Social business, health and well-being: mapping a research agenda

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Preamble

Microfinance currently finds itself embroiled in a debate over its future social and financial direction, with ardent supporters on either side. Yunus, one of the most fervent supporters of microfinance adhering to a social-mission path, emphasises the maxim of microfinance institutions operating as social businesses. These social businesses can function as a mechanism to combat the market failures that lead to material, health and well-being inequalities in society. However, these latter areas have yet to be properly evaluated. Amidst all this, a new Centre for Social Business & Health has been established at Glasgow Caledonian University. Therefore, as well as informing the health economics community about this new centre, the case for social business as a public health intervention will be proposed as well as a framework outlined which expands the variables that need to be measured empirically to assess success in this area.

We are keen to learn from HESG colleagues:

- Whether the perspective of 'social business as a public health intervention' can be portrayed as new?
- If so, whether new insights on how to measure 'success' in this field can be drawn from such a perspective?
- The limitations of the domains and measures that we propose to use in future research as well as previous experience of their application in evaluating microfinance and social business innovations.
- Whether the research questions emanating from our analysis are correct and complete?

Introduction

The persistence of inequalities in health and well-being remains an outstanding global challenge. Despite significant technological advances, this is so, even in the more-advanced economies of the world. Although progress has been made in overall population health in the past ten years, the UK has witnessed a spate of recent and influential reports confirming the widening of 'health gaps' (Wilkinson and Pickett, 2009; Audit Commission, 2010; Dorling, 2010; Marmot, 2010). In our home town of Glasgow, often labelled the 'sick man of Europe, difference in life expectancy between richest and poorest areas can be as much as 28 years.[1]

The main Western paradigm, of meeting health needs through large publicly-funded institutions, such as a National Health Service (NHS), seems to have reached the limits of what can be achieved in improving population health. On the face of it, NHS-type solutions are not as relevant to lower-income countries anyway, where collection of tax revenues is difficult because of poverty and lack of infrastructure. Furthermore, experts agree that a key determinant of health and well-being on which to act is 'material

[1] See http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html

circumstances'. Taxation and benefit systems are obvious distributive mechanisms – but redistribution of resources in this way is not evident in the political agendas of the advanced economies of the world, a feature which seems unlikely to change in the foreseeable future when the main role of taxation will be debt repayment. Increasing direct income distribution through taxation and benefits is controversial anyway, particularly during a period of austerity, and provokes allegations of fostering a culture of welfare dependency among the 'undeserving'.

Thus, there seems to be, at least in part, a convergence on new ways of thinking. In richer countries, this new thinking is more about 'other' (e.g. non-NHS) ways of acting on determinants of health and well-being. In lower-income countries, it is more about filling the gaps that publicly-funded institutions and private companies (such as insurance companies) are not able or willing to enter. This convergence has manifested itself in the notion of social business, sometimes in the form of microcredit or microinsurance entities, as a potential way forward in addressing social problems, poverty and in potentially impacting on health and well-being, directly (through health care as a social business) or indirectly (non-health-care social businesses impacting on health and well-being).

In this paper, we discuss the ways in which social business might act on health and wellbeing first through delivery of health care in higher and lower-income countries, before focussing on the evaluation of 'social business as a public health intervention'. The latter is a new perspective. The success of social business is most often evaluated in terms of financial sustainability and outreach (the number of 'target beneficiaries' achieved). In this paper, the evaluative space is extended to encompass a wider set of outcomes that might be achieved. This step is necessary so that social businesses can be evaluated more in line with their stated missions. Also, although financial sustainability is a key aim for social businesses, some element of public (or other donor) funding is often required for start-up and perhaps on an ongoing basis; each of which may be justifiable within the wider framework of social evaluation offered in this paper.

Although not all of us are health economists, the perspective of this paper comes largely from that area of study. When thinking about 'social business and health', the natural inclination of many people is to think of the potential role for social businesses to operate in the field of health care delivery. Therefore, an explanation of why markets fail in health care is provided, using a conventional health economic case made for extensive government intervention in this area of the economy. We then explain how, even in the presence of such powerful arguments, significant potential and actual roles for social business remain either in service provision (largely in more–advanced economies) or in both funding and provision (in lower-income countries). Finally, we apply the notion of social business as a determinant of health, and provide a conceptual framework for evaluation, identifying broader outcomes for measurement. It will be seen that a key concept underlying the arguments in this paper is the 'caring externality'. If accepted, this notion strengthens potential justification of financial support from public funds for social businesses and for the wider evaluative framework posited. Due to its centrality to the case presented, this article takes as its point of departure a definition of this concept.

The caring externality

The 'caring externality' was first articulated by Culyer (1971). In theory, well-functioning insurance markets target low premiums to those at low risk and higher premiums to those at higher risk. In health, those at higher risk tend to be less-well-off, and thus unable to afford cover. Here, such 'adverse selection' means the market is actually working well, but perhaps too well in that adverse selection presents a social problem because we tend to care about lack of access to health care amongst less-well-off people. This is known as the 'caring externality'. It is referred to as an 'externality' and counts as 'market failure' because societies struggle voluntarily to transfer contributions from those willing to pay to enhance others' access; thus, the argument would lead us along the lines of saying that, if funded through entirely private means, health care would be underprovided because people's willingness to pay for others in addition to themselves has not been accounted for. Though carrying some negative benefits for some due to being compulsory, taxation is the most effective way of achieving the required transfers; bringing a double benefit of transferring income from rich and healthy to poor and unhealthy, as health tends to be associated with wealth.

