

**A study of social enterprise in health policy:  
Comparative approaches where resource and  
policy context differ**

Elizabeth Shan Watson

Submitted in accordance with the requirements for the degree of  
PhD

The University of Leeds  
Leeds University Business School

May 2017

The candidate confirms that the work submitted is his/her own and that appropriate credit has been given where reference has been made to the work of others.

This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

*Assertion of moral rights (optional):*

The right of Elizabeth Watson to be identified as Author of this work has been asserted by her in accordance with the Copyright, Designs and Patents Act 1988.

© 2017 The University of Leeds and Elizabeth Watson

## **Acknowledgements**

Studying for a PhD was always something I wanted to do but never had the time. So revisiting academic life after a twenty-year gap offered the opportunity to develop greater depth of knowledge about social enterprise in health systems but also to pursue a personal interest in other cultures. I came to this research with some clear goals, one of which was to take this opportunity to explore the health system in a low to middle income country, which was where I began my career.

My personal focus therefore presented some challenges for my supervisors. Firstly, I would like to express my sincere gratitude to my advisors Professor Richard Thorpe and Associate Professor Tolib Mirzoev for their continuous support of my PhD study; their patience, motivation and flexibility in their approach to this research. I enjoyed their intellectual challenge and honesty. My thanks also go to Dr Dereck Chitama and Dr Stephen Maluka who provided me with the opportunity to go to Tanzania to undertake my research.

This research would not have been possible without senior people agreeing to be interviewed. They found time in their busy schedules to talk to me and then to comment on some of the ideas that emerged. I am also conscious that, in England especially, they trusted me to respect sensitive political and personal positions.

Thank you also to Nashi, Kwame and their friends and relatives for making my stay in Tanzania fun and sorting out the day to day personal challenges of working in a different culture.

Finally, thanks go to my family for their understanding and empathy as fellow academic travellers in the continuously debated and contrasting approaches of natural science versus social science research.

## **Abstract**

National and international policy actors use social enterprises in health system reform, but their meaning is contested. This inter-disciplinary research examines the logics of social enterprise. It contributes to health policy development in England and Tanzania by developing knowledge and theory of how and why they are used in health system reform.

Institutional logic provides the inductive research framework using comparative, cross sectional case study design. Data collection methods included interviews with policy actors, literature, websites and other media using content, context, time series and narrative analysis.

Three core characteristics of social enterprise were common to England and Tanzania: a social purpose, furthered with use of profits and social entrepreneurial outlook of actors in response to a market. The social determinants of health could be aligned with organisations' social purpose. Three groups of organisations emerged: Holistic, Health care and Lifestyle. Social enterprises' organisational strategies and their business models in each of these groups both respond to and are contingent on the state and market design of the health system.

Socio-cultural and resource contexts constrained or enabled social entrepreneurs' ability to achieve social innovation. The contribution of social enterprises to achieving health equity goals are not translated into the logic of state funded health care services or the market in either country. This is despite advocacy by policy actors and social enterprise policies in England. In Tanzania policy makers do not recognise the potential of social enterprises to achieve health equity goals. In both countries policy implementers and influencers were able to demonstrate how they contribute to health equity through their organisational strategies. Some social entrepreneurs acted collectively as institutional entrepreneurs to advocate for health system change.

A framework and a diagnostic tool have been developed which contain the contingent variables required to introduce this logic into a health system.

## Glossary

The glossary below gives working definitions or interpretations of terms which are explored more fully in the literature review and methodology chapters.

Term	Meaning
Asset Lock	<p>Seen as a key component of social enterprise organisations in England to retain assets to further the social mission of the organisation and prevent external shareholder driven companies from taking over successful social enterprises and using their assets for private gain. Thought to address public concern about privatisation of the NHS.</p> <p>An Asset Lock is designed to ensure that the assets of an organization are used for the benefit of the community. Restrictions may be placed on the transfer of assets to retain them for the benefit of the community. See for example, the guidance on asset locks for community interest companies. OFFICE OF THE REGULATOR OF COMMUNITY INTEREST COMPANIES 2014. Chapter 6 Asset Lock Information and Guidance notes Department for business innovations &amp; skills,.</p>
Business model and Care Model	<p>I have interpreted a business model in this thesis as a component of a care model.</p> <p>Care Model: For the purpose of this research, I am drawing on the chronic care model which includes the following elements:</p> <ul style="list-style-type: none"><li>- Health care organisation: including leadership which creates culture and mechanisms to promote safe, high quality care</li><li>- Self management by the patient: using techniques such as collaborative assessment, goal setting, action planning, problem solving around patient goals</li><li>- Delivery system: ensures effective and efficient clinical care and self management support</li><li>- Decision support: evidence based care is supported, incorporating patient preferences</li><li>- Partnerships with the community are established to provide resources to meet patient needs (eg housing)</li></ul> <p>The care model may change depending on factors such as new evidence, new technologies, changes to funding regimes, new clinical roles or changes to the environment within which care is provided.</p> <p>Business Model: I have used the term business model as both an organisational and care model concept. The</p>

Term	Meaning
	business model is created by the organisation. At an organisational level, it uses the principles of a care model applied to a population (eg a service such as dental care to vulnerable people, or problem such as diabetes). It would not usually apply to individual patient care.
Capacity (in relation to health systems)	Capacity includes the system, organization and individual levels in a health system (LaFond et al., 2002) in relation to a hierarchy of needs ie that skills, tools, staff and infrastructure as well as structures, systems and roles need to be in place to improve the performance of the health system.(Potter and Brough, 2004)
Civil Society	Civil society organisations are self governing private organisations, which people are free to join and to act to achieve social objectives (Heinrich and Malena, 2008, International Centre for Research and Information on the Public, 2007, Salamon et al., 2003)
Community Interest Company	A limited company, with special additional features, created for the use of people who want to conduct a business or other activity for community benefit, and not purely for private advantage. (UK Government, 2016)
Foundation Trusts	NHS foundation trusts, first introduced in England in April 2004, differ from other existing NHS trusts. They are independent legal entities and have unique governance arrangements. They are accountable to local people, who can become members and governors. Each NHS foundation trust has a duty to consult and involve a board of governors (including patients, staff, members of the public, and partner organisations) in the strategic planning of the organisation. They have financial freedoms and can raise capital from both the public and private sectors within borrowing limits They can retain financial surpluses to invest in the delivery of new NHS services.
Health policy	Provides an overall strategic direction for health system development. It can be interpreted as a 'central' element of the health system and one of WHO's (2007) governance building blocks.
Health system change (or reform)	Health system reform involves 'a significant, purposeful effort to improve the performance of the health-care system'. Reforms differ along at least two dimensions: (1) the number of aspects of the health-care system that are changed, and (2) how radically the changes depart from past practice. (Roberts et al., 2008 their emphasis reproduced)
Health system	'The multiple relationships and interactions among the building blocks....that convert these blocks into a system'. (De Savigny and Adam, 2009). The building blocks include

Term	Meaning
	leadership/governance, information, financing, service delivery, human resources, medicines and technology, and the general public. It may also include the logic and values underpinning it.
Health system research	Study of the ‘governance, financial and delivery arrangements for health care and population health services and the broader context in which they are negotiated, implemented and reformed’ pg 19 Hoffman et al, 2012
Institutional logic	Institutional logic is a meta-theory and form of analysis which aims to explain organisational and individual behaviour by considering the social and institutional contexts of actors. (Thornton and Ocasio, 2008)
Institutional Entrepreneur	Institutional entrepreneurs are actors who have an interest in modifying institutional structures or in creating new ones. They leverage resources to create new institutions or transform existing ones (Fligstein, 1997 quoted in Mari & Marti, 2008 pg 40). They compete for the ability to own and frame an idea so that they can express their own self interest in shaping how an idea is institutionalised. (Hardy and Maguire, 2008, Thornton et al., 2012)
ISTC: Independent Sector Treatment Center	ISTCs are independent treatment centers introduced in the NHS Plan in 2000. They aim to perform high volume surgery in areas such as hip replacement, cataract surgery and diagnostic services. The rationale was that waiting times could be cut by separating out high volume, planned surgery from other types of more complex planned and unplanned surgery.
Market forces	In health care Enthoven (2004) describes “market forces” as requiring certain fundamental conditions ie that the buyers are (reasonably well) informed, are using their own money (at least at the margin), and face a choice among competing alternative suppliers. (Enthoven, 2004). Markets may be shaped by the culture and social structure of a system reflecting power, status and domination of social relationships.(Granovetter quoted in Thornton et al., 2012)
NGO: Non Governmental Organisation	Any non governmental institution, independent of governmental control. The use of this term is controversial. I have used it to mean any organization, independent of government control which may or may not hold a contract for the provision of health care services.
NHS	The National Health Service (NHS) provides health care for all UK citizens. In the main, it is free at the point of care and funded by UK taxpayers. It is governed by a constitution. It is managed according to principles and values. (NHS England, 2016a)

Term	Meaning
PPP: Public Private Partnership	A contract between the government and a private company to deliver health care services. The private company may or may not take on some or all of the risks of service provision.
Right to Provide, Right to Request and Pathfinder Social Enterprise	<p>The Department of Health has led other government departments in enabling staff to form mutuals and leave public sector management. Staff-led enterprises have an important role to play in meeting the Government's commitment to improve choice and quality in the delivery of healthcare services.</p> <p>Right to Provide: On 30th March 2011, the Department of Health launched the Right to Provide. It enables NHS and social care staff to apply to their host organisation to set up a staff-led social enterprise.</p> <p>Right to Request (2008): The Right to Provide follows the success of the Right to Request. The Right to Request was open to all staff who deliver clinical care in the community under the Transforming Community Services initiative. 40 services, involving approximately 20,000 NHS staff, left direct NHS management to form social enterprises (Cabinet Office, 2014) It followed the Pathfinder programme (2006) which experimented on a small scale with social enterprises in the NHS.</p>
Social enterprise investment fund (SEIF)	The Social Enterprise Investment Fund or SEIF was set up in 2007 by the Department of Health to invest in social enterprises providing health and social care services in England. The Fund aims to enhance the role of social enterprise in the provision of health and social care. Since it began in 2007 the SEIF has invested more than £110million in the health and social care sector (Social Investment Business, 2016)
Social entrepreneurship	'the innovative use and combination of resources to pursue opportunities to catalyse social change and or address social needs'(Mair and Marti, 2006)
Social movement	Mair & Marti (2006) summarise the focus of social movement researchers : (1) political opportunities and threats; (2) resource mobilizing structures and active appropriation of sites for mobilization; (3) collective action frames and identity formation; and (4) established repertoires of contention and innovative collective action by challengers and their member opponents(McAdam, Tarrow, & Tilly, 2001 quoted in Mari & Marti, 2006, pg 41)
Transforming Community	Transforming Community Services (TCS) is a Department of Health programme of work set up to remove all clinical service provision from commissioners (PCTs) by April



<b>Term</b>	<b>Meaning</b>
Services	2011.To support these changes, PCTs were given 10 model options for their community services provider arms. The three most prevalent options that have been chosen as TCS models are: Integration with an existing NHS Trust; Formation of a new Community Foundation Trust (CFT) and formation of a new Social Enterprise organisation

## Table of Contents

<b>Acknowledgements</b> .....	<b>iii</b>
<b>Abstract</b> .....	<b>iv</b>
<b>Glossary</b> .....	<b>v</b>
<b>Table of Contents</b> .....	<b>x</b>
<b>List of Tables</b> .....	<b>xv</b>
<b>List of Boxes</b> .....	<b>xvii</b>
<b>List of Figures</b> .....	<b>xviii</b>
<b>Chapter 1 Introduction</b> .....	<b>1</b>
<b>Chapter 2 Social enterprise in health systems, an institutional logic approach</b> .....	<b>7</b>
2.1 Introduction.....	7
2.2 Institutional logic as a meta-theory.....	8
2.3 Part 1: Health systems in institutional logic and the role of Governments.....	12
2.3.1 Scope and meaning of health systems concepts.....	13
2.3.2 Role of governments in health system context .....	15
2.3.3 Implications of the health systems literature on the research methodology.....	17
2.4 Part 2: The concept of social enterprise.....	19
2.4.1 Social and economic criteria .....	20
2.4.2 Using organisational culture to define meaning .....	21
2.4.3 Cross cultural definitions in international contexts .....	24
2.4.4 Political definitions of the term .....	27
2.4.5 Implications of different meanings on the research methodology.....	28
2.5 Part 3: Institutional logic and social change .....	28
2.5.1 Change theme 1: Historical contingency of socio-political change .....	30
2.5.2 Change theme 2: Creating social value through social innovation.....	32
2.5.3 Change theme 3: Using health care markets to achieve social change .....	35
2.5.4 Change theme 4: Social entrepreneurs advocating social change .....	37

2.5.5 Implication of social change for research methodology .....	39
2.6 Implications of this review for the research methodology.....	39
2.7 Conclusions.....	43
<b>Chapter 3 Research Methodology .....</b>	<b>45</b>
3.1 Introduction.....	45
3.2 Overview of research methodology.....	46
3.3 Study Design .....	50
3.3.1 Scoping the comparative case study design.....	52
3.3.2 Criteria and process for identifying the second country case study .....	53
3.3.3 Research themes .....	58
3.3.4 Research process .....	61
3.4 Data collection methods .....	64
3.4.1 Documentation .....	65
3.4.2 In depth interviews .....	67
3.4.3 Direct observation and participant observation .....	71
3.5 Data analysis.....	72
3.5.1 Overview of analytical procedure .....	72
3.5.2 How analytical steps were followed .....	75
3.5.3 Theory building.....	80
3.6 Role of the researcher.....	82
3.7 Study Limitations .....	85
3.8 Conclusions and summary.....	87
<b>Chapter 4 Comparing the resource base in England and Tanzania: social enterprise context.....</b>	<b>89</b>
4.1 Introduction.....	89
4.2 Health system vision and priorities in England and Tanzania .....	89
4.3 Scope of state funded health care.....	99
4.4 Implications of resource context for social entrepreneurs .....	101
4.4.1 Securing investment to fund the growth of social enterprise .....	101
4.4.2 Building human resource capacity in social enterprises ...	105
4.5 Implications of the resource base for social enterprise logic.....	107
<b>Chapter 5 Meaning of Social Enterprise in England and Tanzania .....</b>	<b>109</b>
5.1 Introduction.....	109
5.2 The term social enterprise: definitions and characteristics.....	109

