SOCIAL INNOVATION

FOR THE PROMOTION OF THE HEALTH EQUITY

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Social innovation for the promotion of health equity

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'Fair Foundations: The VicHealth framework for health equity' was developed by VicHealth under the leadership of author O'Rourke. It was published in 2013. It is a conceptual and planning framework adapted from work done by the WHO Commission on the Social Determinants of Health (Solar and Irwin, 2010). Social determinants of health inequities are depicted as three layers of influence – socioeconomic, political and cultural context; daily living conditions; and individual health-related factors. These determinants and their unequal distribution according to social position, result in differences in health status between population groups that are avoidable and unfair. The layers of influence also provide practical entry points for action (VicHealth, 2013). Fair Foundations can be accessed at www.vichealth.vic.gov.au.

Summary

The role of social innovations in transforming the lives of individuals and communities has been a source of popular attention in recent years. This article systematically reviews the available evidence of the relationship between social innovation and its promotion of health equity. Guided by Fair Foundations: The VicHealth framework for health equity and examining four types of social innovation—social movements, service-related social innovations, social enterprise and digital social innovations—we find a growing literature on social innovation activities, but inconsistent evaluative evidence of their impacts on health equities, particularly at the socio-economic, political and cultural level of the framework. Distinctive characteristics of social innovations related to the promotion of health equity include the mobilization of latent or unrealised value through new combinations of (social, cultural and material) resources; growing bridging social capital and purposeful approaches to linking individual knowledge and experience to institutional change. These have implications for health promotion practice and for research about social innovation and health equity.

Key words: health policy, innovation, health promoting policies, health promotion programmes

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INTRODUCTION

The role of social innovations in transforming the lives of individuals and communities has been a source of popular attention in recent years (Phills *et al.*, 2008). As interest in the transformative impacts of social innovation grows, so too do questions regarding the nature of social innovations and the empirical evidence of their effects. This article reviews the available evidence regarding the relationship between social innovation and its promotion of health equity and considers the implications for health promotion practice, policy and research.

Social innovation is a broad term used to denote a variety of activities. Common definitions variously characterize social innovation as new and improved solutions to wicked social problems (Phills *et al.*, 2008) or as cross-cutting relational processes that improve institutional responses to complexity in relation to social issues (Mulgan *et al.*, 2007). Social innovation has been linked with public sector reform (Mulgan *et al.*, 2007; Leadbeater, 2007) and with organizational forms that create hybrid (social, environmental and financial) value (Battilana and Dorado, 2010). In the context of healthcare reform, Christensen *et al.* (Christensen *et al.*, 2000) have argued that disruptive innovations—including both new low cost technologies and new business models that challenge the status quo—are required to raise healthcare quality for all.

For the purposes of this article, social innovation is defined according to one of the most widely cited definitions as:

> A novel solution to a social problem that is more effective, efficient, sustainable, or just than existing solutions and for which the value created accrues primarily to society as a whole rather than private individuals. [(Phills *et al.*, 2008), p. 38]

While this conceptualization of social innovation is in popular use, it remains challenging to operationalize for several reasons. First, while the idea of improvement in relation to commercial innovation may be relatively easily measured by indicators such as increased profit margins or reduced unit costs, improvements in addressing social problems are typically longer term, and less clearly attributable to individual interventions and their effects. Second, what constitutes social improvement is a relative concept, subject to contestation by citizens in free societies. Third, the sheer breadth of activities that may constitute new and improved solutions to complex social challenges renders a review of the evidence so wide as to potentially render such an analysis meaningless.

To delimit the focus of the review consistent with the definition adopted combined with preliminary assessment of social innovation types presenting in the literature search, we examine here four types of social innovation:

1. Social movements—or "networks of informal interactions between a plurality of individuals, groups and/ or organizations, engaged in political or cultural conflicts, on the basis of shared collective identities" [(Diani, 1992), p. 1].
2. Service-related social innovations—which seek to improve services that affect socio-economic participation through: joined-up and cross-sectoral service design and delivery; people-centred models of service design and delivery and design-informed thinking about the outcomes services seek to achieve (Leadbeater, 2007).
3. Digital social innovations—or 'a type of social and collaborative innovation in which innovators, users and communities collaborate using digital technologies to co-create knowledge and solutions for a wide range of social needs and at a scale that was unimaginable before the rise of the Internet' [(Bria *et al.*, 2014), p. i].
4. Innovative forms of social enterprise—that is, businesses that exist to fulfil a social (including environmental) objective and typically reinvest a substantial portion of their profit or surplus in the fulfilment of that purpose.