It could also be argued that societies could 'deal with caring' through health care 'safety nets', such as the Medicare and the Medicaid systems for vulnerable groups in the US. However, in the US, this still leaves around one in six people uninsured or under-insured, which seems to go against the caring externality argument, and leaves the US as the main outlier amongst the advanced economies of the world in not being able (some would even say not willing) to ensure 100 per cent coverage of its population in terms of access to health care.

Culyer's great insight reflects a general concern with caring that has existed since the very beginning of economics. Although Adam Smith is often portrayed as the champion of self-interest, he merely recognised self-interest as but one characteristic of people, and not necessarily as a virtue. Equally, Smith recognised that, as social beings, people care about each other:

> "How selfishly soever man may be supposed, there are evidently some principles in his nature which interest him in the fortune of others, and render their happiness necessary to him, though he derives nothing from it except for the pleasure of seeing it."
>
> Smith (1759) *The Theory of Moral Sentiments*

Being a person of his time, Smith made little observation about health inequalities, but was of the view that governments should protect people by involvement in road building, public education, help for the destitute, provision of a system of justice and provision of 'cultural' activities for workers to offset the adverse effects of economic advancement.

More recently, in building the case for social business, Yunus (2010) points to the limits of conventional market-based economics in stating that:

> "And yet this selfless dimension has no role in economics."
>
> Yunus (2010) *Building Social Business*

It could be argued, therefore, that Yunus is using the 'caring externality' to make the case for a new type of non-dividend, non-profit-making business, where the main pursuit is driven by a social mission (such as health care provision, job creation for poverty-stricken youth, etc.).

Pursuit of a social mission itself may be enough to justify the need for measures of 'success' beyond financial return and outreach in the sense of who receives social business services. But, the caring externality argument is more far reaching. Sometimes in conjunction with other claimed sources of market failure, it provides justification for cross-subsidisation (often in the form of government intervention, but not necessarily so) of goods aimed at, or having the effect of, enhancing health and well-being. In the following two sections, these arguments are pursued with respect to health care financing in more and less advanced economies before being discussed in the wider context of social business as a determinant of health. If cross-subsidisation is justified, a further reason for evaluation using the framework outlined below is provided. If resources used in cross-subsidisation could have alternative uses, it is important, therefore, to know what benefits they achieve for resources invested via social business entities.

Market failure in health care

Health care as a 'commodity'

For the next few minutes, the reader is asked to think of health care as a 'commodity'. A commodity is essentially an item that can be exchanged in the market place, i.e. for which there is both a demand and a supply, each of which will interact to determine the optimal amount produced.[2] Although this may be an anathema to many, it is vital to the case for significant government intervention in the health care 'market', allowing us to focus only on the economic, as opposed to humanitarian and political, aspects of the debate.

Health economists make the case for extensive government intervention on the basis of 'market failure'. Markets are merely an efficient way of transferring information (on prices as well as quantities and quality of goods) from producers to consumers. Technically, markets fail when they are so restricted in the function of transmitting information between consumers and providers that government intervention (e.g. an NHS) becomes more efficient or equitable. This is different to the more populist use of the term 'market failure' which refers to outcomes or consequences of market transactions which people do not like. We will focus on the more technical definition, as that is more important in explaining government intervention, health care being a classic case of information transmission breaking down in several ways. In addition to the caring externality, where information on the full extent of caring is not able to be transferred via the market into adequate resourcing of services, what are the other ways in which information transmission breaks down, leading to government intervention in health care

[2] There are other aspects associated with being a commodity, the most important being that the good concerned is not qualitatively different no matter who produces or provides it; gold is gold, orange juice is orange juice etc.

being the global phenomenon it is? We will focus on notions of failing health insurance markets and of consumer ignorance.

However, before this, Table 1 illustrates what such market failure leads to, providing a list of OECD countries in terms of the amount per head that each spends on health care and the percentage of this which comes from the public purse. Of course, amounts of public money spent, and variations in this across countries, would indicate that politics plays a part. The years 1990 and 2006 are chosen arbitrarily to demonstrate that, despite small percentage changes up or down over time, expenditure from the public purse predominates and is sustained over time.