5.2.1 Core characteristics of social enterprise .....	112
5.2.2 Other characteristics of social enterprise .....	116
5.2.3 Core and non core characteristics of social enterprises ...	119
5.3 Political definitions of the term social enterprise in England .....	119
5.4 Awareness of the term and 'fit' with health policy in Tanzania .....	122
5.5 Aligning social enterprise with a community logic .....	124
5.6 The institutional orders of religion, corporation and profession....	127
5.6.1 CSSC and Kilimanjaro Christian Medical Centre (KCMC)	128
5.6.2 PRINMAT: an example of Professional and Community Institutional Orders .....	134
5.7 Integrating the social mission with social determinants of health.	136
5.7.1 Holistic social enterprises (Group A).....	138
5.7.2 Health care social enterprises (Group B) .....	139
5.7.3 Lifestyle social enterprises (Group C) .....	140
5.7.4 Using the social determinants of health and organisational strategies to effect social change .....	141
5.8 Using social value in health care markets .....	142
5.9 Conclusions.....	146

## **Chapter 6 Rationale for and process of introducing social enterprise 148**

6.1 Introduction.....	148
6.2 Why have privately managed organisations in health systems....	149
6.2.1 Innovation.....	150
6.2.2 Choice .....	152
6.2.3 Capacity .....	153
6.2.4 Expertise .....	154
6.2.5 Employment .....	154
6.2.6 Reducing financial risk for the state .....	155
6.2.7 Challenges for social enterprise.....	155
6.3 How private organisations are embedded in health systems .....	156
6.3.1 Relative contribution of privately managed organisations.	156
6.3.2 Historical contingency in the role of the private sector in health care systems .....	158
6.3.3 Market Logic.....	162
6.3.4 The role of event sequencing as a change process.....	167
6.4 NHS managed staff form social enterprises in England.....	168
6.5 Using structural overlap as a change strategy .....	177

6.6 Summary and conclusions .....	180
<b>Chapter 7 Institutional entrepreneurs advocacy strategies to introduce social enterprise .....</b>	<b>183</b>
7.1 Introduction.....	183
7.2 How social entrepreneurs influence the social enterprise agenda	185
7.2.1 Engaging in formal committee structures .....	185
7.2.2 Change by example .....	187
7.2.3 Lobbyists advocating for an organisational form.....	187
7.2.4 Advocacy by Politicians.....	188
7.2.5 Influencing the Influencers .....	191
7.2.6 Stakeholder management .....	193
7.2.7 Sharing knowledge. International influence .....	198
7.3 Implementation of ideas on social value .....	199
7.4 Learning from organisations outside the health system .....	202
7.4.1 Democratic participation in organisational form or culture	203
7.4.2 Partnerships with organisations outside of the health field	205
7.4.3 Building relationships within a locality to address the social determinants of health.....	206
7.5 Translating wants of customers into advocacy for system change	207
7.6 Use of evidence.....	210
7.7 Impact of social entrepreneurs advocacy in England.....	211
7.8 Conclusions.....	216
<b>Chapter 8 Discussion and conclusions .....</b>	<b>218</b>
8.1 Introduction .....	218
8.2 Conceptualising health systems.....	219
8.2.1 Embedding institutional logic into health systems.....	219
8.2.2 Applying health system framework to health policy development.....	223
8.2.3 Implications for the development of theory .....	228
8.3 The conceptualisation of social enterprise .....	229
8.3.1 The logic of social enterprise in England and Tanzania....	230
8.3.2 Changing the meaning of social enterprise over time .....	235
8.3.3 Implications of social enterprise logic for health systems design.....	238
8.4 Using social enterprises to achieve social change.....	239
8.4.1 Developing capability and capacity in new ways .....	241

8.4.2 Creating different types of service innovation .....	242
8.4.3 Managing the tension between social and economic value	243
8.4.4 Application of social enterprise logic to organisational planning.....	245
8.4.5 Implications of social innovation for development of theory	248
8.5 Research objectives and recommendations .....	250
8.6 Conclusions.....	255
<b>List of References .....</b>	<b>257</b>
<b>Annex A Personal perspectives on social enterprise.....</b>	<b>273</b>
<b>Annex B Definitions of statistics used.....</b>	<b>277</b>
<b>Annex C Politicians mentioned by interviewees.....</b>	<b>279</b>
<b>Annex D Diagnostic tool for policy actors .....</b>	<b>281</b>
<b>Annex E Detailed recommendations for policy actors and researchers .....</b>	<b>292</b>

## List of Tables

Table 2.1 Interinstitutional System Ideal Types .....	9
Table 2.2 Nine criteria to describe an 'ideal' social enterprise .....	21
Table 3.1 Countries considered against criteria .....	55
Table 3.2 Research themes .....	60
Table 3.3 Sources of Data for the Study .....	64
Table 3.4 Published data collected for research .....	66
Table 3.5 Policy Actors and scope of data collection in each country .....	69
Table 3.6 Number of interviewees approached compared to the number agreeing to interview in England.....	70
Table 4.1 Demographic statistics for England and Tanzania.....	91
Table 4.2 Health priorities: England and Tanzania.....	95
Table 4.3 Comparison of health priorities and opportunities for social enterprises .....	97
Table 4.4 Options to attract investment .....	102
Table 5.1 Number of interviewees recognising the term social enterprise.....	111
Table 5.2 Perceived characteristics of social enterprises in each country .....	111
Table 5.3 Analysis of Community Logic Categories with Interviewee responses .....	125
Table 5.4 Application of institutional orders and categories of institutional logic to case studies .....	132
Table 5.5 Combining Professional logic with social value.....	135
Table 5.6 Alignment of social mission with social determinants of health.....	137
Table 5.7 Alignment of Social enterprises client groups with their social mission .....	138
Table 6.1 Explanations for private sector provision of Health Services .....	149
Table 6.2 Total Number of Facilities in Tanzania by Facility Type and % of Total Health Expenditure by Facility Type .....	157
Table 6.3 Roles and principles of Monitor and PPP.....	166
Table 6.4 Number of interviewees referencing reasons for social enterprises emerging in policy making in England .....	169
Table 7.1 Change Strategies adopted by social entrepreneurs .....	184

<b>Table 7.2 Comparison of personal experiences setting up Social Enterprises .....</b>	<b>195</b>
<b>Table 8.1 Linking institutional logic, research results and diagnostic tool.....</b>	<b>225</b>
<b>Table D.1 Scoring each dimension for the domain health system capacity .....</b>	<b>284</b>
<b>Table D.2 Composite measure for market .....</b>	<b>288</b>



## List of Boxes

<b>Box 5.1 Business principles and Social Enterprise Characteristics: Interview discussion .....</b>	<b>114</b>
<b>Box 5.2 PRINMAT .....</b>	<b>134</b>
<b>Box 5.3 Legislation: The Public Services (Social Value) Act 2012 .....</b>	<b>144</b>
<b>Box 7.1 Social Enterprise in Primary and Community Care. ....</b>	<b>190</b>
<b>Box 7.2 Health B4 Profit Unite the Union. An example of stakeholder resistance .....</b>	<b>191</b>

## List of Figures

Figure 2.1 Different levels of Health Systems .....	14
Figure 2.2 Proposed health systems framework.....	42
Figure 3.1 Overview of research methodology .....	47
Figure 3.2 Scope of research .....	48
Figure 3.3 Research process .....	62
Figure 4.1 Annual Percentage growth rate of GDP .....	92
Figure 4.2 Human Development Index (points): Great Britain (GB) and Tanzania (United Nations, 2014) .....	93
Figure 4.3 Government expenditure (billions US\$) Great Britain (GB) and Tanzania .....	93
Figure 5.1 Aligning social enterprise with social determinants of health conceptual framework .....	141
Figure 6.1 Tanzania: Legislation over time and health policy challenges.....	159
Figure 6.2 Emerging democratic organisations or organisations with a social mission between 1975 and 2015 in England .....	161
Figure 6.3 Overview of the NHS Market .....	163
Figure 6.4 Power & Health system strengthening in England .....	174
Figure 7.1 Frequency of the use the term ‘Social Enterprise’ by newspaper by year .....	208
Figure 7.2 Types of Change used by policy actors to support emergence of social enterprises in England.....	215
Figure 8.1 Different levels of health systems, institutional logic and change.....	220
Figure 8.2 Proposed diagnostic tool for policy stakeholders .....	227
Figure 8.3 Core and Non Core Organisational Design Options.....	231
Figure 8.4 the Social Enterprise planning cycle: Building on social value .....	246

## Chapter 1 Introduction

‘Everyone has to be a change maker, because if you aren’t able to contribute to change, you’re not going to be a player’ Bill Drayton, CEO and Chair ASHOKA (Drayton, 2011)

This statement made by Bill Drayton, CEO and Chair of ASHOKA at the World Skoll Foundation conference for social entrepreneurship in Oxford in 2011 captured the hearts and minds of aspiring social entrepreneurs. I quote it to reflect the growing interest amongst policy makers, economists, politicians and citizens in creating a new world order, where individuals and communities adopt business principles to effect improvements in society.

Some Government policies at the beginning of the 21st Century particularly in Europe and the US support the growth of ‘civil society organisations’, so called because of their focus on delivering social value as well as profit.(Defourny and Nyssens, 2008, Hulgard, 2010, Nicholls and Cho, 2006, Ridley-Duff, 2007) Emphasis on the ‘triple bottom line’ of social, economic and environmental outcomes as measures of organisational success mean that social entrepreneurs who lead such organisations face additional challenges: not only do they need to make a profit from their business activities, they also need to demonstrate how society will benefit, be it by achieving a social outcome such as reducing poverty or improving the environment. (Elkington, 1994) Such additional challenges are believed by some to result in more innovative ways of working. (Alter, 2005, Alter, 2010, Austin et al., 2006)

Some national governments have supported the spread of social enterprise as an idea for export. The British Council, for example, identify it as one of their four pillars.(British Council, 2016) They work closely with Social Enterprise UK to build capacity internationally, to support shared learning between the UK and other governments in implementation of policies which encourage the growth of social enterprises.(Woodman and Temple, 2011) Countries which have been supported by the British Council include Thailand, Ghana, Philippines, Hong

Kong as well as UK social enterprises wishing to export their services. However, more research is needed to study in-depth, cross country comparisons of social enterprise, particularly in relation to how they achieve social innovation. (Chell et al., 2010)

This phenomenon creates a favourable environment for the growth of organisations which aim to achieve social outcomes such as social enterprises and NGOs (non Governmental Organisations), and is found in multiple sectors. One of these, the health sector, reflects many of the features of this trend. National health policies, to varying degrees, are shaped by international organisations such as the World Health Organisation with its principles of equity, quality and effectiveness (World Health Organisation, 2008b). However, at a national level, the range of institutions which operate in a national health system and the relationships between them will also be influenced by the culture and history of health system development. (Evans, 2005, Gilson et al., 2014)

Health system reforms are used by health policy makers to improve the effectiveness of national health systems. They may take various forms, for example, separating the roles of commissioning and provision of health care services, often by introducing a state managed market. These kinds of reform may encourage a greater role for the private sector (ie non state managed organisations). Sometimes, alternative financing mechanisms, particularly user charges and health insurance may be adopted to reduce the burden of the costs of service provision to the state or extend access to health care services. There may be structural changes, for example, decentralization of state functions to regions. Health system reforms may change the rules within which health actors work and the balance of power within the health sector.

The implementation of health system reform policies at a national level, it is argued, is influenced by beliefs about how health services should be provided (the logic of the sector). (Bevan and Robinson, 2005, McAdam and Scott, 2005, Saltman and Bergman, 2005, Zehavi, 2011) This logic is expressed in the dynamic between multiple actors, each with their own perspective on what needs to change, as well as existing institutions within a system, the governance of the system and the resulting relationships between them. (De

Savigny and Adam, 2009, Gilson and Raphaely, 2008, Reay and Hinings, 2005, Reay and Hinings, 2009, Scott et al., 2000, Scott, 2008)

These different logics are expressed at all levels in the health system. Social enterprises, as organisations within the health system may also be influenced by and influence the logics found in a health system. Their organisational structures and functions and the way in which the unique events associated with health system reform unfold over time and in what sequence may be influenced by the social and political environment.(Evans, 2005) The interpretation of such events reflects shifts in power between actors and resources.(Walt and Gilson, 1994)

The health system, through its common international theme, yet locally specific implementation strategies can be used to demonstrate how and why organisations such as social enterprises can effect change. The relative importance of and expression of the logic underpinning social enterprise in facilitating health system change may vary between cultures, the way in which a national health system and its institutions are governed and actors' use of their power to shape cognition and influence agendas for change.

What is not clearly understood is whether or not social enterprises meet health system policy makers' health system reform objectives and whether different contexts influence their change strategies. If social enterprises do have a unique contribution to make, it is also not clear how the health system environment needs to be designed at a national level to enable them to emerge.

This study builds on previous research of changing institutional logics in national health systems in higher income countries. (Gilson and Raphaely, 2008, Evans, 2005, Harrison and McDonald, 2008, Saltman and Bergman, 2005, Scott, 2013, Reay and Hinings, 2009) I use Thornton and Ocasio's (2008) definition of institutional logic, with its focus on agency:

'the socially constructed, historical patterns of cultural symbols and material practices, including assumptions, values, and beliefs, by which individuals and organisations provide meaning to their daily activity, organise time and space, and reproduce their lives and experiences'. (Thornton and Ocasio, 2008 quoted in Thornton et al, 2012 pg 2).

Institutional logic enables this study to examine social enterprise as a phenomenon that may be perceived to exist with a distinct meaning.

The overall aim of the research is to explore why, to what degree and how health policy makers use the phenomenon of social enterprise to effect change in different resource contexts.

The specific objectives of this research and research questions are to:

1. enhance understanding of the concept of social enterprise in its ability to effect change within different health systems.

