(iii) Women in decision-making and leadership roles</td>
<td>(ii) Greater economic independence among women</td>
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<td>(iv) Use of local knowledge</td>
<td>(iii) Affirmation of Himba pastoralist culture</td>
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<td>(iv) Participation in decisions about how to share communal benefits and election of leaders</td>
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<td>conservation and development goals</td>
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<td></td>
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<td>Target beneficiaries: Harvesters in indigenous Himba communities (Namibia)</td>
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<tr>
<td>Lanctôt et al 2012</td>
<td>Country: Canada Social: Although there is evidence that work improves the quality of life of people with severe mental disorders, job tenure tends to be brief and rate of employment in the regular job market rarely exceeds 10-20%. Policy: Not specified</td>
<td>Type of social enterprise: WISE with five divisions that either offer community services or manufactures merchandise</td>
<td>(i) Professionalism around performance of tasks and recognition as being part of the workforce (ii) Interpersonal relationships that are based on harmony, mutual respect and good communication (iii) In the absence of a desirable working condition (e.g. interesting work), other conditions (e.g. equitable wage or interpersonal relationships) are present</td>
<td>(i) Improved sense of competence (ii) Enhanced feelings of being a good worker (iii) Reduced effects of stigma (iv) Sense of belonging (to the enterprise)</td>
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<td>Target beneficiaries: People living with disability, unable to work under standard conditions</td>
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| Macaulay et al 2018 | **Country:** Scotland  
**Social:** Not specified  
**Policy:** Politicians have claimed Scotland to be ‘the most supportive environment in the world for social enterprise’ | **Type of social enterprise:**  
(a) WISE that provides employment in retail outlets and service roles  
(b) Community development social enterprise that provides training and educational opportunities to local community members; and support to small businesses  
(c) Cooperative that provides affordable housing and other facilities  
**Target beneficiaries:**  
(a) Adults living with physical and/or mental disability, excluded from mainstream employment  
(b) Local community in decline following demise of the largest industry and employer  
(c) Local residents in a deprived area | (i) Org structures that give responsibility to community (e.g. community development-based social enterprise and community-owned cooperative)  
(ii) Productive relationships between the local community, social enterprise and local council  
(iii) Safe and inviting physical spaces  
(iv) Work tasks that involve social interaction, availability of healthy food options, physical activity | (i) Wellbeing derived from feelings of ownership and control; collective efficacy (in community-owned enterprises with community embeddedness)  
(ii) Reduction of stress  
(iii) Recognition of own abilities, leading to general wellbeing  
(iv) Boosted self-worth  
(v) Improved financial situation |
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</table>
| Maguirre et al 2016 | **Country:** Mexico  
**Social:** Forest-related activities are the main source of income for the Ixtlán community (population of 2,718). Ixtlán used to live in a subsistence economy based on agriculture and cattle.  
**Policy:** Indigenous communities are mainly organised under communal property and have special protection of customs and territorial integration under articles 4 and 27 of the Mexican Constitution. | **Type of social enterprise:** Enterprises (inc. timber, hardware, eco-tourism, microlending, sustainable forest management, eco-tourism park) that provide employment and economic resources to local indigenous communities  
**Target beneficiaries:** Ixtlan, Capulalpam, La Trinidad and Santiago Xiacui indigenous communities | (i) Women hold decision-making, management and worker roles in Ixtlán enterprises—although are still in the minority  
(ii) Formal jobs with benefits mandated by law, with access to no-interest loans  
(iii) Policies that prevent employees from being fired  
(iv) Ongoing training and opportunities for promotion | (i) Changes in cultural norms around women’s role in society  
(ii) Women more independent and more participatory in political and social events  
(iii) Families are more involved in the political, economic and environmental activities of the community  
(iv) Economic stability, growth in local markets  
(v) Reduction of poverty  
(vi) Strengthened identity and commitment to the community |
| Svanberg et al 2010 | **Country:** Scotland  
**Social:** People with mental health problems face barriers to employment, including lack of choice and opportunity, stigma, pressures of working while coping with symptoms of mental illness and disincentives to employment embedded in the benefits system.  