We review the relationship between these four types of social innovation and their promotion of health equity, drawing on Fair Foundations: The VicHealth framework for health equity, to guide our analysis.

METHODOLOGY

A systematic review of the available scholarly and grey literatures was undertaken, based on a four-stage process. Due to space constraints, we have provided details of this process in Supplementary data, Appendix 1 outlining the full, systematic design and procedure used (including search databases used). An example of the data extraction tool is provided in Supplementary data, Appendix 3.

In Figure 1, we summarize each of the four stages in our systematic approach. In Stage 1, we determined our search boundaries based on VicHealth's Action Agenda, the levels of influence depicted in the Fair Foundations Framework, and the research team's expertise on social innovation. Scholarly research, evaluative evidence and applied case studies from the field were included. Stage 2 of the systematic review process comprised a rigorous search of the identified engines and databases using key words within the search strings. Stage 3 involved a more

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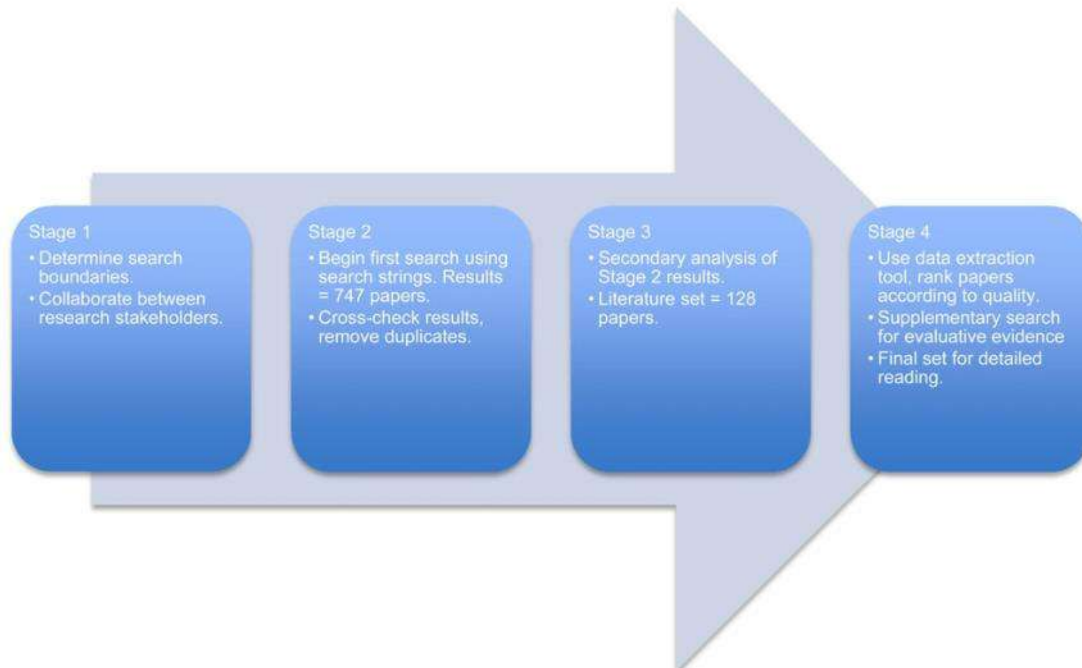

Fig. 1: Summary of the four-stage systematic search.

focused analysis to isolate cross-disciplinary studies, and those that applied to multiple layers of the Fair Foundations Framework. In Stage 4, we reviewed and ranked the papers remaining in the set using a data extraction tool. We then undertook a supplementary literature search for evaluative evidence related to dominant exemplars of social innovation identified through this process (see Supplementary data, Appendix 1 for a full description of the search strategy employed). Based on our reading of the remaining papers in Stage 4, we conducted a narrative synthesis. Following Popay *et al.* (Popay *et al.*, 2006), we followed an iterative process in deploying the narrative synthesis, that is, our analysis was developed alongside our on-going reading of the corpus. This allowed the research team to judge the effectiveness of the reported social innovations on their own merits, as well as alongside the Fair Foundations Framework and checking the robustness of our process.

FINDINGS: SOCIAL INNOVATION AND HEALTH EQUITY

The review finds some evidence of impacts of social innovation on health equity, and a burgeoning body of literature describing growth of these activities. The review suggests that particular types of social innovation impact in different ways on different levels and triggers for action of the Fair Foundations Framework.