Research questions:

- i. how is the term social enterprise described and how is it described in different health system contexts?*
- ii. which institutional logic orders contribute to the meaning of social enterprise in different domestic health systems.*
- iii. If a distinct logic is seen to relate to and underpin social enterprise, how is it used to effect change in the logic of a health system?*

2. Understand how different approaches are shaped and have been adapted to national contexts in order to support policy actors to design and implement social enterprise policies to effect change within health systems.

Research questions:

- i. To reveal the rationale that policy actors employ when advocating for the introduction of social enterprises into health systems.*
- ii. Who advises policy makers on the development of social enterprise in health systems? When do they act, why and how?*
- iii. To what extent do the material and cultural foundations of a health field influence the type of organisational strategies, business models and plans adopted by social entrepreneurs?*

3. Compare the key contextual influences eg socio-political and economic factors on the design and implementation of social enterprise strategies to effect change within different health systems.

Research questions:

- i. To what extent does the conceptual framework of a 'field' that might be found in institutional logics complement approaches to health system research?*

- ii. Which contextual factors affect design and implementation of social enterprise policies and in what way?*
  - iii. How are health system related issues or changes considered in the development and implementation of policies on social enterprise?*
4. Develop recommendations for policy makers, and other actors, for improving the design and implementation of social enterprise strategies to effect change within health systems.

Research questions:

- i. Are there recommendations that can be made from this research for each type of policy actor to improve the support for social enterprise?*
- ii. How might researchers conduct research that better informs further development of social enterprise?*
- iii. To what extent does an understanding of institutional logic meta theory offer a new mode of enquiry for health systems researchers?*

The benefits of this study are many and below I summarise the main three. First, it provides a better understanding of the application of the concept of social enterprise in effecting change within health systems. This learning will help policy actors to develop, influence and implement policies which claim to use the opportunities offered by the ideas found within social enterprise. Greater clarity about what social enterprises can offer to those tasked with improving the effectiveness of health systems can focus policy making and its implementation.

Second, it provides empirical evidence on the implementation of social enterprise in health systems, drawing on the comparison between the two different health systems. This comparative approach allows common themes to be identified which are independent of health system context, whilst also enabling learning between health systems on what contextual influences impact upon social enterprises ability to trade in a health market.

Third, it develops policy implications and recommendations for improving the design and implementation of social enterprise strategies within national health systems. Social enterprises emerge from the results of this study as a distinct, albeit contested, type of organisation with their own logic. Policy makers have

an opportunity to build on this logic to allow social enterprises to contribute to health policy goals.

This thesis is structured into three parts. The first part, Chapter 2 reviews the literature using the concepts in institutional logic to develop a framework which informs the research methodology (Chapter 3). The second part of this thesis, the results of the study are presented in Chapters 4 to 7. The socio-political and resource context is presented first as this forms the context for the study. This is followed by three chapters which reflect each of the themes of the study. These are the meaning of social enterprise (Chapter 5), why and how social enterprises are introduced into health systems (Chapter 6) and ways in which institutional entrepreneurs advocate for inclusion of social enterprise into health policy (Chapter 7). Part 3, Chapter 8, contains a discussion of the implications of this study for policy actors.



## **Chapter 2 Social enterprise in health systems, an institutional logic approach**

### **2.1 Introduction**

In this chapter I summarise the literature review on the scope and definitions of the key concepts underpinning this research. In the previous chapter, social enterprise was introduced as a growing phenomenon worldwide. It was stated that the term 'social enterprise' and its meaning is influenced by health system contexts and different actors beliefs about how a health system can be organised to achieve reform objectives.

In the context of this study, institutional logic reflects on the idea of a health system as a field, which changes through the agency of individuals acting together or individually. I use institutional logic to frame my approach to interpreting meanings of social enterprise and whether or not it has its own distinct logic. I also use it to structure an analysis of health system change through the agency of individuals. Section 2.2 sets the scene by describing the key concepts used from institutional logic meta-theory in this study.

The next three sections of this chapter draw on the literature to build a framework that was applied for this research project. At the end of each section, I examine the implications for the research methodology, which are brought together in the concluding sections of this chapter. Each part is summarised below. Section 2.3 (part 1) reviews the literature on the health system as research field. This section includes a review of how researchers have described the meaning of health systems concepts, the role of national governments and policy actors in health system reform.

This is followed by Section 2.4 (part 2) which summarises research on the meaning of social enterprise and how these meanings can be interpreted using the concept of institutional orders. I explore four different ways of interpreting meaning. These ways of interpreting meaning are used to propose three criteria which act as a working definition of social enterprise.

Social change emerged as a fundamental purpose of social enterprises. Section 2.5 (part 3) therefore focuses on how individuals aim to achieve social change by acting as social entrepreneurs. Institutional logic approaches interpret change as competition between different actors' logics. Using the three change processes from institutional logic, I identify four specific types of change.

This chapter concludes with a section on the implications of this literature review for the research methodology which includes the development of a framework to conceptualise the health system field.

## **2.2 Institutional logic as a meta-theory**

In Chapter 1, I used Thornton and Ocasio's (2012) definition of institutional logic. The meta-theory offers a way of interpreting belief systems through the cognition and behaviour of actors in time and space. It uses a theoretically abstract and analytically distinct set of ideal types, called institutional orders, which enable a separation of ideology and organisation.

The idea of society as an inter-institutional system is a central construct of this research approach. Society is envisaged as composed of seven different institutional orders which compete with each other at any point in time. Table 2.1 below describes each of these institutional orders against logic categories.

Each of the seven institutional orders is defined by nine logic categories. These describe an 'ideal type' used to guide concept development rather than used as rigid definitions. Different factors influence an individual and allow them to operate within one or more of the institutional orders and categories.

Table 2.1 Interinstitutional System Ideal Types  
(Thornton, Ocasio, Lounsbury 2012 pg 73)

Y-Axis	X-Axis: Institutional orders						
Categories	Family	Community	Religion	State	Market	Profession	Corporation
<b>Root metaphor</b>	Family as firm	Common boundary	Temple as bank	State as redistribution mechanism	Transaction	Profession as relational network	Corporation as hierarchy
<b>Sources of legitimacy</b>	Unconditional loyalty	Unity of will. Belief in trust & reciprocity	Importance of faith & sacredness in economy & society	Democratic participation	Share price	Personal expertise	Market position of firm
<b>Sources of authority</b>	Patriarchal domination	Commitment to community values & ideology	Priesthood charisma	Bureaucratic domination	Shareholder activism	Professional association	Board of directors. Top management
<b>Sources of identity</b>	Family reputation	Emotional connection. Ego-satisfaction & reputation	Association with deities	Social & economic class	Faceless	Association with quality of craft. Personal reputation	Bureaucratic roles
<b>Basis of norms</b>	Membership in household	Group membership	Membership in congregation	Citizenship in nation	Self-interest	Membership in guild & association	Employment in firm
<b>Basis of attention</b>	Status in household	Personal investment in group	Relation to supernatural	Status of interest group	Status in market	Status in profession	Status in hierarchy
<b>Basis of strategy</b>	Increase in family honor	Increase status & honor of members & practices	Increase religious symbolism of natural events	Increase community good	Increase efficiency profit	Increase in personal reputation	Increase size & diversification of firm
<b>Informal control mechanisms</b>	Family politics	Visibility of actions	Worship of calling	Backroom politics	Industry analysts	Celebrity professionals	Organisation culture
<b>Economic system</b>	Family capitalism	Cooperative capitalism	Occidental capitalism	Welfare capitalism	Market capitalism	Personal capitalism	Managerial capitalism

Institutional logic considers the context an organisation operates in, called the 'field'. It favours cultural strategies which legitimise change, the primary focus of research being on the ways in which cultural belief systems operate in the fields within which actors in organisations operate. (Scott, 2013) Of importance to this research is that I define a 'field' as a domestic health system; it forms the primary unit of analysis. This research focus builds on Bourdieu's (1977) early work which defines a 'field as the relationships between actors and organisations involved in social and cultural production and who continually compete to advance their interests and influence the rules which underpin how institutions and actors behave'.

Within a 'field' such as a health system some institutional orders may be more evident than others. For example in the US health field the different institutional logics associated with the market, state and professions may be present and competing with each other at a point in time. (Scott, 2008)

Actors may express different categories of institutional logic from different institutional orders. It may be inferred that this 'mix and match' approach reflects the tension between different actors, they may choose to express different types of logic from different institutional orders based on a combination of what they believe will enable them to achieve their organisational objectives and cultural values.

The institutional orders have relevance to both context and organisation. In this research, the institutional orders of the state and market are important, because, as will be described in section 2.3 on health systems, the state has a specific role in that it defines the rules and practices of the health system, including a market in health services. The institutional order profession is relevant because an important group of actors, health care professionals, hold expert knowledge about how to deliver health services and how they perceive the need to organise to deliver care. The corporation and religion institutional orders may also reflect individuals cognition about how they should organise themselves in relation to the health system. The institutional categories reflect different perspectives on this idea of institutional order. For example, corporations are viewed as a hierarchy of individuals with bureaucratic roles whilst in the professional order, professionals (in this case health care

professionals) are viewed as networks of individuals where personal reputation and quality of craft are important sources of identity.

Table 2.1 also proposes an institutional order 'community'. The institutional order 'community' has been introduced by Thornton et al (2012) as a new order. They argue that it reflects unique ways of organising, with its own logic, which is related to commitments to a group of actors who share values and ideology. Social enterprise therefore may be expressed by this logic of 'community'. In this research the meaning of 'social enterprise', may be contested by different actors. The institutional logic approach offers a way of structuring the logic of the concept of the institutional order 'community' to identify if social enterprise has a distinct logic of its own.

Individuals may use these different logics to influence change which may occur at three levels:

1. individuals, who compete and negotiate with each other;
  2. organisations, which may act cooperatively or in conflict with each other;  
and
  3. institutions, which are interdependent and also contradict each other.
- (Thornton and Ocasio (2008))

In later publications, Thornton et al (2012) propose a fourth level, the macro-societal level. This additional level reflects challenges from cultural anthropologists, who argue that cultural and societal values also need to be included in the theoretical framework. (Saltman and Bergman, 2005) In relation to the structure of health sector institutions and the range of policy options for health sector reform, Saltman and Bergman (2005), for example, argue that institutions in a health system are only intermediate expressions of deeper cultural norms. Using Sweden as an example, they argue that the core values and cultural beliefs of public responsibility and health security held by Swedish citizens have remained unchanged over time despite various health system reform initiatives. (Saltman and Bergman, 2005). The research approach used in this study assumes that policy actors are partially autonomous and may interact with the structure of the health system at the individual, organisational, institutional and macro societal levels to effect change in the field as a whole.

This research therefore allowed for policy actors to introduce a competing institutional logic, the idea of social enterprise, into a health system. To do this, individuals must have both a willingness to act and access to resources to enable them to act. For example, individuals may act because their social position within a health system enables access to resources (Battilana, 2006, Ferlie et al., 2005). This resource context is therefore important. The research approach considers resources as both a limiting and enabling influence on individuals ability to change the combinations of logic in a health system.

In this research project, I will focus on the institutional orders state, market, community, profession and corporation. My approach uses the idea of 'logic' to understand what change individuals seek to effect through their 'social enterprises'. It recognises that health system change is likely to be constrained or supported by the complex interplay of historical factors, culture and the structural and power relations between different levels of the health system and policy actors. (Thornton and Ocasio, 2008)

### **2.3 Part 1: Health systems in institutional logic and the role of Governments**

As outlined in section 2.2, the scope of this research equates the idea of a health system with the institutional logic concept of 'fields'. For this study a health system needs to be understood in the context of governance, financial and delivery arrangements for both health care and population health services. Further, a health system reflects a constantly changing architecture of interactions and synergies, (De Savigny and Adam, 2009) with competing logics present at any point in time (Scott, 2000, 2008). The scope of analysis needs to allow for the relational components (diMaggio and Powell, 1983) of fields between actors as well as Scott and Meyer's (1983) later emphasis on regulative and funding context.

This section therefore reviews different health system concepts in order to define the scope of the health system (section 2.3.1). Governments have a specific role in health system design and reflect the institutional order 'state'. This role for governments and its implications for health policy development are considered in section 2.3.2. The final section (2.3.3) brings together these

concepts to outline the research elements which need to be considered in an analysis of the health system as a field using institutional logic meta-theory.

### **2.3.1 Scope and meaning of health systems concepts**

A 'health system' consists of organisations which together have a relationship with the planning and delivery of health care services and may include suppliers, patients, regulatory agencies and others. Research in higher income countries using institutional logic, identified a relationship between changes to the structure of the health system, power relations between actors, and the dynamic between different institutions orders. For example Reay and Hinings (2005) analysis into the changing logics of health system reform in Alberta, Canada were able to demonstrate how business management ideas and practices were, over time, integrated into day to day working practices of health policy makers in government.

