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Health Inequalities Policy Review

Social Enterprise and Health

Social enterprises are businesses with social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners (DTI 2002). They operate in all areas of the economy, tackle a wide range of social and environmental issues, and are active in a diversity of markets, including health and social care.

Social enterprises are often found in areas of poverty, deprivation and ill health and impact on areas of life that help improve the health and well-being of individuals, families and their communities. In addressing health inequalities in our society, there has tended to be a focus on a deficit model – which strives to fix problems, needs and deficiencies.

More recently, Scottish Government has indicated its support for a "preventative spend" approach which would direct resources to the support of the assets-based model. This approach focuses on the capacity and potential for individuals and communities to positively take control of the factors that influence poor health. The benefits of such an approach are being recognised as a way of moving things forward.

Social enterprises will play an important role in sharing their valuable experience and assisting to embed an assets-based approach in mainstream practice. Social enterprises are impacting on vulnerable, hard to reach, disenfranchised and under-served groups but their worth and value need to be more fully recognised; and their potential to deliver more fully realised.

Community Benefit Clauses in Procurement

Community Benefit Clauses (CBCs) are contractual clauses which can be used to build a range of economic, social or environmental conditions into the delivery of public contracts. CBCs can be viewed as contributing to the Best Value and sustainable procurement agendas, and allow organisations to contribute to the achievement of outcomes which benefit their communities by specifying contractual requirements which seek to deliver such wider social benefit.

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Public Social Partnerships (PSPs)

Public Social Partnerships are a model for the Third Sector to be involved earlier and more deeply in the commissioning and service design process. It is based on the principle of the Third and Public Sectors engaging in co-production to design a new, or re-design a current, service with the goal of delivering better outcome-focus for citizens. Once designed and trialed, the services can then be commissioned for the longer term through a competitive tendering process.

Procurement is an integral part of policy development and service deliver and an outcomed focus approach uses the power of public spend to deliver genuine public value beyond simply cost and quality of purchasing.

Review Questions

What is the character of health inequality in Scotland/your area? What do health inequalities mean/how are they manifested in the lives of communities and families across Scotland?

Scotland's overall health might be improving, however the gaps of life expectancy are widening. There are considerable health inequalities across Scotland, both between different geographical areas and within cities and towns. A difference of one or two digits in a postcode or a distance of one or two miles can have a significant impact on both life chances and life experiences in Scotland. There is 28 year difference in life expectancy between best and worst off in the City of Glasgow and 25% of males in the City of Glasgow will not make it to 65 years of age.

Health inequalities can be manifested in a number of different ways, from the obvious difference in life expectancy to issues surrounding quality of life and ability to access services. There needs to be a change in how we view health and wellness. There has been a top-down and disempowering approach to fixing ill health instead of a well-being approach to supporting healthy individuals and communities.

What role can health and other public services play in tackling health inequalities?

A modern-day conundrum is that health inequalities have widened alongside a world class NHS. This is not an argument against an NHS but it does raise questions about policy and financial support going forward.

Health services have a role to play in delivering services for all communities. However these services need to be better designed and commissioned so they are fit for purpose and offer interventions which effectively address these issues. Attention should also be paid to the emerging work on co-production when designing the shape of future services, so that communities can be part of determining what services look like. Community planning partners also have a role in ensuring that organisations are working effectively together towards, agreed, shared outcomes and that budgets and spending are aligned to drive these changes.

Social enterprises are impacting on vulnerable, hard to reach, disenfranchised and under-served groups but their worth and value needs to be more fully recognised; and their potential to deliver more fully realised. We need to get away from the focus on social enterprise as an alternative deliverer of services. One of the big ideas of the Yunus Centre is that any social enterprise, given that by definition they will be acting on some aspect of social vulnerability, can be portrayed as addressing upstream social determinants of health. If this can be evidenced, then it strengthens the case further for social enterprise to be attracting (public) resources and influencing the policy architecture.

What can be done within current devolved arrangements to tackle health inequalities?