Table 1 Total health expenditure, and percentage of total which is public, in OECD countries (1990 and 2006)

Country	1990 total health exp US$PPP	% public	2006 total health exp US$PPP	% public	Absolute % increase
Australia	1318	67	3141	68	+1
Austria	1205	74	3606	76	+2
Canada	1678	75	3678	70	-5
Czech Rep	576	96	1509	88	-8
Denmark	1453	83	3362	84	+1
Finland	1292	81	2668	76	-5
France	1520	78	3449	80	+2
Germany	1602	76	3371	77	+1
Greece	707	63	2483	62	-1
Iceland	1376	87	3340	82	-5
Ireland	796	72	3082	78	+6
Italy	1321	78	2614	77	-1
Japan	1082	78	2578	81	+3
South Korea	371	37	1464	55	+18
Luxembourg	1486	93	4303	91	-2
Mexico	260	41	792	44	+3
Netherlands	1403	78	3516*	62	-16
N Zealand	937	82	1856#	78	-4
Norway	1363	83	4520	84	+1
Poland	258	96	910	70	-26
Portugal	614	65	2120	71	+6
Spain	815	79	2458	71	-8
Sweden	1492	90	3202	82	-8
Switzerland	1782	68	4311	60	-8
Turkey	171	61	591+	71	+10
UK	968	84	2670	87	+3
US	2738	40	6714	46	+6

Source: OECD Health Data 2008. * 2004. # 2003. + 2005
$PPP is simply a form of currency conversion making spends across countries more easily comparable

The case for market failure in health care is not new. Specific aspects have been well-rehearsed by Nobel laureates, such as Arrow (1963), as well as many other social policy commentators. (For more detailed arguments and relevant references, see Donaldson and Gerard (2005)).

The failure of health insurance and the problem of consumer ignorance

Without government intervention, an insurance market would develop to deal with unpredictable health care needs. Indeed, there are examples of such markets in various contexts around the world. However, insurance is particularly problematic in health care. First, fixed costs of billing and advertising tend to inflate premiums. Note the US, where one in four dollars of health expenditure is spent on administration. This prices some people out of the market who would otherwise have been willing to be insured at more actuarially-fair prices (i.e. premiums that reflect risk and not the add-on costs of administration). A larger, non-competitive company could spread such add-on costs across more enrollees, but equally such a monopolistic situation would present the opportunity for that company to exploit consumers. The only way to mitigate this problem without exploiting consumers is government intervention.

The second source of market failure in insurance is ‘moral hazard’, whereby the very act of becoming insured changes the way people behave. Because the concept of being insured encourages people to think that a third party (i.e. the insurer) will pay, the market fails to input cost considerations into the decisions of consumers and providers leading to cost inflation without much return in health benefits. This is the root of the continuing challenge of cost inflation in US health care, where entities that are one step further removed than insurance companies from the transaction (i.e. employers) pay many of the premiums; a combination of ‘fourth as well as third party pays’ leads to spiraling resource use.

The problem exists in public systems too, but government funding and supply side controls (through the ability to limit human and capital resource) allows the lid to be kept on costs. A naïve observer would say that user charges could control costs. However, charges choke off demand only amongst the poor (and less healthy), are indiscriminate in type of demand choked off (for needed as well as unneeded care) and do not control total costs anyway (as the system simply switches its care-giving powers to those willing and able to pay). It may also seem ironic that the greatest problems with cost control exist in those systems with the greatest prevalence of user charges, such as France and the US. The main arguments against user charges are outlined elsewhere by Evans et al. (1993).

Markets work well when consumers are well informed, which tends not to be the case in health care. Consumers are then protected in terms of quality through granting license to practice only to those with the qualifications to do so. By doing this, however, we indirectly give market power to professions. This requires what Evans (1987) has referred to as the ‘countervailing power’ of government, to promote a counter-balance to the market power of health professions in negotiating with these professions over rates of pay and provision of care.

What type of system?

The above arguments present a strong, many would say compelling, case for significant government intervention in health care, but does not prescribe exactly what form such intervention should take. Thus, although most advanced economies of the world seem to have adopted publicly-funded systems and many lower-income countries have adopted elements of such systems, the details of these systems vary greatly. Generally, however, three main types of public-funding exist, as listed in Table 2.

Table 2 Main types of publicly-funded health care systems

System	General description of source of funds and objectives
Beveridge	• Established in UK after Second World War, arising from Beveridge Report first published in 1943, and is basis for UK and other systems now. • Funded from central or regional taxation. • Aimed at covering all inhabitants from outset. • If taxes are progressive (whereby) higher earners pay a higher percentage of extra income earned to government, then this system can be highly redistributive (i.e. transferring resources from rich to poor).
Bismarck	• Often termed 'social insurance' and established in Germany in late 19th Century (under Chancellor Bismarck), although much developed since then but is still basis for system in Germany (and other countries) now. • Funded from contributions from employees/employers, but now with state subsidies. • Initially aimed at providing a level of cover for payers. • Culturally, does not have same explicit redistributive agenda as Beveridge-type systems, although older people and unemployed are covered by other sources of funding, such as state subsidies.
Semashko	• Established in countries of Eastern Europe under communism (and named after Nikolai Semashko, People's Commissar of Public Health in the Soviet Union from 1918 to 1930). • Funded from taxation, but now abolished and has developed to mirror Beveridge-type systems. • Given its origins, there is more emphasis within such a system on trying to achieve equality of services offered, although this is an issue in all systems, to a degree.