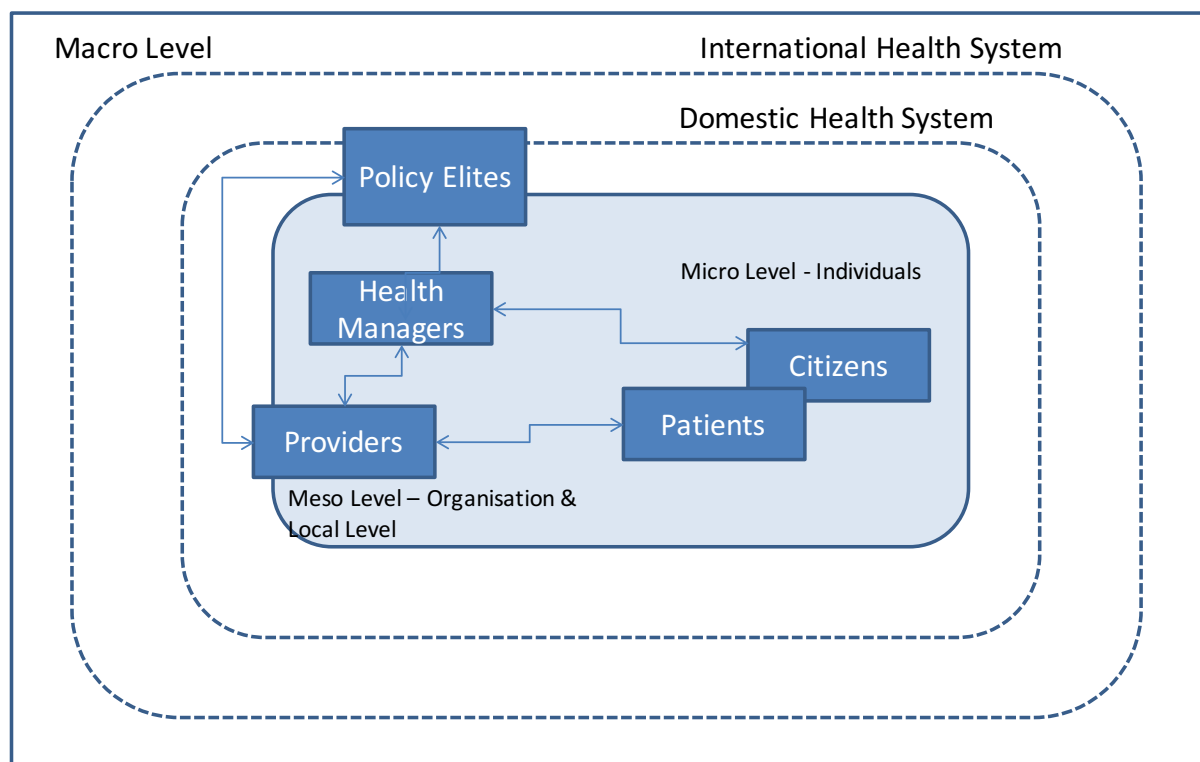
There are three main frameworks, which describe the scope of a health system. (Bossert, 2012) The first is based on functions such as financing, governance, service delivery, human resources (Mills, 2012) . The second is the WHO building blocks framework of service delivery, workforce, information, medicines, financing and governance (World Health Organisation, 2007). Finally the Harvard School of Public Health uses analytical categories starting from a vision which recognises ethical choices linked to different views about equity in health system performance. They argue that the basis for understanding what impact the policy levers (which they call control knobs) such as financing, macro-organisation, payment, education, persuasion and regulation have on reform strategies cannot be reduced to technical issues alone. Their view on health systems recognises that any policies need to be sensitive to local circumstances. (Roberts et al., 2008)

There is a great deal of overlap between these frameworks. My interpretation of health systems for this study is based on all three frameworks and includes functions (Mills, 2012) and building blocks (World Health Organisation, 2007) as well as an ethical perspective. The ethical perspective is important in this study. As described in Chapter 1, social enterprise advocates claim a new world order based on new ways of achieving social change through organisations and the context within which they conduct their business. The health systems context,

in which organisations such as social enterprises claim to have an ethical outlook, brings in the cultural perspective. In this research, the health system expresses this duality between structure and culture, reflected in the type of institutional orders present and their associated logics.

A conceptual model is required which acknowledges how the dynamic between actors may, within cultural and historic moments in time, influence the way in which health system reform strategies are played out. As a starting point, Gilson's (2012) conceptual model of the different levels in a health system is helpful when considering the context of social enterprise. This is reproduced in Figure 2.1 below.

Figure 2.1 Different levels of Health Systems



From Gilson L, ed (2012) pg 24

This model reflects the different policy actors as well as the different levels of health systems. This structuration of the health system reflects social enterprises as providers, working at different levels in domestic and international health systems, but also the influence of individuals, which I call 'policy actors' in shaping domestic and international health systems. Using



Gilson's (2012) framework as a starting point, it can be hypothesised that policies which encourage social enterprise in a domestic health system will be designed by networks of policy actors. Power is conceptualized by actors ideas and interests, working in networks of relationships. They may be continually influenced over time by various factors such as the international health system, health managers and by citizens, patients and providers of health care. (Buse et al., 2012, Smith, 2015) Advocates of an organisational type such as social enterprise, may attempt to influence policy makers to introduce system change which promote 'their' beliefs about what needs to change.

I return to my interpretation of a health system in section 2.3.3 when I consider health system research. In section 2.6 I build on Gilson's model to describe how I am integrating learning from this review into a revised framework to guide the research methodology.

### **2.3.2 Role of governments in health system context**

National governments have a specific role in health system design. WHO (2008b, 2008c) places specific responsibilities on national Governments to protect health, to guarantee access to health care and to safeguard people from the impoverishment that illness can bring.

'The ultimate responsibility for shaping national health systems lies with governments. Shaping does not suggest that governments should – or even could – reform the entire health sector on their own. Many different groups have a role to play: national politicians and local governments, the health professions, the scientific community, the private sector and civil society organizations, as well as the global health community. .... the responsibility for health that is entrusted to government agencies is unique and is rooted in principled politics as well as in widely held expectations.' (WHO, 2008c pg 82)

Health can therefore be viewed as a 'social good' (Weinstock, 2015) This results in a complex institutional environment. Governments need to engage with the multiple actors involved in health system policy and service delivery to design a locally specific health system which meets the perceived health needs of its population. Organisations may be established by a Government to perform different roles eg policy regulation, funding or service delivery. Government may directly manage these organisations or create a more plural system of direct management of some, allowing other sectors to participate by

performing some roles (eg England) (Harrison and McDonald, 2008) or remove itself from some functions altogether (eg US where health service delivery is managed by independent providers in a market).(Enthoven, 2004, Scott et al., 2000) However, institutional logic approaches move beyond this structural interpretation of the role of government. Through the logic categories which describe the state institutional order, the cultural perspective is included as well. The framework used in this study builds on previous work conducted by other health system researchers who have used institutional logic in countries such as the UK (Harrison and McDonald, 2008, Pollitt et al., 2010), US (Scott, 2008, Scott et al., 2000), Canada (Reay and Hinings, 2005, Reay and Hinings, 2009), and Europe (Evans, 2005). Each of these researchers analyse how governments influence the dynamic between different institutional orders in a health system. The tensions between them over time, each competing for power over others through the actions of policy actors, focuses the analysis on governments' cultural role in health systems design. At a national level, these tensions may be expressed through national health policies.

Health policy processes aim to implement change, which in turn is dependant on context. (Walt and Gilson, 1994) Policy actors negotiate context, policy content and processes to realise policy change. Policy champions may advocate for causes. This political entrepreneurship aims to institutionalise domestic priorities to support a cause. (Shiffman et al, 2012, Crichton, J, 2012) The power of actors to use cognition to shape meaning and perception is particularly important in this research. (Buse et al, 2012)

Social enterprises as providers of health care, may influence individuals, ('policy actors'), at different levels to shape the structure and culture of domestic health systems. It can be hypothesised that policies which encourage social enterprise in a domestic health system will be designed by networks of policy actors.

Power is conceptualized by actors ideas and interests, working in networks of relationships. They may be continually influenced over time by various factors such as the international health system, citizens, patients and providers of health care. (Buse et al., 2012, Smith, 2015) Advocates of an organisational type such as social enterprise, may attempt to influence policy makers to introduce system change which promote 'their' beliefs about what needs to

change. The actions of these policy entrepreneurs must be interpreted critically as they may be acting to further their own interests. (Oliver and Mossialos, 2005).

Nevertheless, health policy, led by national governments, provides an overall strategic direction for health system development. It can be interpreted as a 'central' element of the health system and one of WHO's (2007) building blocks. Policy and policy change is always contested in public and within bureaucratic arenas. Furthermore, policy decisions may have unintended consequences. Effective policy change is not technocratic or evidence based. The change process must therefore acknowledge and incorporate the values and interests of policy actors. (Gilson and Raphaely, 2008) In institutional logic, actors who aim to change the logic of the field have a distinct role, which will be discussed in more detail in section 2.5.

Health policies result in courses of action or inaction that affect institutions, organisations, services, funding arrangements of the health system; and the actions and intended actions of organisations external to the health system which impact on health. In this research, the policy actors contest the logic of the state's role and policies in health system design at a field (health systems) level. The next section draws on previous research on the institutional logic of health policy to contribute to the development of a conceptual model to frame this research which reflects the conceptualising of a health system described in section 2.3.1 and the role of Governments contained in this section 2.3.2.

### **2.3.3 Implications of the health systems literature on the research methodology**

The literature review uncovered no research on the values and motivations of individuals (health policy actors) involved in embedding social enterprise into health system reform policies. The literature from England, where health policy makers and both Labour and Coalition governments have encouraged the emergence of social enterprise is still limited and focuses on the motivations of staff choosing to leave the NHS to set up social enterprises rather than those of policy actors (Addicott, 2011, Hall et al., 2012) with an interest in social enterprise at the field level. A conceptual model is required to frame this study which acknowledges how the dynamic between actors may, within cultural and

historic moments in time, influence the way in which health system reform strategies are played out.

A recent review of the scope and meaning of health systems concepts, identify forty one different health system research frameworks. (Hoffman et al. (2012) They classify these frameworks against two axes: their stated goal and their view of the scope of a health system. The goals may include: understanding, comparing, informing change or evaluating a health system. The scope may be:

- a sub framework (focused on parts of the health system),
- system framework (focused on the whole system) or
- supra framework (focused on how other societal systems interact with the health system).

The scope of this research is at the supra framework level. It reflects the four levels of institutional logic described in Section 2.2 ie individual, organisation, institution and macro-societal levels which are not encompassed by a sub framework or system framework and also Gilson's (2012) structuration of a health system in section 2.3. By including this supra framework level, I recognise the context within which individuals in the domestic health system act, which may include the social care system, education or other societal systems related to health care.

Section 2.3.2 described how policy actors negotiate context. In Chapter 1, the ability to trade products and services in a market was viewed as important. For this research, the logic of a market in health systems is politically inflected, influenced by policy actors who advocate for social enterprise values and concepts to be built into market design. This means that at the health system level (field) I need to build into my research approach an understanding of the meaning of social enterprise and its perceived value to a health system. Social enterprise then becomes a way for actors to realise a collective rationality and it becomes a central organising concept.

However, the introduction of a type of organisation like social enterprise with a potentially different logic to others, may be limited by the capacity of a health system. Conceptual models which define the scope of health system capacity

building may distinguish between the system, organization, health resource, individual and community as analytical categories (LaFond, 2002) or define the components of system capacity building as based on a hierarchy of capacity needs. (Potter and Brough, 2004) Potter and Brough (2004) argue that unless structures, systems and roles are in place, any other capacity needs such as skills, tools, staff and infrastructure which are higher up the hierarchy will not result in improved performance of the health system. It can be hypothesised that certain structures, systems and roles need to be in place when introducing a new type of organisation, such as social enterprise with its own logic into a health system. For example Helderman et al (2005) comment that a health system needs to have the right instrumental (eg an agreed currency for payment of services) and institutional (eg market regulation) conditions for implementation of social enterprise policy.

The research methodology used for this study therefore needs to include government and society (the supra framework), policy actors and health system capacity. It needs to consider the different levels of a health system and actors values and interests when advocating for change.

This section has focused upon the level of analysis of a national health system. Building from this, there are two further elements to field level analyses in institutional logic which are relevant for this research. The first concerns the meaning of social enterprise in the health system field and collective views about this meaning as a central organising concept (Section 2.4). The second focuses on change processes and the actions of policy actors at an institutional level (Section 2.5).

## **2.4 Part 2: The concept of social enterprise**

Using institutional logic, one line of enquiry is to identify if the idea of social enterprise has a collective rationality and value to a health system. There is much debate about the meaning of the term social enterprise. Dacin et al. (2010) have a useful summary of the many different definitions of social enterprise and its related term social entrepreneurship in the literature. Social enterprises can be businesses whose founders, acting as social entrepreneurs, aim to make a difference, trading to achieve social objectives and reinvest

surplus for the purpose of the business or community (Harding and Harding, 2008, Defourny and Nyssens, 2006, Defourny and Nyssens, 2008, Social Enterprise UK, 2012a, Alter, 2005) They may also be defined by an additional criterion ie in relation to how far they involve actors in their governing bodies (Defourny and Nyssens, 2006, Defourny and Nyssens, 2008) This latter definition means that cooperatives are sometimes included in the scope of the term 'social enterprise'. (Teasdale, 2012) Others add an expectation that a social enterprise should be innovative (Austin et al., 2006, Alter, 2005).

This section describes the breadth of these definitions. I have grouped the literature into four sub-sections. The first uses social and economic criteria. An important second grouping of the literature uses organisational culture as a defining criteria. This might be found in combination with social and economic criteria. Here, organisational culture is expressed through a culture of social entrepreneurship reflected in social entrepreneurs' strategic focus on achieving social change. Thirdly I review the literature on cross cultural definitions. Although there has been relatively little research on differences in meaning between cultures, some researchers argue for distinct culturally specific definitions, which therefore need to be considered in this comparative study. Recognising that social enterprise may be used to further political agendas, I summarise political interpretations of the term in section 2.4.4.. These may build on social and economic criteria to further political ideologies of the time but also be influenced by culture. Implications for the research methodology are brought together in section 2.4.5.

### **2.4.1 Social and economic criteria**

Previous academic research has demonstrated a lack of specificity of the concept itself allowing social enterprises to be positioned within a 'galaxy' of social enterprise criteria (Defourny and Nyssens, 2006, Defourny and Nyssens, 2008 pg 5). Defourny & Nyssens (2008), for example, identify nine criteria which together describe an ideal type of organisation rather than a set of economic and social qualifying conditions, and are summarised in table 2.2 below.