SOCIAL MOVEMENTS AND HEALTH EQUITIES

Of the four social innovation types reviewed, social movements have had the most significant known impacts on the socioeconomic, political and cultural factors that inform health inequities. There is substantial documentation of historical instances of social movements playing a catalysing role in re-shaping public policy and cultural norms related to both health services and the social determinants of health, through sustained advocacy for equality of marginalized social groups. In the case of traditional or 'old' social movements—class-based movements concerned primarily with material needs of particular groups (Habermas, 1981)—social movements played an explicit role in health equity improvements, with a particular focus on alleviating poverty and class-driven effects of food insecurity and inadequate housing (Brown and Fee, 2014).

So-called 'new social movements' (Habermas, 1981)—that is, democratically driven and identity movements that emerged in the late 1960s and early 1970s—have also played significant roles in redressing health inequities for

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particular social groups. Examples of such movements include second-wave feminism, civil rights, disability rights and Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) identity movements. New social movements explicitly focused on redressing health inequities have typically not been addressed by new social movement scholars (Scambler and Kelleher, 2006; Brown and Fee, 2014) although such movements have played a role in both addressing and bringing to global attention the social determinants of health (Brown *et al.*, 2004; Narayan, 2006; Brown and Fee, 2014).

The literature is consistent in identifying that the main social innovation of new social movements is the way they give expression to new forms of knowledge—often based in the experience of movement activists themselves—which challenge social and environmental inequities reproduced through institutionally sanctioned sources of expertise (Munch, 2006; Scambler and Kelleher, 2006; Raphael, 2009; Cornish *et al.*, 2014). In short, new social movements challenge the social construction of expert knowledge and the institutional conventions arising from it, leading to institutional change. For example, second-wave feminism has played a substantial role in influencing institutional changes—including changes in policy, legislation, service design and availability, and cultural norms that guide socio-economic participation—in western societies to reduce gender-related health inequities, primarily by introducing women's experience into public debate, medical discourse, popular media and political deliberations (Burgmann, 2003; Munch, 2006).

A second aspect of social innovation with which new social movements are associated is their use of diverse communication forms, or acts of cultural persuasion, in both expressing movement objectives and widening collective commitments to action (Burgmann, 2003; McCammon *et al.*, 2007). The rise of online technologies has supported new campaigning strategies for social movement actors (Turner, 2013). These strategies have resonance for health equity promotion as they are explicitly concerned with changing attitudes and behaviours in support of more sustainable and just social conditions.

While there is clear evidence that some social movements have had significant impacts on the socio-economic, cultural and political contexts that influence health inequities (Brown *et al.*, 2004; Brown and Fee, 2014), the wins for some social groups contributed to by social movements may in some cases exacerbate health inequities for other groups. In the case of second-wave feminism, for example, the movement and its successes have been criticized for framing social determinants of health inequities around gender issues to the exclusion of other social stratifiers, such as race and ethnicity (Thomlinson, 2012).

SERVICE-RELATED SOCIAL INNOVATION AND HEALTH EQUITY

The review finds some evidence of impacts of service-related social innovation on health equities, particularly at the levels of daily living conditions and individual health-related factors. Historical forms of social innovation of this type have also influenced socio-economic, political and cultural determinants of health equities.

In its early iteration, the welfare state—which is perhaps the most significant form of social service innovation of the last century (Mulgan *et al.*, 2007)—responded to the perceived limits to sustainability of social support previously provided through civil society (Mulgan, 2006). The introduction of the welfare state had a major effect on the institutional structuring of social support in most developed economies. Evidence related to the relative impacts of the introduction of the welfare state on population health inequities is not readily available. However, comparative evaluations of the relationship between different welfare regime types (see Esping-Andersen, 1990) and population health find that welfare regimes differ in their impacts on health equities at the individual health and daily living conditions levels, with more redistributive regimes associated with reduced infant mortality (Navarro and Shi, 2001; Chung and Muntaner, 2006), reduced inequality in employment status and self-reported health for women (Bambra and Eikemo, 2008).

Emergent approaches to social innovation are typically characterized as responding to the inadequacies of the contemporary welfare state—which has become increasingly residualized across all regime types—while simultaneously responding to changing demographic needs of an increasingly mobile population and globalized economic system (Oosterlynck *et al.*, 2013). These approaches seek to improve services that affect socio-economic participation through: joined-up and cross-sectoral service design and delivery; people-centred service models and design-informed thinking about the outcomes services seek to achieve (Zeisel, 2013; Nandram *et al.*, 2014).