Despite the differences among systems it is likely the similarities are more significant for our purposes. Through different routes, there is an attempt at universal coverage of the population. This is generally achieved through some element of compulsion in that everyone has to pay their taxes or, in a Bismarkian-type system, everyone has to contribute to a sickness fund. People seem to accept this compulsion to contribute, although a *quid pro quo* is that richer people in most countries are free to 'top-up' their public coverage with private insurance and we allow physicians to supplement their public-sector incomes by spending limited amounts of time practising in this market.

Probably the final characteristic to note is that 'insurance' in these funding systems is based on groups, and not individuals as in a classic private insurance model. This means that attempts are made to work out entitlements for everyone, which obviously creates tensions as there are only limited resources available in total. A different kind of 'contract' is created between patients and payer in a public as opposed to a private system. Generally, people have to wait longer in publicly-funded systems because bed

occupancy rates tend to be higher; peak flows of demands on the system are harder to accommodate when, on average throughout the year, 90% of beds are occupied. In the US, only about two-thirds of beds are occupied on average; this is because, when one is paying privately, the ‘contract’ requires instant access to care once a diagnosis is made. Thus more ‘spare capacity’ is required of a private system to ensure peak flows of demand can be met. Another key aspect associated with publicly-funded health care, however, ensures that standards are maintained in such a constrained environment. With the vocal middle classes locked in, the demands they might place on the system in terms of maintenance of quality end up being of benefit to more vulnerable groups in society; our view is that such latter groups would get left behind in terms of standards of service offered if the middle classes were able to opt out completely.

The US, of course, embodies a ‘fourth way’ of dealing with market failure not listed in Table 2; that is, to attempt to plug the gaps for the vulnerable by having a Veterans Administration, Medicare for older people (and some other groups) and Medicaid (for those below a certain level of income). The rest is left to the market. This is a gross simplification of what is a very sophisticated health care system. For example, not everything is free at the point of delivery in the three public systems mentioned. The key point, however, is that around 50 million Americans fall between the cracks by being underinsured or having no private or public coverage. Fears abound as to what might have to be given up by those already covered if the US were to move to what is generally called a ‘single payer’ system so as to include those currently excluded. To ‘sell’ reforms to society at large, governments (not just in the US) tend to make them voluntary. The problem is, however, that voluntary reforms rarely work. All that happens with voluntary reforms in market-based systems is that those patients who are already low-cost, and who would likely financially benefit from the reform, make the required change. Those who would not benefit financially stay in the more-established part of the system and, overall, costs continue to rise without necessarily being focused on meeting most need. For example, a patient with a chronic illness who is being well-cared for in the existing part of the health care system (and whose care is paid for, after having paid their premium), may be very reluctant to move to a new form of coverage on the basis of lower cost, as they may perceive this as being of potentially lower quality. Meanwhile, a healthy, low-cost patient may see it as an opportunity to move to a lower cost part of the system. However, system costs overall will not change.

Health care reform and social business

It is unlikely, due to cultural and historical factors, that any given country would move from one to another of the general systems listed in Table 2. However, the basic point is that all such systems, including the US, are faced with the same fundamental problem; once prices at the point of consumption of health care are covered (or heavily subsidised) by the State, claims on resources will be greater than the total resource available. Scarcity needs to be managed, leading to a set of common policy questions across such systems.

One such question is whether, despite the above arguments ruling out the market as the basis for a whole health care system, there remains a role for the use of market forces

within a UK NHS-type framework. Internationally, many governments have experimented with such ‘internal markets’, although evidence on their impact on health care efficiency is sparse (Donaldson and Gerard, 2005). Essentially, such markets encourage health care providers to compete on quality and price in order to win contracts from public funders, such as health authorities. Large elements of this are also to with empowering service users (Le Grand, 2003). Recently, this policy agenda has been explicitly extended to social enterprises in the UK, especially in England. Although the Social Enterprise Coalition has estimated that over 6000 social enterprises already provide services to the NHS in England, the ‘Right to Request’ initiative has introduced the right for all primary care trust staff to request the setting up of social enterprises to provide a range of services (Department of Health, 2010). So far, these have included initiatives such as increasing access to psychological therapies, improving end of life care and widening the range of children’s services. Of course, this builds on the fact that social enterprises in UK have often filled a service ‘gap’, particularly in context of vulnerable groups such as the homeless and drug users.

Despite the paucity of rigorous evaluations of internal markets in general and the role of social enterprises in that, a key issue that is likely to grow in importance in coming years is that of the relative efficiency of social enterprises in providing publicly-funded health services. Within that the research questions are largely twofold. What are the relative costs, compared with more-traditional forms of provision? What of the quality of care provided and its associated health outcomes?

Lower-income countries: an exception to market failure arguments?

It is important to remember that, even in the poorest countries of the world, such as Bangladesh, 35-40% of health care expenditures come from the public purse. Thus the above arguments apply in that context. Nevertheless, one of the great ironies of health care financing is that, despite the strong equity-based arguments against use of market forces to finance health care, this type of financing is highly-prevalent in the lower-income countries of the world. As economies develop and eventually begin to think about funding a more coherent health care system, a major challenge is the level of state infrastructure necessary in order to collect funds. Many lower-income countries lack the kind of formal economy that would be recognised in many higher-income countries, making collection of funds (in the form of taxes) difficult. Such countries, therefore, tend to start by taxing groups that are easy to capture, such as civil servants and other public sector employees, with the remainder of the population facing either severely limited access or paying privately.