Table 2.2 Nine criteria to describe an 'ideal' social enterprise

Economic criteria	Social criteria
<ol style="list-style-type: none"> <li>1. a continuous activity producing goods and/or selling services,</li> <li>2. a high degree of autonomy,</li> <li>3. a significant level of economic risk,</li> <li>4. a minimum amount of paid work.</li> </ol>	<ol style="list-style-type: none"> <li>5. an explicit aim to benefit the community,</li> <li>6. an initiative launched by a group of citizens,</li> <li>7. a decision-making power not based on capital ownership,</li> <li>8. a participatory nature, which involves various parties affected by the activity,</li> <li>9. limited profit distribution.</li> </ol>

From Defourny and Nyssens, 2008 pg 5

Ridley-Duff & Bull (2011) build on the concept of a 'galaxy of social enterprises' (Defourny and Nyssens, 2008) to argue that social enterprises are 'cross-sector' ie that they may span any sector (private, public or 'third') depending on their origins and ethos. Their classification system acknowledges the diversity of 'social enterprise' organisational types, allowing for historically and culturally specific forms to emerge. It acknowledges how the interests of many actors can be expressed in the meaning of the term social enterprise and it begins to demonstrate a link with broader social and environmental change objectives.

More recent literature builds on this theme to describe social enterprises as 'hybrid' organisations. (Doherty et al., 2014) By pursuing the dual mission of financial sustainability and social purpose, they don't fit neatly into conventional categories of 'private', 'public' and 'not for profit' organisations. This hybridisation draws on different logics and value systems, resulting in novel institutional forms. Battilana and Lee (2014) go further to define 'hybrid organising' as 'the activities, structures, processes and meanings by which organisations make sense of and combine aspects of multiple organisational forms' (pg 398) This more recent approach to the meaning of social enterprise recognises the systemic and cultural definitions moving beyond the static and structured criteria proposed by earlier researchers such as those of Defourny & Nyssens (2006, 2008)

#### **2.4.2 Using organisational culture to define meaning**

Social entrepreneurs may be distinguished from traditional entrepreneurs because their earned income strategies are tied to their social mission.

(Boschee, 2006) This approach to meaning emphasises the social entrepreneurial process, rather than the label social enterprise. This research uses the institutional logic framework to recognise that individuals may act through their organisations at different levels of a field ie at organisational, institutional, health system or socio cultural levels to effect change to the different logics of a health system. Social entrepreneurship may be the result of the actions of individuals within a team, an organisation, or a community of organisations working together as a collective. (Peredo and McLean, 2006 pg 64)

Anderson (2014), who advocates for this interpretation, identifies three components of social entrepreneurship. These are:

1. a clearly defined social mission with creation of social value as the principle purpose
2. primary change effort or a component central to its implementation should be innovation or pattern setting
3. the application of business principles to the change effort (calculated risk taking, business practices, sustainability over time, process and outcome evaluation with product or service revision, scalability).

All too often, the literature on social entrepreneurs focuses on the founder of the organisation. (Mair and Marti, 2006 pg 37) The highly individualistic, hero type conceptualisation of social entrepreneurs is increasingly contested. (Nicholls, 2010) Research on entrepreneurship suggests that it needs to be understood as the interplay between people, culture and context rather than the actions of a single person (Grenier, 2006). From a global perspective, the focus on a single entrepreneur can appear like western imperialism. The more team based approach to social entrepreneurship compares favourably with locally driven, inclusive processes of change, (Grenier, 2006) and which is found in the European literature on social enterprise. (Defourny and Nyssens, 2008, Nicholls and Cho, 2006)

If social enterprises are defined by their distinct culture of social entrepreneurship, they may also be conceived as network organisations, blending the competing demands of multiple constituencies to achieve a social



purpose. If this is true, then social entrepreneurs' management strategy may be distinct. Ridley Duff & Bull (2011) for example, view strategic formulation in social enterprises as an emergent process which integrates different strategic management approaches to pursue social and economic objectives. (Ridley-Duff and Bull, 2011)

Putting these ideas together, Jiao (2011) proposes a conceptual model for social entrepreneurs based on the following characteristics:

1. desirability and feasibility of social entrepreneurship in decision making process (for example human capital) is positively related to social enterprise activities
2. higher levels of human capital are positively related to the success of social entrepreneurial activities
3. interaction between human capital and the desirability of social entrepreneurs in decision making process is positively related to the success of social entrepreneurial activities
4. social entrepreneurial networks influence their performance
5. if social entrepreneurs have a high degree of cognitive desirability and feasibility and perceive they have a high level of social capital their commitment to social entrepreneurial activities will be high
6. environmental factors eg support, education, funding, monitoring are positively related to social entrepreneurship.

The emergent approach to strategic development of social enterprise with cycles of business development linked to management approaches which emphasise networks and stakeholder management suggests that social entrepreneurs may demonstrate particular characteristics. However personal and psychosocial factors, which have also been identified by (Miller et al., 2012) as a pro social motivator to create a market based organisation, need to be considered in context. These contextual factors may influence the ability of social entrepreneurs to act. They may be sociological (eg networks, teams, role models), demographic, environmental, expected values, situational variables or associated with organisational characteristics. (Raghda El Ebrashi, 2013) Each of these factors may impact upon a social entrepreneur's strategic decision

making, enabling or restricting strategic options for the growth of the social enterprise and realisation of its social purpose.

As different entrepreneurial roles may be performed by different actors within a team, organisation or community, this research needed to capture the constituency actors claimed to represent and their relationship to that constituency. This social entrepreneurship will be expressed at an organisational level by the development of strategies that social entrepreneurs devise to achieve their social goals. Their organisational strategies will be influenced by the context within which social entrepreneurs act. The interaction between context and organisational strategy was therefore an important theme of the research approach.

The next section takes an international perspective by focusing on the proposed cultural differences in the meaning of social enterprise.

### **2.4.3 Cross cultural definitions in international contexts**

Social enterprise actors at an organisational level have an important cultural context. For example, Ridley Duff & Bull (2011) describe the differences between US and European debates on the definitions of social enterprise. In EU-style social enterprise they argue that community action in Europe, building on historical democratic processes which are sensitive to different stakeholders differentiate it from US-style social entrepreneurship. The latter they characterise as focused on individual action, using the market to respond to social issues. This philanthropic, 'top-down' approach to achieving social outcomes focuses on adhering to a 'vision' rather than accommodating the views of different stakeholders. However, this neat separation of US and European approaches to social entrepreneurship has been challenged by some academics who argue that there is no such clear distinction, demonstrating that difference can be evidenced in both the US and European contexts (Bacq and Janssen, 2011). What all researchers agree on in the literature reviewed for this project is that actors influence the idea of social enterprise within a cultural and historical context. Arguably there are two broad approaches to the definition of social entrepreneurship, which they express through their organisations, social enterprises. Firstly, US style models prioritise an elite cadre of social entrepreneurs. The second approach emphasises system based innovation

models of social transformation, which are partly a response to market failures in welfare, public and environmental products and services.

The definition of social enterprise as a tool for social transformation is particularly found amongst European researchers. They argue that the boundary between the state and civil society organisations is becoming increasingly blurred as civil society organisations take on functions which were the preserve of the state, particularly in the delivery of human services (Defourny and Pestoff, 2008, Nicholls, 2010, Hulgard, 2010, Powell, 2007). Archembault (2009) even goes as far as to suggest that there is a growing recognition amongst European policy makers (top-down) and civil society organisations (bottom up) of a European civil society which recognises that civil society is an integral part of European identity, and expressed through increasing partnerships between the civil society institutions and governments at all levels. This is in part a reflection of the changing relationship between Government funding philosophies with an increase in contracted services rather than grants (Defourny & Pestoff (2008), Nicholls (2010) and Hulgard (2010). Ridley-Duff & Bull (2011), develop Hulgard's (2010) approach further by arguing that in Europe the social enterprise phenomenon is neither a component of third sector development nor an advance of private sector practices into the third sector, but a product of

‘the tension between attempts to reform the public sector through the introduction of private sector management rhetoric, and radical responses to those attempts by local politicians and community entrepreneurs with socialist sympathies’ (Ridley-Duff and Bull, 2011 pg 39)

Some research which compares the relative impact of the welfare state and civil society on health and health inequalities has found that where national welfare systems are weak or health expenditure is low a more effective civil society is positively associated with better health. In these circumstances civil society may act as a replacement for the state. (Olafsdottir et al., 2014)

There is extensive literature on civil society and its meaning in different political and socioeconomic contexts (see for example Heinrich and Malena, 2008, International Centre for Research and Information on the Public, 2007, Salamon

et al., 2003) and geography. (Somerville and McElwee, 2011). Space is an important consideration for entrepreneurship in a geo political context (Steyaert and Katz, 2004). It includes relational space for learning, exchanging ideas, sharing experiences to be creative, promoting trust and coordination across systems and sectors (Sacchetti and Campbell, 2014). Policy actors may cross national boundaries, advocating for a form of social enterprise in health systems. They may be found in national policy roles or in international health care organisations.

These social entrepreneurs may play an important role in catalysing policy. (Mintrom and Norman, 2009) The influence of different actors in the emergence of national social enterprise policy is illustrated by Kerlin (Kerlin, 2010 , Kerlin, 2013) who explored the use of the term in the US, Western Europe, Japan, Eastern-Central Europe, Argentina, Zimbabwe/Zambia and South East Asia. She demonstrated how different socio-economic conditions might influence the emergence of social enterprise as a phenomenon. She also recognises the role of power, illustrating how international aid agencies in Zimbabwe and Zambia support social enterprises to emerge. She goes further arguing that the state plays a key role in understanding a country's model of social enterprise by incorporating the context (including civil society and democratisation) and organising patterns in a country into its policies for change. (Kerlin, 2013) .

The political, economic and historical context is important to politicians interpretation of meaning and purpose. Park and Wilding (2013), in their comparative study of the emergence of social enterprise in England and South Korea argue that the social construction of social enterprise is influenced by earlier policy and political choices. They showed similarities across the two countries of political orientation of government, public policy orientation and rationality of contracting out public services, reinforced by a market approach. Dissimilarities included the economy, problem definition, role of policy entrepreneurs and the position of government on contracts for services all of which result in social enterprises with different defined roles. Arguably, in South Korea social enterprises were used to promote employment whilst in England, to achieve social impact.

In this research therefore the methodology allowed for the idea of geographical space, linked to civil society for sharing of ideas and development of partnerships to emerge. Taking the unit of analysis as the domestic health system, the approach allowed for the diffusion of meaning internationally, recognising that international actors may influence policy actors interpretations of meaning at all levels in the health system.

#### **2.4.4 Political definitions of the term**

At the field level of enquiry, previous published research has shown how national Governments may use the term for political purposes. The term social enterprise is recognised by some national Government policy makers but not others. In Germany, social enterprise as a concept is not part of the political agenda, leading some researchers to hypothesise that this is because of the particular social partnership between the market and the state which doesn't lend itself to a classification of 'social enterprise' organisations (Defourny and Nyssens, 2008, Defourny and Nyssens, 2006). However other research of policy actors in Tanzania, also demonstrated a lack of awareness of the term. In this country, the researchers suggested that this reflected a lack of recognition of the potential contribution of social enterprises by policy makers (Mori and Fulgence, 2009) .

However, it would be a mistake to assume that the meaning of the term social enterprise is linked to national boundaries. Teasdale (2012) describes how the discourses of different actors in England has influenced changes to the meaning of the term over time. Over the past thirty years, policy makers have kept the definition loose so that the positive characteristics of the different organizational forms can be recognized allowing the phenomenon of social enterprise to be used as a policy tool to address various social problems. This ambiguity allows both policy actors and organisational actors to legitimise policy action, allowing governments to draw selectively on competing myths to create a loose policy idea of social enterprise and its contribution to the economy over time.(Teasdale et al. , 2013)

In this research, therefore, the approach needed to recognise that policy actors at the level of national Governments may choose to define the term social

enterprise to further differentiate political or ideological goals over time and that the meaning of the term may cross national boundaries.

#### **2.4.5 Implications of different meanings on the research methodology**

The framework used in this study therefore needed to include a focus on 'social enterprise' as a phenomenon. It needed to take account of the social construction by actors of the meaning of the term internationally and also allow for economic, social and culturally specific criteria. These different ways of interpreting meaning need to be understood within the context of the health system.

Different interpretations of the meaning of social enterprise raise questions about how far the meaning of social enterprise represents a different logic to others. Thornton et al (2012), drawing on community forms of organising, suggest that this is a separate institutional order called 'community' which has its own logic, distinct from others. From this review, three common characteristics of social enterprise can be identified across all the literature. These are: an explicit aim to benefit the community through their social purpose, a social entrepreneurial outlook and investment of profit from trading activities to achieve a social purpose. Recognising that other characteristics might be present, the research approach needed to allow for the breadth of social enterprise characteristics to be identified.

However there is also another theme to this research, which is focused on social change. Building on section 2.3 on the role policy actors play to influence policy context, content and process, social entrepreneurs may act at the field/organisation interface to effect change to the health system itself. Social entrepreneurs are seen as playing a role, by trading in a market of health care services, in achieving social change, which can be viewed as a new and fundamental aspect of civil society, with its own logic. (Nicholls, 2010)

### **2.5 Part 3: Institutional logic and social change**

Achieving social change emerged in Section 2.4 as central the meaning of social enterprise. It is reflected in organisations' social mission and

organisations' culture. It underpins policy actors engagement with policy content, context and processes.

In institutional logic three types of change processes can be identified. (Thornton and Ocasio, 2008) The first of these is the actions of entrepreneurs who act to change the logic of the health system for the benefit of their social purpose. These actors are called 'institutional entrepreneurs' in institutional logic. The second, structural overlap occurs when previously distinct individual roles and organisational structures and functions are forced into association. For example, mergers and acquisitions create contradictions in health systems and within organisations which create entrepreneurial opportunities for institutional change. The third, event sequencing focuses on the importance of history in both understanding when and how social enterprises emerge in health systems.

Actors may work individually or together in communities of interest to achieve change, sharing conceptual frameworks which influence their behaviours. (Friedland and Alford 1991; Thornton et al 2012). Some of these conceptual frameworks may be shared by all operating in the field, whilst others may offer different and competing cognitive frames for different groups of participants (Fligstein and McAdam, 2012: 10-11). Social entrepreneurs therefore may face multiple and contradictory logics when managing or advocating for social change to achieve their social purpose.

Research on how social entrepreneurs embed the idea of social change into their actions can be grouped into four change themes, each of which draws on one or more of the three change processes described in the institutional logic approach. These are:

1. Theme 1 in section 2.5.1 considers how the emergence of social enterprise is contingent upon historical socio-political contexts
2. Theme 2 reviews the research on how social value is created through social innovation (2.5.2) followed by its closely aligned theme 3,
3. the market in health care services(2.5.3).