Much more can be done under existing devolved powers to address these inequalities; from tax-raising powers, encouraging a greater role of social enterprise in health and social care delivery (which can happen, in theory, through health and social care partnerships, although there are cultural and territorial barriers are still there), but also encouraging social enterprises and other different types of health-generating entities through more positive funding arrangements, which could be arrived at by listening to the sector about what arrangements would make their lives better in terms of sustainability, whilst realising there is not a bottomless pit.

Another area of focus for policy makers is the role of food in addressing health inequalities. Food is not just a basic matter of eating three times a day, it also provides a vital tool in enhancing quality of life and boosting personal health, and in building social capital, self-respect and community cohesion. A better food policy should also be a core part of the preventive health care agenda, helping to reduce obesity and associated ill-health and reduce the incidence of other diet-related illnesses.

How could we use further devolved powers to help tackle health inequalities?

Not sure responding to the challenge of health inequalities replies on further devolved powers. It does reply on a major shift in where investments are made and a stronger focus on prevention and connectivity. The social model of health is the appropriate one for tackling those long term health and wellbeing conditions which arise from a range of psychological and social causes and which are tackled most effectively through local community-led interventions. The Government response to long term debilitating conditions will not be effective if it continues to be based on short term campaigns, short term funding programmes, expecting to scale up test sites or pilots and failing to recognise and sustain investment in the potential and effectiveness of community led health and wellbeing improvement organisations.

What mechanisms can be deployed to better join up policy and public services to tackle health inequalities?

No-one is really taking a systems-based approach to health and health inequalities. We need experiments whereby some localities are encouraged to work in such a manner and compared with others that are carrying on as normal. Secondly, transformational change can only happen when there is real partnership with the medical and social models of health and wellbeing. Lastly, a human centred approach would be taken and there would be a participatory approach to planning.

On example is our food policy in Scotland. It has done a fantastic job in boosting in our exports, contributing to our GDP and developing our economy, but so much more could be done to ensure that good food isn't just for posh people and that everyone has access to affordable, healthy food and is able to prepare and eat it. The health, environment and food and drink policies that we have need to be much better aligned.

What can be done to tackle the Inverse Care Law in health and other public services?

There are basic allocation of resources issues for the NHS. The recent argument to have 'proportionate universalism' is a recognition of the growing need to target resources, however you present it. The community empowerment bill could be a powerful first step is giving communities access to land and assets and a voice in service design, but communities will need to assistance to access these opportunities. Otherwise, these opportunities will remain open only to those communities who already have the skills to access these assets. We also want to see the Bill go even further, and to create a new community right to grow on vacant, derelict or underused land.

A better approach would be organisations like The Scottish Centre for Health and Wellbeing (SCHW) which offer a positive contribution to tackling the Inverse Care Law as community-led health improvement anchor organisations would be embedded in their communities, advocate on behalf of their communities, make effective local partnerships with the HNS trusts and local councils and most importantly would engage local people in ways which current public service find difficult or impossible but sometimes also find them easy to ignore.

Is democratisation of health services important in tackling health inequalities?

The public service has been described as being characterised as a hierarchical type of culture focused on internal stability and adherence to rules and procedures rather one of flexibility, innovation and openness. A participatory approach to planning and delivery of services would focus on how people can thrive, not just get by in the best circumstances and need further support and higher care needs in the worst circumstances.

How could community development efforts be better supported to tackle health inequalities?

- Start with listening to social enterprises on the ground – as to how things could work better in this regard
- Understand of the needs of communities and how to support and foster connectivity.
- Take risks and make real investment on what brings health and wellbeing to people.

How could resource allocation (this could be geographic and in other budget planning terms) to health and public services be re-allocated to tackle health inequalities?

Resource allocation formulae (at least for health care) does try to take this into account. The problem is to do with what happens to the money once allocated to various agencies (like health boards). Most do not operate with explicit framework for managing scarce resources which might involve setting criteria against which competing claims can be made (including on equity grounds), with such claims properly costed as well.

Are there any specific policies, initiatives or research evidence from Scotland, UK or internationally that you know of that would help provide ideas in helping tackle health inequalities?

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Glasgow Caledonian University and The Yunus Centre for Social Business and Health's 5 year research programme which commenced this year, *Developing methods to evidence* 'Social enterprise as a health intervention'. (Attaching the Case for Support).

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