Health equity issues addressed within the literature on services-related social innovations include: socio-economic participation and cohesion (Andreotti *et al.*, 2012); childhood (Radcliffe *et al.*, 2013); obesity (Trowbridge and Schmid, 2013); physical activity (Marinescu *et al.*, 2013); ageing (Byles *et al.*, 2014); mental health (Beidas *et al.*, 2013); women's health (Alyaemni *et al.*, 2013; Houweling *et al.*, 2013); and sexual health (Herrick *et al.*, 2014). A common identified characteristic of these social innovations is their integrative approach. This includes integrating: government and non-government organizations, some of which have not traditionally been recognized as welfare

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actors (Bason, 2010; Herbert and Best, 2011; Patterson *et al.*, 2014); welfare and other policy fields, recognizing the social effects that occur at the intersection between policy domains (Trowbridge and Schmid, 2013) and social and economic development (WILCO Consortium, 2014). Many emergent service-related social innovations focus on grassroots responses to gaps in welfare state provision (Kerlin, 2013), seeking context-specific and locally responsive solutions to inequities (re)produced through standardized welfare responses (Andreotti *et al.*, 2012).

Demographic shifts are precipitating changes in how public health programmes are designed (Dadich and Hosseinzadeh, 2013), in order to bring about improvements in public attitudes to key health equity issues, such as obesity (Allender *et al.*, 2011) and ageing (Gibson, 2014). Research suggests that encouraging and sustaining innovations in primary health care is a central part of the challenge when addressing equity issues in developed economies (Sibthorpe *et al.*, 2005). Especially important is bringing together three core elements: social relationships, networks and champions; political, social and financial resources and; the motivation of agents in a prevailing system (Sibthorpe *et al.*, 2005).

Many service-related social innovations are targeted at the levels of daily living conditions and individual health-related factors. These focus on growing social support resources and stimulating attitudinal change by increasing bonding social capital within peer groups (Bennett *et al.*, 2008; Evangelou *et al.*, 2013), and bridging networks and generalized trust between affected groups and the wider public (Sherry *et al.*, 2011; DiPietro and Klingenmaier, 2013).

DIGITAL SOCIAL INNOVATION AND HEALTH EQUITY

Most digital social innovations are mediated through the Internet or are enabled by new technology trends, including open data infrastructure; open hardware and open networks (Bria *et al.*, 2014). The potential systemic impact of digital social innovations is greatly anticipated, but currently under-evaluated (Bria *et al.*, 2014). Bria *et al.* (Bria *et al.*, 2014) suggest that unlocking the untapped potential of digital social innovations could transform industries, including healthcare. In the specific case of mobile health (mHealth) innovations, key factors for success have been identified as the level of stakeholder collaboration (Gerber *et al.*, 2010), government involvement (Mechael, 2009), technology effectiveness (Kumar *et al.*, 2013) and adaptability to local contexts (Aranda-Jan *et al.*, 2014).

Much of the limited evaluative evidence of the impacts of digital social innovations identified through this review is specific to communication platforms. One such platform is Patients Like Me (PLM), which is an online peer-based data sharing platform, for individuals and families affected by illness to share their experiences with each other and the medical community. PLM has been found to play an important part in empowering consumers of health care services (Lober and Flowers, 2011) and improving patients' disease self-management (Househ *et al.*, 2014).

The literature suggests the appeal of online communication platforms are their effectiveness in encouraging participation, creating safe spaces to inform, diffuse and discuss health issues (Rhodes *et al.*, 2010; Allender *et al.*, 2011). However, the literature finds that, in order to properly engage communities, web-based interventions for health equity promotion should not assume equality of access to this information and should acknowledge technological as well as geographic barriers to access (Eysenbach, 2000; Kawachi and Berkman, 2001; Eysenbach and Köhler, 2002). Furthermore, these successes and benefits are somewhat offset by the increasing evidence that social networking platforms can exacerbate social stigma (O'Keeffe and Clarke-Pearson, 2011).

Similarly to some examples of service-related social innovation, many forms of digital social innovation are predicated on user-centred design through crowd-sourced and peer-based knowledge creation. For example, Fablab Amsterdam is a social enterprise 'fabrication laboratory', which develops low-cost technologies through collaborative learning between designers and individuals with physical impairments (Bria *et al.*, 2014). This work is consistent with Christensen *et al.*'s (Christensen *et al.*, 2000) call for low-cost disruptive innovations in healthcare.