4. Theme 4 focuses on social entrepreneurs who use their agency to influence health system reform and act as institutional entrepreneurs (section 2.5.4).

### **2.5.1 Change theme 1: Historical contingency of socio-political change**

My approach builds on analysis of health system reform in Europe which demonstrated how institutional entrepreneurs are influenced and/or constrained by the socio-political environment. (Evans, 2005) I therefore contextualised this research by understanding the social and political environment within which social enterprises operate. (Sewell, 1996 pg 844, Rico and Costa-Font, 2005)

Part of this research approach aimed to identify entrenched, historical contradictions in the relationships between actors in social enterprises which may limit the effectiveness of some government policies. For example, by examining the origins of organisations in the English NHS, Bevan and Robinson (2005) describe how successive health policies between the 1970s and 1990s resulted in suboptimal control of total costs, inequitable distribution of hospital services, and inefficiency in delivery of care. They argued that the economic logic of achieving one or more of these objectives was always compromised by the conflicting political logic of a state controlled hierarchical system where doctors controlled access to health care resources ie both the supply and demand for health care, whilst ministers were accountable for its performance.

This relationship between health system change and ideological beliefs is highlighted by Buse et al (2012) who link it to the reinvention of government, influenced by neoliberal economic thinking. Public choice theorists and property rights theorists, they argue, influenced thinking about the role (and therefore the logic) of the state. The former because politicians promote policies which maximize their chance of re-election. The latter which links perceived poor performance of the public sector with lack of incentives to maximize efficient use of resources. A broad definition of health system reform has been developed by Roberts et al (2008) who says it involves 'a significant, purposeful effort to improve the performance of the health-care system'. (Roberts et al., 2008 pg 9). In general reforms arise because of the rising costs of healthcare, rising expectations of citizens, limits on the capacity of



governments to pay the costs of healthcare and concerns about the way in which health systems are currently operating.(Roberts et al., 2008) The neoliberal health reform agenda may be at odds with social entrepreneurs' strategies which aim to address the social determinants of health. The underpinning causes of health inequality: power inequalities, social status and connections or class inequality, are not addressed in ideological neoliberal health reforms. (Scott-Samuels and Smith, 2015)

Of importance to this research is how the idea of social enterprise may be influenced by interpretations of health system reform, bound by these ideologies. For example, neoliberal economic thinking assumes a 'structural' conceptualization of power ie something appropriated by individuals or organisations. An alternative 'post structural' account of power proposes that it is more diffuse and mobile, allowing for individual agency with actors working as a network, coming together on ideas and interests to influence policies (Smith, 2015). Social entrepreneurs, through their communities of interest which aim to achieve social change, may reflect this fluid approach to forming coalitions to influence health policy making and implementation.

Existing structures and consequences of past decisions will influence the implementation of reform. (Crichton, 2008, Mosquera et al., 2001, McIntyre and Klugman, 2003) Evans (2005), in his review of European health system reforms, argues that even if changes in health policy and institutional structure appear radical, if there are opposition forces and weak advocates of change, reforms will only be partially implemented. Micro practices of power by frontline managers may influence how policies are implemented. (Gilson et al., 2014) Geographically based social organisation and political culture within a country can also dominate how health reforms are implemented ( Atkinson et al. (2000)) and the perceptions of communities within society about the role of a health system. (Saltman and Bergman, 2005) When implementing health policy, social entrepreneurs geographical context within and between domestic health systems may be an important consideration.

Yet Evans (2005) also argues that in Europe, despite great variety in health system design, which at least at first sight results in unique health care institutions specific to each European country, there are several similar health

policy themes which result in a parallel evolution of health systems, despite their various structures, history and cultures. This historical context is played out as Governments' role in facilitating change evolves over time. In relation to social enterprise policy for example, some European Governments have set the legal framework for embedding social entrepreneurship in health system reform policies. They may have passed legislation which specifies new organisational forms or, in England, by building certain contractual requirements, such as added social value, into competitive tendering opportunities.(UK Government, 2012b) Helderma et al. (2005), for example, have associated the term social enterprise with market oriented health policy reforms in the Netherlands where individual providers and insurers, by being given greater autonomy in exchange for risk bearing, have become social entrepreneurs. This study therefore needs to allow for governments designing health policies to express similar concepts of social value in different ways.

### **2.5.2 Change theme 2: Creating social value through social innovation**

Of importance to this research is the introduction of social innovation as a way of achieving health system reform in state managed health systems. I am using Mair and Marti's (2006) description of social entrepreneurial processes for social change:

‘the innovative use and combination of resources to pursue opportunities to catalyse social change and or address social needs’(Mair and Marti, 2006 pg 37)

Mair & Marti (2006) argue that it is both the social value creation and the entrepreneurial nature of the process and associated behaviours, which differentiate social enterprises and social entrepreneurship from other types of organisation.

Further clarity on the nature of the social impact and innovation that social entrepreneurs seek would help to understand the logic underpinning social entrepreneur's change objectives. In a national health system, moral agency might be an important value which policy actors need to consider when designing health system reform strategies. (Frith, 2014) Particularly when considering the role of supposedly 'ethical' business propositions like social

enterprises in a health care market, the idea of social impact and how this is accounted for becomes important.

However social visions may be linked to different values which may be incompatible with each other. In section 2.3.2, I described how the socially heterogeneous nature of society means social entrepreneurs may have fundamentally divergent social objectives. Some social visions may marginalise communities. Further, social visions can be articulated in monological or dialogical ways. A subject centred approach, based on an entrepreneur's vision is monological. It contrasts with more consensus based, participatory, dialogical approaches. (Nicholls and Cho (2006)) These contrasting approaches link back to the nature of civil society and the way in which social enterprise as a concept is articulated in culturally specific narratives and which was explored in section 2.4.4.

There is no exact way of defining whether social goals qualify as social entrepreneurship. (Peredo and McLean, 2006)) In an attempt to define the social and economic missions of organisations, Stevens et al. (2014) suggest that the tension between social and economic goals are not enough to define a social mission. They identify two types of grouping from existing research. The first is using social value to address the social challenges in communities in response to specific problems. 'Social value' is viewed as subjective and context specific to address a social problem. The second is bringing about change by creating social value rather than wealth for individuals. In this second approach, the idea of social value is not used to address a social problem but is associated with limiting the accumulation of wealth by individuals. For the purposes of this research I focused on the first type of grouping where the creation of social value is expressed to address specific challenges in communities.

The social determinants of health were used in this research to guide the analysis and interpretation of social value, underpinning ideas of health equity. (World Health Organisation, 2008a) Young's (2006) framework of social value expresses this orientation and was used in this research methodology to frame discussions with policy actors. It describes social impact in terms of the extent of social change achieved:

- Social added value: entrepreneurs aim to return more value to their intended beneficiaries for comparable resources expended than other ventures eg ChildLine International
- Empowerment and social change: aim to create a shift in social/economic relations of disadvantaged groups eg ethical retail models – The Body Shop
- Social innovation: allow people to achieve more for less, or solve problems that are otherwise insoluble eg eBay, Big Issue ie combine existing elements in new ways
- Systemic change ie transforms the architecture of how things work eg Grameen Bank Group

This is a helpful distinction because it defines a gradation in the extent of social impact, from relatively modest, (‘added social value’) through to social transformation by achieving ‘systemic change’. Social entrepreneurs could aim to achieve one or more of these social aims. By clarifying the degree of social impact, it addresses the issue of scale, ie how social ventures can be widely replicated to achieve social transformation (large scale change). Scale can be linked to innovation and is sometimes suggested as a core feature of social entrepreneurship. (Anderson, 2014).

Achieving social value can be interpreted as an innovative way of addressing the underlying social causes of ill health. Other researchers have identified four types of social innovation, of which innovative forms of social enterprise are only one.<sup>1</sup> Mason et al. (2015) in relation to social enterprise, proposes that responses may be ‘upstream’ to the social determinants of health (Roy et al., 2013) and/or ‘downstream’, work integrated social enterprise which create pathways to employment for people disadvantaged in the workplace. However, there is no evidence that social enterprises are more innovative and responsive than other types of health care organisation. In his review of the published

---

<sup>1</sup> The other three types are social movements, service related social innovations and digital social innovations.

research, Roy (2014) found that only five studies linked social enterprises to the social determinants of health.

Nevertheless, it can be argued that social entrepreneurs, through their social innovations integrate work across political and social systems to:

- Address system failures at local levels eg economic shocks
- Recognise and harness talent or unrealised value eg resources or people to tackle new policy or practice
- Support upstream interventions which require new alliances and collaborations and new organisational forms. (Mason et al., 2015)

Social innovation must therefore be incorporated into social entrepreneurs' organisational strategy. This is expressed within the organisation through a culture of social entrepreneurship which was described as a defining criteria of social enterprise in section 2.4.3. In so doing, relationship building and networks are an important aspect of management strategy and leadership style which recognises and harnesses talent to achieve social change. In terms of this research therefore, the organisational strategies designed by social entrepreneurs in relation to their social missions may take a number of factors into consideration. They may include the extent of social change envisaged, who the beneficiaries of the social vision are, and the assumptions about community representation and engagement.

To achieve social change, social entrepreneurs use a market in health services to realise social innovation. The logic of a market, one of the institutional orders in institutional logic, has a specific importance to social enterprises in health systems and is the focus of the next section.

### **2.5.3 Change theme 3: Using health care markets to achieve social change**

Markets for health care services are controversial. (Mintzberg and Azevedo, 2012, Mintzberg, 2012) The arguments for and against a market in health care services assume varying degrees of freedom from state control and criticize the power of those with a vested interest in designing markets to further their own interests. Some argue that competition and the introduction of for profit companies will reduce quality of care, that there is a power imbalance in the

policy making process which has been captured by for profit companies. Critics point to the lack of evidence for the effectiveness of policies which promote the 'privatisation' of health systems such as the NHS in England (Reynolds, 2011, Mindell et al., 2012).

Some academics have suggested that market mechanisms, if carefully designed, can achieve social outcomes. Anderson (2014) for example, has suggested three types of social entrepreneurship, each of which uses markets in different ways to achieve social change. The first is where innovation centers on creation of a new benefit to a group through its delivery system. The second changes the way in which an existing benefit is delivered to improve access to or performance of services. The third uses financing schemes to enable benefits to be delivered consistently to a target group over time.

However, there has been very little research on how the logic of the market in health care services influences relationships between organisations. A notable exception is Lyon (2013) who explores how inter-organisational relationships in quasi markets, such as state funded health systems, can be formal (based on contract) or informal (common understanding and word-of-mouth); vertical (ie through the supply chain) or horizontal (across service providers). Competition and markets may influence the nature of collaborative relationships formed by social entrepreneurs. It is unknown how the introduction of market mechanisms with more emphasis on competition may change these collaborative relations. (Lyon, 2013).

The debate in the literature on the role of markets in health care systems demonstrates that a single institutional logic order, such as 'market' may be interpreted differently. Ham (2013) for example suggests that in health care, markets need to operate in different ways in relation to patient needs: cooperation or competition between health care providers will be required to address different types of problems experienced by patients. It may be inferred from this line of reasoning that social enterprises with a social purpose linked to resolving a problem may seek or advocate for different market rules depending on whether they perceive cooperation or competition strategies to be of benefit to them as social entrepreneurs.

Relational systems between organisations within the field will influence the extent to which actors shape the development of markets in the health care system. In health systems, these are largely controlled by the state. For example governance systems impose regulatory and normative rules on activities and actors within the field (Scott, 2000). Regulatory bodies in health systems play a key role in ensuring standards of care (eg CQC in England) or regulating the market (eg Monitor in England). Their role needed to be considered during the data collection phase of this study to explore the way in which they influence the context within which social enterprises' compete for contracts to deliver health care services.

It may be inferred from this review that social enterprises engaging in a health market may be disadvantaged if its design does not support social innovation to achieve social value. This research therefore recognises that the Governments role in setting the rules and regulations which incentivise spheres of activity are important. (Anderson's (2014) These may include how commerce is conducted, rights of workers, environmental issues which determine the social and economic contexts in which change agents operate and affect choices they make regarding how best to focus their efforts. (Stiglitz, 2007) Licencing requirements, tax treatment and other rules affecting organisations may also impact upon the ability of change agents to experiment and express their social entrepreneurial ambitions for social change. However, this research also recognises the role of social entrepreneurs as policy actors, influencing government strategies on health system reform and is the focus of the next section.

#### **2.5.4 Change theme 4: Social entrepreneurs advocating social change**

In section 2.3.2 I drew on the health policy research to describe how policy actors aim to influence the context, content and process of policy formation. These actors may be referred to as policy entrepreneurs in the literature. In institutional logic, actors who demonstrate this strategic behaviour are called 'institutional entrepreneurs' but their ambition is broader than influencing policy. In this research I have used the idea of institutional entrepreneurs to understand how they influence the institutional logic of the domestic health system within

which they engage. Institutional entrepreneurs engage in competition between themselves to win legitimacy, framing an idea so that it becomes institutionalised into the logic of the field. (DiMaggio, 1988, Hardy & Maguire, 2008).

I draw on the theory of agency found in institutional logic where actors are viewed as partially autonomous from social structure. In the institutional logics approach strategic behaviour involves individuals capacity to conceptualise and act on alternative views of rationality within organisations and the field (health system) context.

The challenge for the institutional entrepreneur is to create an environment where existing and new actors stand to gain from the success of the institutionalisation project. In this research, therefore, I captured the ambitions of social entrepreneurs and other policy actors, who aim to change the health system to support the spread of social enterprise ideas in the health system.

Actors perception of opportunity varies depending on their social networks and temporal orientation (past, present or future) (Dorado, 2005). For this research, therefore, I am building on the literature reviewed in section 2.4, which emphasised the importance of the team or community contribution to the development of a social enterprise. Rather than relate the idea of institutional entrepreneur to an individual, I am assuming that individuals may not act alone, but in communities of interest, coming together to effect change in the institutional field of a domestic health system. These communities of interest may be in conflict with each other, over the fluid meaning of social enterprise and the material and cultural changes which need to be made to institutions within the health system field.