**Policy:** Not specified | **Type of social enterprise:** Social firms that aim to support social inclusion and empowerment through meaningful activities (e.g. bicycle maintenance and restoration; wood work and furniture making)  
**Target beneficiaries:** People excluded from mainstream society | (i) Structured activity: routine work, albeit with flexibility around types of tasks  
(ii) Tasks that required ‘doing’ rather than ‘talking’, and creating something visible  
(iii) Accepting colleagues, social group  
(iv) Choice around whether and when to work in the workshop or participate in therapeutic support | (i) Increased motivation to attend work  
(ii) Sense of contributing to community by serving customers and participating in community events  
(iii) Improved sense of confidence; self-efficacy  
(iv) Sense of belonging, success, growth, and hope about the future |
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<tr>
<td>Williams et al 2010</td>
<td>Country: Australia Social: The unemployment rate for people living with psychiatric disabilities has been reported as 70-80% in Australia, the UK and among recipients of standard vocational rehabilitation in USA. On average, people who obtain employment following vocational rehabilitation work for less than 6 months a year. Policy: Not specified</td>
<td>due to issues such as mental illness (iv) Project leaders who created an atmosphere of acceptance and inclusion</td>
<td>(v) Improved mental health and sense of wellbeing</td>
<td></td>
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<tr>
<td></td>
<td>Type of social enterprise: WISE that offers commercial cleaning services to businesses Target beneficiaries: Not specified</td>
<td>(i) Regular work schedules, tasks and locations with opportunities to negotiate changes (ii) Opportunities for training, responsibility and autonomy (iii) Friendly, supportive and cooperative (not competitive) team members, who provide genuine feedback (iv) Remuneration and workplace entitlements</td>
<td>(i) Sense of confidence and little stress about one’s ability to complete tasks (ii) Enhanced perspective of one’s present and future (iii) Enhanced sense of inclusion and being valued (iv) Motivation to stay healthy and engaged (v) High level of job satisfaction</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Phenomenon of Interest</td>
<td>What was evaluated</td>
<td>Research type</td>
<td>Research design</td>
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<tr>
<td>Bertram and McDonald 2015</td>
<td>The role of secondary mental health services in supporting service users to achieve vocational goals such as employment, education, training and volunteering</td>
<td>The experiences of people in contact with secondary mental health services</td>
<td>Qualitative, co-designed evaluation</td>
<td>In-depth interviews</td>
</tr>
<tr>
<td>Chan 2015</td>
<td>The availability, mobilisation and use of social supports (i.e. assistance through interpersonal relationships) in social purpose enterprises</td>
<td>The perceptions and experiences of those who support or witness the support provisions</td>
<td>Mixed-methods study</td>
<td>Quantitative survey; semi-structured phone interviews</td>
</tr>
<tr>
<td>Ferguson 2012, 2018</td>
<td>The efficacy of a Social Enterprise Intervention (SEI) relative to Individual Placement and Support (IPS) in achieving non-vocational outcomes for homeless youth with mental illness</td>
<td>The wellbeing of service users, indicated by mental health status, housing stability and use of social support</td>
<td>Quantitative randomised comparative efficacy study</td>
<td>Surveys: baseline and follow-up (at 20–24 months)</td>
</tr>
<tr>
<td>Galloway et al 2016</td>
<td>The positive and negative effects of commercialising a plant product on indigenous peoples</td>
<td>The economic activities and social relationships of harvesters in indigenous Himba communities</td>
<td>Mixed methods, comparative case studies (2)</td>
<td>Participant observation (3yr), focus groups, interviews, document analysis</td>
</tr>
<tr>
<td>Study</td>
<td>Phenomenon of Interest</td>
<td>What was evaluated</td>
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<tr>
<td>Lanctôt et al 2012</td>
<td>The quality of work life of people with severe mental disorders whilst working in social enterprises</td>
<td>The meaning that people with severe mental disorders give to their quality of work life</td>
<td>Qualitative, phenomenological study</td>
<td>Semi-structured interviews (two per participant)</td>
</tr>
<tr>
<td>Macaulay et al 2018</td>
<td>The diversity of health and wellbeing outcomes from different types of social enterprise-led activities (in terms of whether, how and for whom the outcomes occur)</td>
<td>The views and interpretations of previously unrepresented stakeholders</td>
<td>Qualitative comparative case studies (3)</td>
<td>In-depth, semi-structured interviews; focus group</td>
</tr>
<tr>
<td>Maguirre et al 2016</td>
<td>The social enterprise mechanisms that enable women’s empowerment and influence local development</td>
<td>The worldviews of local indigenous communities</td>
<td>Qualitative case study (1)</td>
<td>In-depth, semi-structured interviews; observation</td>
</tr>
<tr>
<td>Svanberg et al 2010</td>
<td>The experiences of recovery from mental illness in the context of emerging social firms</td>
<td>The meaning of recovery, the experience of mental illness and working in an emerging social firm.</td>
<td>Qualitative, comparative case studies (2)</td>
<td>Open-ended interviews</td>
</tr>
<tr>
<td>Williams et al 2010</td>
<td>The views of employees living with a psychiatric disability about working in a social firm designed to provide an inclusive and supportive workplace</td>
<td>Employees’ individual and shared perspectives of their work environment</td>
<td>Qualitative study</td>
<td>Semi-structured interviews</td>
</tr>
</tbody>
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