SOCIAL ENTERPRISE AND HEALTH EQUITY

The function of social enterprise as a socially innovative response to health inequities is two-fold. First, social enterprise has been advanced in some jurisdictions as an alternative health services provider, responding to gaps in geographic and/or culturally appropriate mainstream service provision (Hall *et al.*, 2012; Park and Wilding 2013). Second, social enterprise has been conceptualized as a form of 'upstream' intervention that addresses the social determinants of health (Roy *et al.*, 2013). In each case, the introduction of social enterprise constitutes a process innovation, where improvements to the business model are expected to deliver improvements in service design and accessibility.

With regard to the function of social enterprise as alternative health services providers, examples include the

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transfer of some National Health Services (NHS) to social enterprise 'spinouts' in the UK (Hall *et al.*, 2012; Roy *et al.*, 2013) and the establishment of multi-stakeholder social cooperatives in Italy, which provide both health and social services and employment opportunities to disadvantaged groups (Thomas, 2004; Mancino and Thomas, 2005). Research on the effects of Italian social cooperatives suggests that their principal social innovation is the trust and bridging social capital generated by their multi-stakeholder organizational form and that their main impacts have been increased citizen engagement created by the ownership structure and opportunities for socio-economic participation of previously excluded social groups (Thomas, 2004; Mancino and Thomas 2005).

As an 'upstream' response to social determinants of health inequities (Roy *et al.*, 2014a,b), the available evidence suggests that social enterprise plays a role primarily at the individual and daily living condition levels of the Fair Foundations Framework. A dominant form of social enterprise in European, North American and Australian contexts is work integration social enterprises (WISE), which create pathways to employment or permanent employment opportunities for people who are disadvantaged in the labour market (Spear and Bidet, 2005). The primary social innovation of WISE is that they mediate gaps between mainstream employment services and the open labour market for particular social groups, thereby contributing to a more equitable and just employment system. There is a growing literature that suggests that, at the individual level, WISE are effective at increasing the latent benefits of employment (Jahoda, 1982), including increased self-efficacy, self-esteem and social relationships, for specific social groups such as newly arrived migrants and refugees (Barraket, 2013), people with a disability (Warner and Mandiberg, 2006), homeless young people (Ferguson and Xie, 2008) and people with mental illnesses and addictions (Krupa *et al.*, 2003; Lysaght *et al.*, 2012). WISE have been found to allow for design of work settings that are responsive to the needs—such as language, childcare support, task structuring, and wrap-around support —of particular social groups (Krupa *et al.*, 2003; Ho and Chan, 2010; Lysaght *et al.*, 2012; Barraket, 2013).

DISCUSSION AND CONCLUSIONS

Mulgan *et al.* (Mulgan *et al.*, 2007) suggest that the defining characteristics of social innovations are that they create new combinations from existing elements; cut across boundaries between sectors and disciplines and create lasting relationships between previously separate groups. This review of the available evidence suggests that characteristics of social innovations that effectively address health inequities are consistent with Mulgan *et al.*'s (Mulgan *et al.*, 2007) broad characterization. The evidence reviewed in this article suggests a number of implications for the promotion of health equity.

First, the evidence suggests that a prevailing characteristic of social innovation is its responsiveness to failures or shocks of economic, social welfare and wider political systems (Oosterlynck *et al.*, 2013). Much of the early literature on social innovation in relation to health equity has focused on practice in developing economies (see, for example, health initiatives in Nigerian schools (Huaynoca *et al.*, 2014), and diabetes control interventions in Bangladesh (Islam *et al.*, 2014)). This in part reflects the function of social innovation as a response to failures of or gaps in institutional systems. Recent and fairly rapid growth of activity in OECD countries particularly in Europe is, in part, a response to region-wide shocks produced by the Global Financial Crisis (Ruckert and Labonté, 2014). In terms of health equity promotion, this suggests that the greatest value of social innovation lies in its capacity to redress system failures at local levels.

Further, despite their diversity, a characteristic of most of the social innovations included in this review is that they recognize and harness latent or unrealized value. This includes recognition of the value of: resources—such as people's knowledge, labour, so-called waste products and communities' financial capital—typically discarded or ignored by mainstream systems; bringing different types of stakeholders together to tackle a problem and applying non-traditional disciplinary insights to a new area of policy or practice. This suggests that creating new resource combinations (Mulgan *et al.*, 2007) and looking for the resource value *in* social problems may have utility in devising high impact approaches to health equity promotion.