In section 2.4.3 culture was suggested as important socio-political context in cross cultural research on social enterprise. By comparing two contrasting health systems, England and Tanzania, I allowed for different cultural values to influence individuals' actions. If actors share common aspirations, their patterns of behaviour may vary depending on their culture. (Swidler, 1986) Culture may therefore support change by providing actors with a 'tool kit' from which they select different actions. Institutional logic approaches recognise that individuals



and organisations access cultural fragments differentially in different social situations. These cultural toolkits are dependent on situational cues (Thornton et al (2012)). In this research, therefore, even if social entrepreneurs in England and Tanzania share common social objectives when they act as institutional entrepreneurs, the health system context within which they work and their own cultural values may influence their social entrepreneurial opportunities which are, in turn, expressed through their organisational strategies and business models.

### **2.5.5 Implication of social change for research methodology**

The research methodology therefore needed to include the concept of social change across each of these four change themes and using the three change processes found in institutional logic. In an institutional logic approach, change in health system logic is viewed as a dynamic between different institutional orders, expressed through the competing actions of institutional entrepreneurs. One logic may be replaced by another or a change in the balance of power between different types of logic may occur. Change may be transformative or developmental. Transformational change involves replacement of one logic with another whilst developmental change results in the assimilation, expansion or contraction of existing logics in a field. (Thornton, 2012) If social enterprises have a distinct logic then this research can elucidate how it competes with other logics which may exist in a health system over time.

It can be argued that health system reform, by its nature is aiming for large scale, transformational change. Existing organisational forms are delegitimised by changes in power alignments which offer new cultural-cognitive frameworks upon which 'new political policies, new legal mechanisms, and new normative frameworks' (pg 49) are normalised. (Dacin et al. , 2002) In institutional logic meta theory, the competing logics underpinning national policy making are viewed as a catalyst for change.

## **2.6 Implications of this review for the research methodology**

New types of organisations, social enterprises, are being introduced into some health systems yet their meaning is contested. In sections 2.3 to 2.5 I built a

research framework which consists of three interrelated components. These are:

1. The health system as a 'field' where governments have a specific role in relation to society and other systems. Actors influence government within cultural and historical moments in time. The research framework needs to acknowledge the capacity of health systems to incorporate a new logic such as social enterprise.
2. Actors agency, who will argue for and contest the meanings of a new phenomenon, such as social enterprise. These meanings may be culturally and historically specific.
3. Achieving social change through actor agency particularly through the creation of social value at an organisational level, using markets to deliver health care services, acting as 'institutional entrepreneurs' to influence health system reform and associated socio-political change.

Recognising that health systems are extremely political environments which are constantly changing meant that one of the challenges to this research was whether any differences in the logic of social enterprises in different national health systems and within communities of interest can be interpreted meaningfully. (Hoffman et al., 2012). Taking an institutional logic approach to frame this research means that the observed logics are a consequence of change, not a cause (Thornton and Ocasio, 2008). Arguably, change resides in a combination of market selection pressures, powers of institutional actors and changes in the relative prevalence of societal-level institutional logics. (Thornton and Ocasio, 2008)

The research methodology therefore needed to consider the following:

- the heterogeneity of actors and how their activities are translated into symbolic systems of meaning (Zilber, 2006) and processes of practice creation ie novel innovations or activities.(Lounsbury, 2007). In this

study I grouped policy actors into policy makers, policy implementers and policy influencers.<sup>2</sup>

- implementation of the same health policy, driven by the same ideology, in different social and political environments, which resist or enable reform, can create different types of institutions and change processes in geographically distinct places. (Zehavi, 2011) In this study I identified the different meanings of the term social enterprise for different actors and compared these across the two health systems.
- different parts of the health system may respond differently to the same reform phenomenon because of differences in the dynamic between the material and symbolic. In this study I compared the organisational strategies and business models used to effect change across different social enterprises and national health systems.
- different levels of the system may reflect different and conflicting values and meanings for change. Where social enterprise is present at a national health policy level, I analysed the reasons for change at different levels of the health system.
- mobilising mechanisms which mediate change pressures and a significant contention within a health system may be used to articulate threats or opportunity. (McAdam and Scott, 2005) In this study, I explored what role social enterprises play in market based health reforms and in relation to health system capacity.

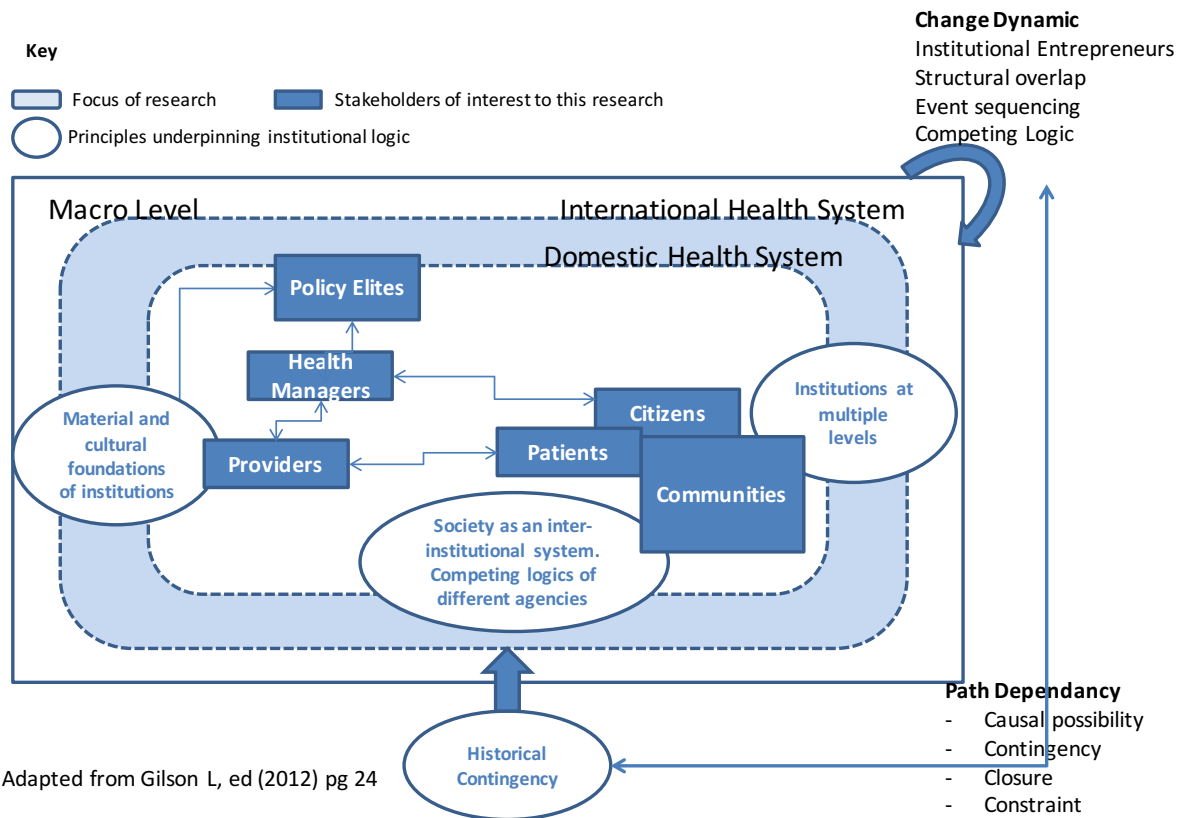
The analytical framework underpinning institutional logic complements the conceptualisation of the health system described by Gilson (2012). Figure 2.2 illustrates the overall framework which I use in this study. Society may be conceptualised as consisting of institutions which function at different levels. In this context these are the international and domestic health systems, organisations and individuals. As described in section 2.3.3, the health system will be contextualised within the idea of society and other influencing systems.

---

<sup>2</sup> Actors can play different roles in different contexts. They may act at both an organisational level or system level. Actors roles can change within the same policy processes. (Walt and Gilson, 1994, Buse et al, 2012)

Bringing into the model the three types of change found in institutional logic introduced in section 2.5, the change dynamic continually interacts with each level of the health system. Change is reflected in historical path dependant processes which will identify causal possibility, contingency, closure and constraint (Bennett and Elman, 2006) and the agency of actors. (Scott, 2014, Thornton et al, 2012)

Figure 2.2 Proposed health systems framework



Adapted from Gilson L, ed (2012) pg 24

The focus of this research is at the domestic (national) health system level. It recognises that individuals (described in sections 2.4 and 2.5) acting as social and institutional entrepreneurs at all levels may influence how institutions in a domestic health system function. Building on this literature review and the development of institutional orders (Thornton et al, 2012) I have added another actor – communities, to reflect individuals acting together as citizens in communities of interest. These ‘communities’ may be geographically based or focused around one or more interests (eg a disease or ideology). It builds on

this review of the research on social enterprise, which suggests that ideas of community are important in the study of social enterprises.

## **2.7 Conclusions**

This chapter brings together the research on social enterprise and health systems. An institutional logic theoretical framework builds on a social construction of the idea of social enterprise. It allows meanings to emerge over time in a health system and in response to the cognitive-cultural toolkits of policy actors, who may act together or in contradiction to each other. The health policy environment will enable or limit the actions of these policy actors to influence the logic of social enterprise in a health system and for the effect of different resource environments on the application of any underpinning logic of social enterprise.

As a starting point for this research Gilson's (2012) health system framework was used as it expresses both the levels of a health system as well as the dynamic between actors and the institutions within it. Roberts et al's (2008) broad definition of health system reform recognizes but is not bound by a narrow focus on neoliberal and other ideologies. Their definition allows for different logics behind health system reform within the structured approach expressed in Gilson's (2012) health system framework. It also complements the approach to defining the meaning of social enterprise and social entrepreneurship in that it recognizes the particular cultural, political and historical context of health system reform.

There are no agreed definitions of social enterprise. However, drawing from the literature, in section 2.4.5, three core characteristics of social enterprises can be used to define a working definition. These characteristics are found in organisations which aim to benefit of a community through their social mission, where profits are reinvested to further the social mission by trading in a market with a culture of social entrepreneurship. Additional characteristics such as organisational governance arrangements, social innovation and community focus may also be relevant.

Social entrepreneurship has a distinct meaning, which is linked to achieving social change within a given cultural and historical context. Social entrepreneurship is expressed by actors engaging in a market for health care services. In the health system context, this market will be designed and managed by government within an ideologically based logic of the need for reform.

Social enterprises, with their focus on achieving social change, can be expressed in relation to the social determinants of health. Social entrepreneurs may be of interest to health policy makers designing health system reforms because through their underlying social goals, they create an institutional vehicle for enabling a policy dialogue about how health need might be met differently.

If the underpinning concepts of civil society are drawn upon, social entrepreneurship may therefore also be characterised by collective action and democratisation to achieve a social purpose. The extent of social change that social entrepreneurs aim to achieve needs to be interpreted with an understanding of which communities or actors may benefit from social entrepreneurial actions and which may be marginalized.

The framework developed from this review of research within the context of institutional logic principles, guides the research methodology in Chapter 3.

## **Chapter 3 Research Methodology**

### **3.1 Introduction**

Social enterprises and health systems are fuzzy concepts, subject to different meanings and interpretations by policy actors. Chapter 2 summarised the literature, describing this fluidity of meaning, which exists across socio-political and economic systems. Institutional logic meta theory provides a way of interpreting the meaning of social enterprise as well as understanding the change processes in health system reform. Such an approach allows a researcher to understand better how reality is socially constructed by different actors, whilst not assigning any value to one interpretation of the logic of social enterprise over another.

From the literature review, we can infer that the behaviour of policy actors can respond to and be influenced by underlying social and economic structures. The literature review also suggests that the meaning of the term social enterprise is sensitive to time, culture and interpretations by different actors. From this perspective the use of the term social enterprise can vary between contexts. The research framework developed in Chapter 2 acknowledges that the meaning of the term also changes as actors share information requiring sensitivity in the methodology to variables such as time (history) and place (geography). The epistemological stance behind this research is therefore both to understand how social reality is perceived and to map contexts in relation to concrete health system change strategies.

This chapter describes the research methodology. It starts in section 3.2 by explaining my ontological and epistemological positions and how they work through in the structure of this study. Section 3.3 describes the study design. I begin by explaining my approach to case studies. I then describe the development of the three research themes, drawn from the literature review and the research objectives, followed by a summary of the research process. How the data were collected is documented in section 3.4. Section 3.5 describes how I analysed the data using grounded analysis. This section concludes by

linking the methodological approach used with a discussion on how the research contributed to the development of theory. It became clear that my position as both consultant and researcher needed further examination as part of the research methodology. Section 3.6 is a reflection on how these roles influenced this study. The study limitations are noted in section 3.7.