This is illustrated, at least in part, by Figure 1, adapted from the work of Normand and Busse (2000). A major task of all health care funding systems is to transfer funds from the population to health care providers. This can be done directly, via out-of-pocket payments (or user charges), or through payment into some sort of risk-pooling entity, which could be private or public. As economies and infrastructure develop, the aim of most health policy makers becomes that of moving from private forms of financing, on

the right side of Figure 1, towards mechanisms of public provision depicted on the left. Out-of-pocket payments and private insurance tend to be more regressive and the poorest and neediest pay a much higher proportion of their income towards health care. Indeed the poor are often excluded from markets altogether because of challenges of affordability.

This shift from the right to left, from private to public mechanisms is likely to be a slow process, but what are the masses of the least-well-off in the world to do in the meantime? Over the past 20-30 years, microinsurance has grown to provide basic packages of health services funded by poor people paying small sums to a collective, sometimes with some subsidies and often run as a social business (i.e. where surpluses are reinvested into services to continue meeting the social mission). It could be argued that this mimics what many people (especially in the West) might think of as the role of government (in Figure 2, this is illustrated by the dashed extension to the risk-pooling box in Figure 1). Out-of-pocket payments still tend to exist under such arrangements (as indeed they would under more standard private insurance). We now know, from the recent work of people like Dowla and Barua (2006), that even the poorest people, in global terms, will pay into such institutions. Thus microcredit is admitting people into the market who are willing to pay but who were excluded by previous institutional arrangements, whether through governments or large insurers. Given that many microinsurance organisations operate as social businesses, with a mission which is distinct from private providers, but where they also compete with such private providers in a 'market place', then whether this is a case of markets adapting or reparation of a form of market failure is not clear.

Figure 1 The main mechanisms for transferring health care payments from populations to providers

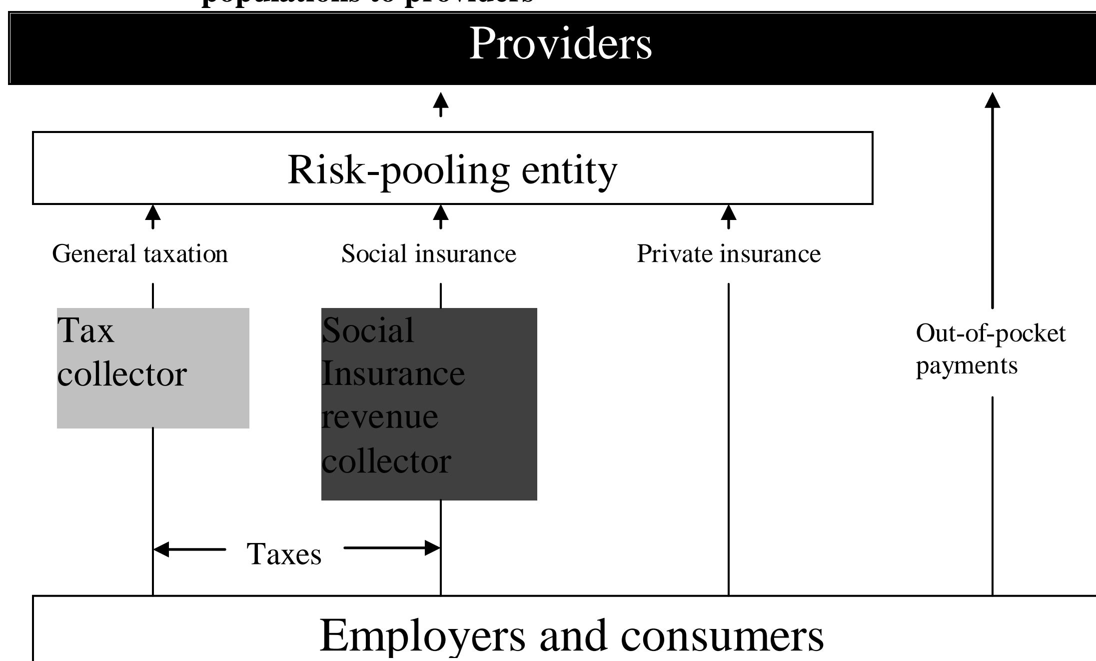
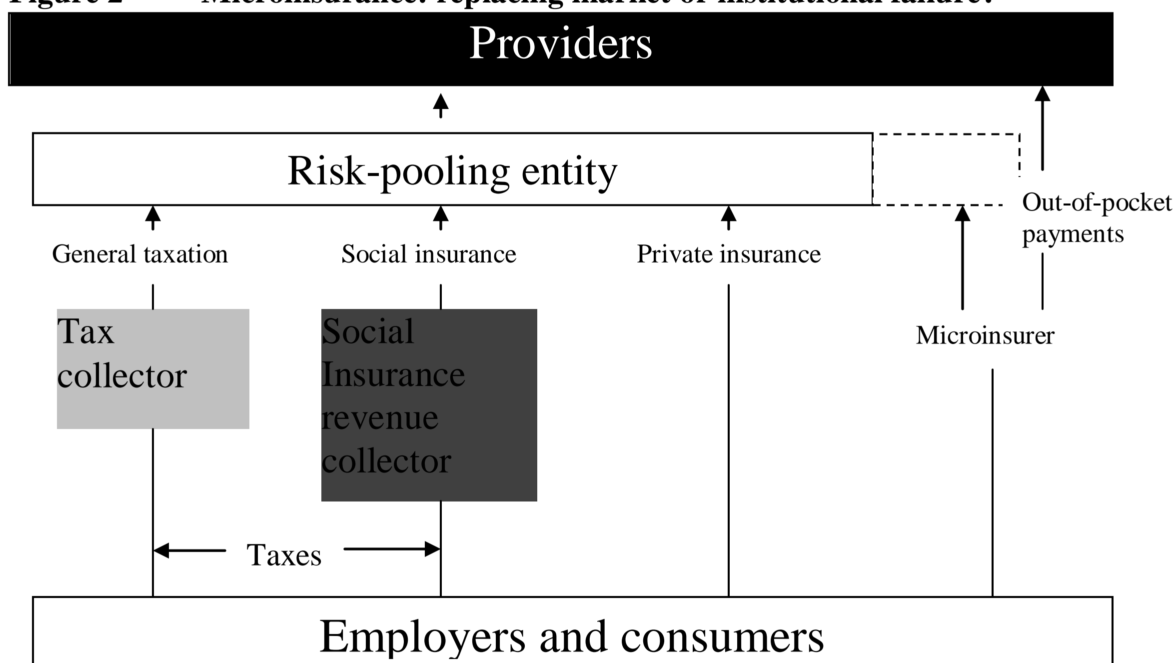