In addition, a number of the social innovations reviewed here can be best characterized as upstream or parallel interventions (Roy *et al.*, 2013), which—consistent with the social determinants of health approach—recognize the complex interplay between the 'causes of the causes' of health inequities (WHO, 2008). Upstream interventions typically require new alliances and collaborations as well as new organizational forms (Roy *et al.*, 2013; Battilana and Lee, 2014). Consistent with complex systems thinking, many approaches to social innovation relevant to health equity promotion are designed with attention to the integration between elements in social and political systems (WILCO Consortium, 2014). This includes integration to maximize value and integration to minimize problems arising from unintended consequences (Patterson *et al.*, 2014). This integration advances joined-up thinking, not just in the design of the intervention, but in the wider practices of those individuals and

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organizations involved in the process (Bason, 2010; Dadich and Hosseinzadeh 2013). It can also build consensus around particular interventions, which improves their effectiveness although, as noted by some, challenges in collaboration need to be appraised in light of the intended effectiveness of interventions (Sørensen and Torfing 2011; Suárez, 2011).

Integration may occur not just across policy domains or sectors, but also between different levels of the system (Herbert and Best, 2011; Radcliffe *et al.*, 2013; Ramos *et al.*, 2013). While different types of social innovation may be primarily focused on particular levels of the health inequities system as depicted in the Fair Foundations Framework, very few address only one level, typically because they recognize interdependence between levels.

Most of the social innovations reviewed in this report are social in both their means and their purpose (Mulgan *et al.*, 2007). Social movements are a sometimes powerful form of collective action that affect people's feelings of belonging and identity whilst also seeking to address institutional problems (Melucci, 1996). Many forms of innovative social enterprise embed sociality—through ownership, governance or production processes—in their business models (Mason *et al.*, 2007; Battilana and Lee, 2014). Emerging approaches to social innovations in service design are explicitly concerned with people-centred models and with rehabilitating or establishing social relationships within communities in a fast moving world (Mair and Martí, 2006; Reddy *et al.*, 2009). Many, although clearly not all, digital social innovations draw on the crowd-sourcing capabilities and potential for connecting up afforded by online and mobile technologies (Hargreaves, 2003; Rhodes *et al.*, 2010; Bria *et al.*, 2014). Through all of these examples, people and the relationships between them are viewed as both a significant source of new thinking for change and as a driver of new needs to which social innovations must respond. A factor that differentiates many of the examples reviewed above from earlier social change efforts is a strong focus on developing bridging social capital—or links between diverse groups—as well as bonding social capital between participants. In addition, most social innovations related to health equity promotion are characterized by recognition of the relationship between process (of intervention design and implementation) and outcomes. They are often predicated on process innovations that involve user-centred design, partnership and collaboration, with the development of hybrid programmes or organizations the most acute manifestation of these. Because of this, social innovations may have greater transaction costs than more traditional forms of intervention for heath equity promotion.

Finally, it must be observed that the review of the evidence indicates there is relatively limited evaluative evidence of the impacts of contemporary social innovations. In part, this reflects a paradox of the effectiveness of social innovation; that is, by the time substantial change can be measured, the intervention may no longer be considered innovative. However, it also reflects relative immaturity in evaluation and impact measurement in some jurisdictions, as well as the complexities of measuring change in relation to wicked social problems.

The systematic review reveals several gaps in knowledge that require further research. First, is the need for a consistent evidence base of which interventions work in which contexts and why. Presently, there is limited co-ordination and methodological consistency in the way that social innovation in health promotion is studied. A coordinated and longitudinal approach would provide a robust evidence base on which health promotion practitioners can determine leading-edge practice in this area.

Second, although there is growing discursive evidence showcasing how social innovation is applied in new ways to tackle health inequities, there is little systematic analysis of the benefits of new interventions compared with more traditional forms of service design. Comparative studies, which examine the relative impacts of traditional and innovative interventions, are needed to better understand the costs and benefits of emergent approaches. More generally, much of current practice lacks evaluative evidence, and requires longitudinal analysis. Finally, the review reveals very limited analysis of how social innovation is diffused. This question is central to understanding how the impacts, rather than the activities of social innovation, scale.

SUPPLEMENTARY MATERIAL

Supplementary data are available at *Health Promotion International* online.

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