Figure 2 Microinsurance: replacing market or institutional failure?



To help address such a question, each of the main sources of market failure in health care, detailed above, can be considered in terms of microinsurance:

- One would expect microfinance organisations to face challenges with respect to meeting administration costs. As small entities, they are bound to experience challenges with diseconomies of small scale. Nevertheless, people still enrol and if attempts are made to ‘piggyback’ administration onto already-existing organisations (e.g. micro lenders in organisations such as BRAC and Grameen Bank in Bangladesh) scale economies can still be achieved.
- Moral hazard is less of a problem due to severe limits on total resources made available and, to some extent, user charges. The main moral hazard challenges are more structural in the sense of countries like Bangladesh having more doctors than nurses and the incentives to maintain such an arrangement. It is likely that greater efficiencies could be achieved through many of the main health-producing interventions being provided by nurses and other health workers which would allow for gains in health at less cost.
- Such organisations meet adverse selection issues head on. This is indeed inherent in their mission. Some will even go as far as to provide free care to the very poorest (who might live, say, in camps), subsidised by other payers who, though still poor, are slightly better off.
- Since microinsurance can be seen as a direct response to adverse selection, it could be argued that the caring externality is internalised. However, this may make the meeting of the financial sustainability goal of social (or any) businesses of this nature very challenging. Indeed, many such organisations will receive subsidies either from a larger umbrella organisation or through donations. Although many health microfinance organisations are acutely aware of the need

to become self-sustaining, such subsidy can be justified through the caring externality argument invoked by Culyer (1971) for health care whereby people are willing to make transfers to satisfy their caring externality and thus see enhancement of opportunities for others in accessing such care, leading to an overall net gain in social welfare.

- Asymmetry of knowledge between consumer and provider remains an issue in such organisations, as in all forms of health care. Without countervailing power, provider capture, especially by the most powerful professions (usually doctors), remains a risk, as discussed under the point about moral hazard above.

Nevertheless, as we have said, it would certainly seem to be the case that microinsurance has, in part, filled a gap that governments and large financial institutions either would or could not. This poses some interesting questions for future research. In relation to Figures 1 and 2, will it be the case that the dynamic of shifting from right to left of these figures over time continues in the future now that microinsurance has begun to fill the financing and provision gaps on the right? What will the health care systems of the future look like as lower-income economies develop? With microinsurance taking a foothold, it would seem that moves to State-led solutions over time might not be as straightforward as we might once have assumed. If this is the case, with microinsurers operating on more of a social business model (i.e. with a social rather than profit-led mission and, thus, ploughing any surpluses back into service development) and having shown that the poor will pay, will they be able to retain the loyalty of their customers, particularly if for-profit private insurers spot opportunities to move into such markets? What questions, if any, might this raise for regulation of such markets?

Operationally, these newer forms of health care financing face the same global challenges of managing scarcity of resources that challenge all types of health system. If public funding is required, what should be its extent? What are the most efficient ways of providing services to meet health needs and by what criteria should these be assessed?

Social business and determinants of health and well-being

Beyond social businesses providing health services and an alternative to traditional health insurance (or out-of-pocket payments), there is a bigger picture to consider. That is of participation in social business itself acting as potential determinant of improved health and well-being or even delivery of 'social goods' having an indirect impact on health and wellbeing (i.e. not just through employing people, but because their very raison d'être is to enhance a community or to improve the quality of life of deprived or excluded people). Indeed, many social businesses would express their missions in such terms – e.g. through providing opportunities for people who would otherwise be long-term unemployed, communities can be sustained, dignity restored (or enhanced) etc. Given such stated aims, it could be argued that this alone provides adequate justification for evaluating social business in such terms. However, another reason for justifying such evaluations is, once again, the caring externality. If society cares about such social goals and is willing to transfer some resources, often public, to support their pursuit through social business,

then it is important to assess the extent to which such goals are attained because such transfers always have alterative uses – or opportunity costs.

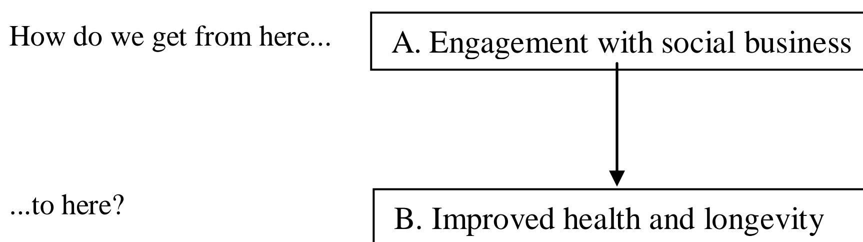
With governments looking for new ways to manage welfare and also to new solutions for the sustained public health challenges outlined at the start of this paper, it will be important to be able to monitor the longer-term success (or otherwise) of such alternatives. Starting social businesses to meet health and other social needs is one alternative, as is encouragement of less-well-off people to actually participate in social business.

But how is the evaluation of such policy initiatives to be done? Here we provide merely a brief framework which indicates the types of study we would hope to see in *Social Business* in the future and acts as something upon which to build.

Social business, health and well-being: the 'causal' chain

If improvements in well-being were to be characterised as leading to enhanced health and longevity in the future, this then begs the question of how we get from A to B in Figure 3.

Figure 3 The causal chain of social business and health: getting from A to B?

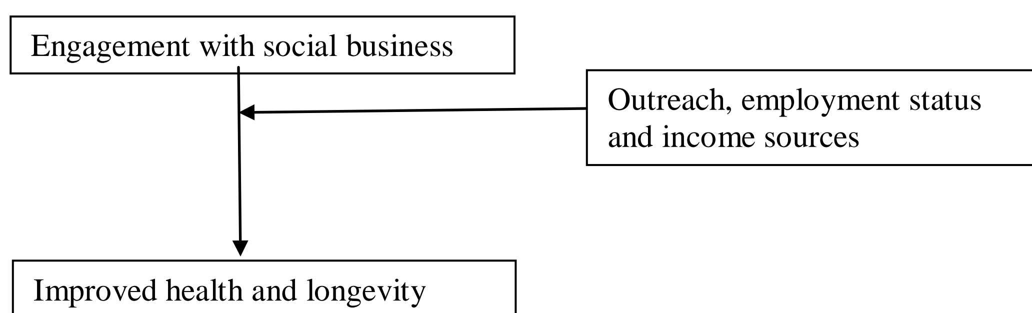


To answer this, we first need to establish the plausible mechanisms of getting from A to B, and then attempt to measure them. Some such mechanisms are more obvious than others. A simple model for an evaluation, based on a 'determinants of health' framework of Mohindra and Haddad (2005), is built up in the following Figures.

For now, the relationship in Figure 3 is posited because we know income is strongly related to health, and the views of many experts are that income redistribution is the surest way to achieve reductions in health inequalities. There is evidence that societies which are more equal in terms of income redistribution and perceptions of social position also do better in terms of overall health measures (Wilkinson and Pickett, 2006). As already discussed, with little political desire at present for (income) redistributive policies along these lines in many such countries, social business and microcredit could be considered as ways to achieve this. It would at least redistribute income from savers (and other donors) to borrowers and, in cases of successful enterprises built upon such credit, ensure income enhancement for beneficiaries and their families. It may also decrease reliance on the welfare system and engender extra impacts from people helping themselves.

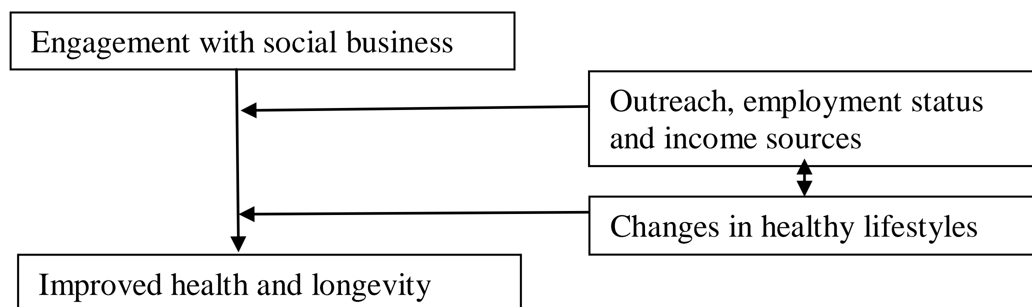
Other links are more tenuous, but still plausible – see Figure 4 - because there is evidence that these things are all linked; but tenuous because we know a lot less about whether acting on these variables in some way can exert a positive impact on outcomes. On the face of it, it may seem that microcredit and other social business innovations provide a possible solution to the chronic problem of worklessness[3] that exists in so many low-income communities. Indeed, this is why it is worth a try. However, it would require monitoring not only of income levels of intervention recipients, but also of whether such services reach those for whom they were initially intended. This is especially necessary in countries with well-established welfare systems through which some level of income-support is already provided and may indeed militate against engagement with some such interventions, such as microcredit.

Figure 4 The causal chain of social business and health: intermediate outcomes I



One may also question how it is the case that engaging with social business interventions should change the lifestyles of loan recipients in ways consistent with ultimate health improvement. If health improvement were to follow in the long run, might we expect to observe changes in smoking behaviour, environment, diet, physical activity and the like in the interim? Hence, the further addition, now to Figure 5. Again, this would require collection of data from loan recipients over time on such aspects and comparison of these data with trends in the general population and also in equally-deprived areas with no access to social business interventions.

Figure 5 The causal chain of social business and health: intermediate outcomes II

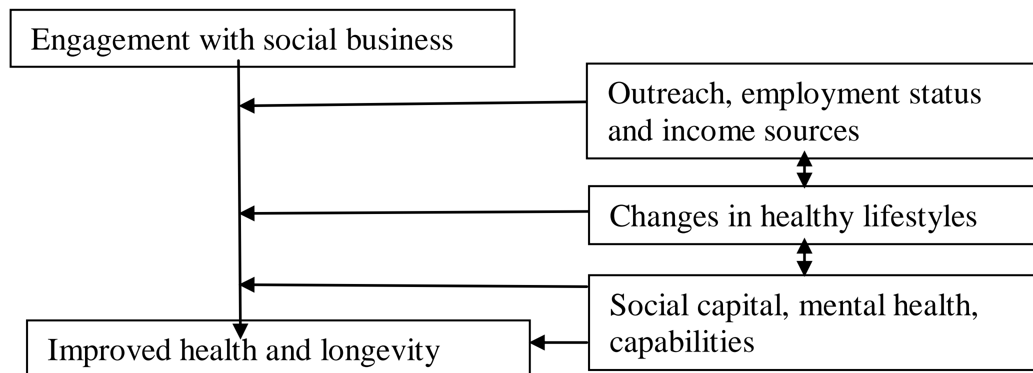


[3] This often referred to as 'worklessness', the rather trendy and non-specific term that does however serve a useful purpose of highlighting the issue of economic inactivity as well as unemployment. It is often used to refer to people who, it is claimed, are not seeking work, families in which no-one is employed and communities with major problems of unemployment and economic inactivity, often experienced not only in high rates amongst the population at any one time but also over time and, on occasion, across generations.

Social business, social capital and happiness

Completing this simple model (see Figure 6), in many respects, social business-type interventions rely on 'social capital', the idea that, with a little help, a community can group together and make quite significant advances in improving itself. But does it also add to social capital? Again, such impacts on the wider community in terms of its cohesiveness can, to an extent, be measured (Pronyk et al., 2008; Bynner and Paxton, 2001). At the most basic level, do beneficiaries of social business stay in their communities or migrate from them? Likewise, the psychological health of individuals in such communities can also be tracked over time and measured against relevant comparators. Indeed interventions to supplement income have been criticised for missing major opportunities to assess impacts on health outcomes (Conner et al., 1999; Ludbrook and Porter, 2004). Going beyond what might be seen as narrower health outcomes, health researchers have been active in trying to operationalise Sen's notion of capabilities into parsimonious measures to be applied to study participants over time (Coast et al., 2008) and aspects such as dignity and autonomy can be captured by measures of confidence and ego development from psychology (Loevinger, 2006; Eriksson and Lindstrom, 2005). Currently, we are undertaking a systematic review of the literature, using the method recommended by the Cochrane Collaboration, in order to examine whether microcredit is effective in producing health outcomes in the general population and in people of low socio-economic status in particular.

Figure 6 The causal chain of social business and health: towards final outcomes



All of the above mechanisms have been portrayed in what might seem like a rather quantitative 'model' linking income, money and enterprise to health and happiness. However, to gain a richer understanding of how social business can enhance people's lives, or what the barriers to success might be, rigorous qualitative research is also required to explain the links in the model through the personal stories of intervention recipients. Furthermore, the relationships may often not be as linear as portrayed by the arrows in the diagram. For example, one may first build social capital which then leads on to improvements in healthy lifestyles, leading through to ultimate health improvements.

Conclusion

Meeting health and health care needs and reducing inequalities in health and well-being are fundamental roles of societies. Nevertheless, these challenges are persistent and stubborn both globally and within countries. Social business is but one solution upon which policy makers seem to have converged across countries in recent years.

In aiming to provide solutions to health care access and also to other social challenges, social business can act as a determinant of health and well-being. This leads us to a framework that opens the 'evaluative space' for social business beyond financial payback and outreach, important though these may be.

We hope the framework we have outlined can be seen not only as outlining an agenda for research action but also something to be further theorised and conceptualised through applied studies of 'social business, health and wellbeing'.

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