### **3.2 Overview of research methodology**

This study focused on a single phenomenon, social enterprise. The framework presented in Chapter 2 expressed three interrelated themes:

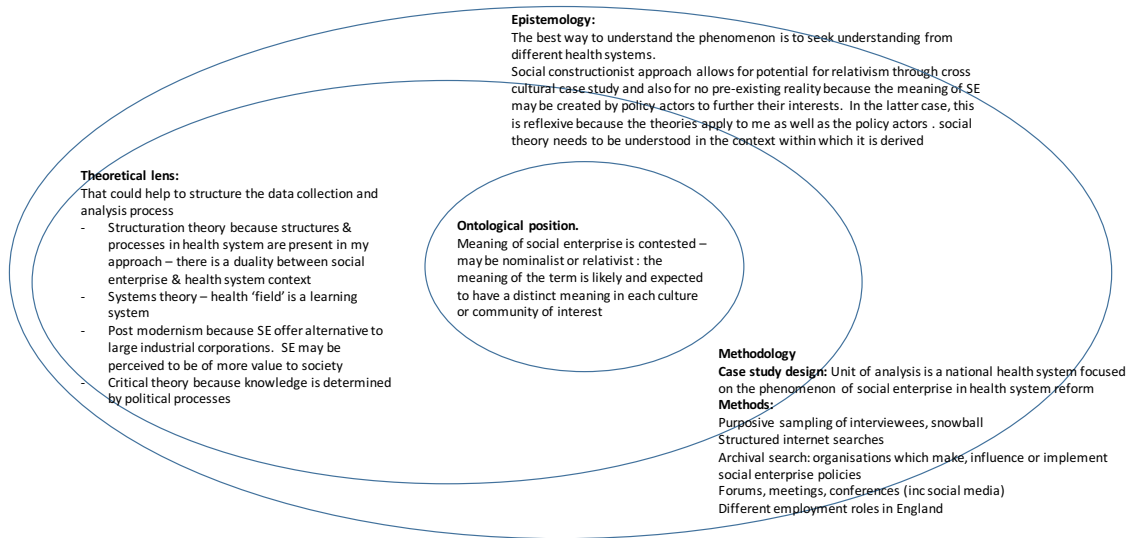
1. the context of a domestic health system
2. the meaning of the term 'social enterprise' and
3. processes associated with actors actions to change health systems to effect social change

The review of published research demonstrated that there is no one meaning of the term social enterprise nor how it was being put into effect in health systems to bring about social change. The previous chapter indicates how social enterprise is a fluid concept subject to different interpretations by actors. Thus meaning may be contested and in addition it might also change over time, across cultures, between different communities of interest and in different contexts.

The research methodology used to explore a phenomenon of this kind is a constructionist one, summarised in the figure below.



Figure 3.1 Overview of research methodology



The study design needed to allow for either the fact that no definitive meaning to the term ‘social enterprise’ emerged, or that clear patterns of meaning emerged as the study proceeded. My ontological position is that there is most likely not one single reality to be found and that social enterprise may be a relative concept, specific to context and sensitive to the perspective of the different actors. This was shown to be the case by researchers who studied the emergence of new phenomenon in other fields (Greenwood and Suddaby (2006) and in health system reform in Europe (Bevan and Robinson, 2005, Evans, 2005, Oliver and Mossialos, 2005, Pollitt et al., 2010).

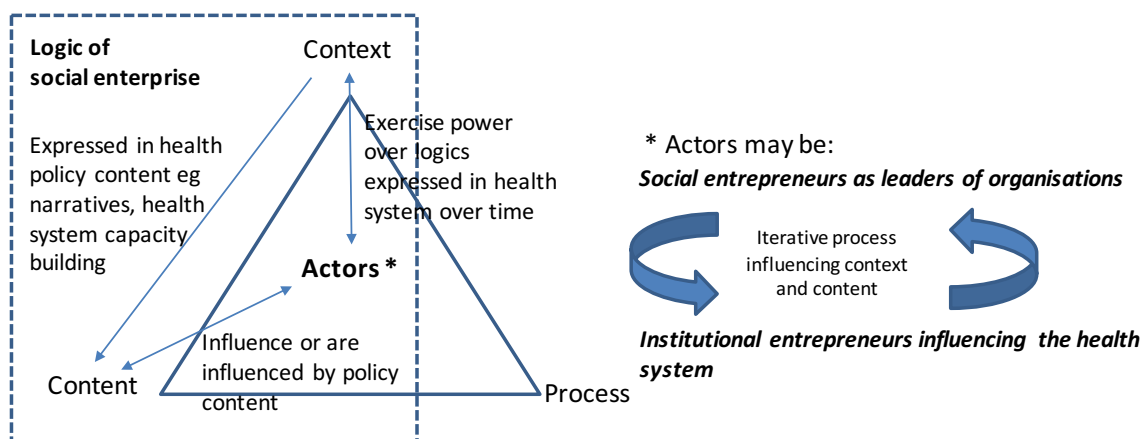
In line with my ontological view I adopted a social constructionist approach to this study, in order to allow meanings to emerge through the iterative process of collecting and analysing data as the research proceeded. I therefore made few assumptions in terms of how actors constructed meanings but rather allowed it to emerge ie I took as far as possible the definitions and understanding of what social enterprise meant from policy actors themselves. This does not necessarily mean that the facts described to me by policy actors were absolute truths, but need to be viewed as context-dependant interpretations. (Gummesson, E, 2000). Epistemologically, therefore, the distinction made between social enterprises as organisations and the health system as an environment where social enterprises interact represented a duality where structuration theory and systems theory were helpful. There were also, I felt,

aspects of post modernism at work as the values expressed in the idea of social enterprise and knowledge, are influenced by political ideologies.

The guiding theoretical framework to structure the data collection and analysis was institutional logic. Chapter 2 indicates that institutional logic allows a study of contemporary events within a historical and systems context, by recognising the role of actor agency within a health system and competing socio-cultural logics. It takes a broadly subject approach ie the research question focuses on how individuals create meaning, interact and construct their world (Cunliffe, 2011).

As a consequence the focus of this research is at a macro field and societal levels of the health system, rather than a micro level. This is illustrated in the diagram 3.2 below.

Figure 3.2 Scope of research



My research approach brings the three perspectives, context, content and actor agency together. Actors, it is recognised, may play more than one role; they can be both social entrepreneurs who lead organisations or institutional entrepreneurs who deliberately aim to influence the logics underpinning health system design. In a similar way, social entrepreneurs may be both leaders of social enterprises or act outside their organisational boundaries to influence social change. They may be individuals, individuals working collectively in organisations or working together as communities of interest. They may also (perhaps even likely to) have imperfect information about each other and the different roles they take on when influencing social change.

The research hypothesises that actors will be constrained or enabled by Governments who promote and control economic exchange (eg through regulation) by aiming to foster stewardship behaviour among actors and limiting undesirable transactions. Also hypothesised is that this context may in turn influence social entrepreneurs organisational strategies and business models. Of particular importance appears to be a consideration that in health systems governments (representing the logic of the state) have responsibility for designing a national health system to meet the perceived needs of its populations. Institutional entrepreneurs may attempt to limit the control and agency of governments.

It is also recognised in this research approach that broader society values may constrain actors possibilities for action. As a consequence, the study design needed to recognise that the context of the health system is often not transferable from one jurisdiction to another (Hoffman et al., 2012). Policy decision making in health systems is very political with multiple actors. (Gilson and Raphaely, 2008) It is also strongly influenced by public opinion, which makes knowledge transfer difficult. (Saltman and Bergman, 2005) I needed therefore to build in some flexibility into the study design to allow for these different policy contexts.

The inter disciplinary nature of this research ran the risk of satisfying the requirements of neither management research nor health policy/systems research. I spent some time during the analysis phase of this project understanding the approach of each. The focus of this research is on the health policy and institutional environment in the domestic health system. This meant that a detailed analysis of policy processes or a systematic assessment of actor power was not within the scope of this study. Nor were analyses of leadership styles in relation to change or detailed single disciplinary approaches to management research such as organisational change, financing etc. My eclectic approach to this research project ran the risk that the underlying assumptions between management research and health systems or policy research were incompatible with each other. Tensions existed between these disciplines which are reflected in this research and include, the position of actor agency in relation to the development and implementation of policy versus the

role of management agency in influencing change; the position of organisational strategy and business models more commonly found in management research in relation to the broader health systems and policy environment when considering health system reform; and the study of institutional logic which is found in management research but not so frequently in health policy and systems analysis.

The next section describes how I built on these considerations in the study design.

### **3.3 Study Design**

The study design was based on a comparative case study approach to compare the domestic health systems of England and Tanzania. A case study in the context of this research was at the level of a national health system, reflecting the concept of a 'field' in institutional logic theory. In this section, I describe my approach to the case studies and the method used to identify the comparative case study.

The case study approach allows for the study of phenomenon. It was particularly suited to this study because social enterprise can be considered as a phenomenon expressed through actors in both organisations and health system contexts. The case study approach offered intensive, in depth study and which was integral to enabling me to challenge my assumptions. (Flyvbjerg , 2006) It allowed inductive theory building from cases where constructs are developed, measures explored and theoretical propositions tested. (Eisenhardt and Graebner (2007).

The unit of analysis used in this study is a domestic health system. It reflects Stake's (2007) description of a case, which is a bounded system with patterns of behaviour. National governments in this study were viewed as stewards of health systems, where policy actors shape how the system is governed and the relationships between organisations (Siddiqi et al., 2009). One of the assumptions underpinning this research therefore was that systems and institutions in the health system are not fixed. Social enterprises may offer more value than other organisations and that this is identifiable through this research

study design and, drawing on this duality of structure and culture is expressed through individual or collective events, actions and activities (Pettigrew et al., 2001) within a national health system.

Case studies are useful for refining theories and suggesting complexities for further investigation. They may enable a holistic view (Gummesson, 2000) and also allow for a single case to indicate a conceptual category (Glaser & Strauss, 1967). In this way, a case study approach is a process which allows the research to identify what is common and what is particular about a case. Stake (2007) describes how case studies may be expressive, demonstrating unique features which may or may not be generalizable, or instrumental, which demonstrate general principles. My research questions informed my approach to case studies ie a case might allow generalizable interpretations of the meaning of the phenomenon 'social enterprise' in the context of a health system but also that there might be learning which is unique to one of the health system's ie that each case may represent different versions of reality (Glaser & Strauss, 1967). Identification of the second case study therefore involved identifying a contrasting health systems context in terms of resources. However, because I was interested in identifying the behaviour of policy actors in relation to the phenomenon of social enterprise, I also need to set certain criteria for selection which went beyond the resource context.

Whilst still retaining the cross country comparison I did consider other definitions of a case. For example, I could have examined a particular programme of activity by taking a programme such as maternal and child health, or a single geographical location within a country such as a county, city or state. However, I rejected these options as I considered the notion of social enterprise to be an organisational construct rather a programme within or between organisations. Other researchers have described how regional culture, management and socio-political context impact upon implementation of national policies. (Atkinson et al., 2000, Miller and Millar, 2011) Restricting the research to one region within a country might, I thought, introduce bias into the research. The research might also have been restricted to the implementation of social entrepreneurship in a particular sector. In England, for example, social enterprise policy has been implemented for different types of health services

organisation (community health or primary care in particular). However, even within England, the type of organisation does not determine the range of services it delivers. Consideration of one type of organisation only might therefore limit the scope of the research unnecessarily. For the purposes of this study, therefore, the scope of the case study need to reflect the whole health system.

To make the scope of this research manageable, I did restrict the organisational scope of this research to social enterprises which deliver health services. Organisations which might perform other functions in a health system such as regulatory bodies or providers of support services eg information technology services were excluded from the research scope.

The identification of the second case study and the approach to the comparative case study design is presented in sections 3.4.1 and 3.4.2. The research process is summarised in the last section 3.4.3, demonstrating how the case studies, research themes and research approach worked together as a whole.

### **3.3.1 Scoping the comparative case study design**

As described in the previous section, for pragmatic reasons, England was one of the case studies. The comparative case study approach adopted was fundamental to the study design. I considered two contrasting health systems to be sufficient to challenge the meanings of social enterprise across different socio-cultural and resource contexts. Most research on health systems focus on either high income countries or low to middle income countries. My choice of a contrast between the two has not previously been done. Using the framework developed in Chapter 2, a domestic health system therefore formed the unit of analysis and within each case I focused the research on a single phenomenon, 'social enterprise'. This approach allowed me to generate theory by giving consideration to local conditions as well as provide an opportunity to develop generalised theory across both case studies.

Previous research suggested that resources were important in the ability of advocates of social enterprises' to act. Comparing the resource context was an

important factor in the design of the methodology for this study. The two case studies therefore needed to demonstrate very different resource contexts.

In England, where social enterprise is known to be present in the policy making process, my study design allowed for collection and analysis of data on how the principles underpinning social enterprise were introduced and then implemented in health system policy. England was one of the cases by default as I particularly wanted to draw on my work experience. In the comparison country, I needed to locate how the idea of social enterprise is understood by policy actors and expressed in the health system, before scoping the analysis.

### **3.3.2 Criteria and process for identifying the second country case study**

This section will focus on the way in which the second country case study was identified, using five initial criteria. These were:

1. Implementation of health policies which aim to deliver access to a universal health care system needed to be present (World Health Organisation, 2008b).
2. Health system policy allows different types of organisation with different objectives to operate within a health care delivery system. As the term 'social enterprise' is not necessarily recognised in different cultures or health policy context, lack of explicit health policies concerning social enterprise will not exclude consideration of the country for inclusion in the study.
3. Civil society: Engagement with citizens and communities is central to health policy development; governments do not restrict citizens rights to freedom for collective action.
4. Relationship to the market. Health care service provision needs to be contestable ie a market needs to exist in some form to allow different types of provider to deliver health services. To achieve access to a universal health care system, services may be funded wholly or in part by the Government.
5. The main language spoken in the country should be English. It would be too costly to have documents translated and to incur the additional expense of a translator to conduct in depth interviews.

Other practical criteria include ease of access to policy actors and stability of the country. Table 3.1 below describes the evaluation of five potential countries against these criteria.



Table 3.1 Countries considered against criteria

<b>Country</b>	<b>Different types of organisation deliver health services?</b>	<b>Civil society? Freedom to associate?</b>	<b>Presence of a market in health service provision?</b>
Tanzania <sup>3</sup>	Health sector strategy plan has specific objectives to include private sector in health financing and delivery. Recognises various forms of private sector (including civil society)	Each region has a Civil Society Organisation (CSO) which works with Councils and Council Health Management Teams (CHMTs) Civil society is 'embedded' within the CHMT structure.	Yes. No explicit management of market to favour one 'type' of provider over another.
Uganda <sup>4</sup>	Yes, recognises a mixed public/private/not for profit mix of organisations in health policy. The private health system comprises the Private-Not-for-Profit organisations (PNFPs), Private Health Practitioners (PHPs) and the Traditional and Complementary Medicine Practitioners (TCMPs).	Active support for civil society through Village health teams & Health unit management committees.	Is explicit recognition in health policy that private providers will have contracts, also to improve fiscal & financing systems to promote private sector growth. There is an explicit policy around public private partnerships in health. Aims to strengthen district & local level structures to support this.
Ghana <sup>5</sup>	Yes, recognises public/private/not for profit mix of organisations in	One of measures of health policy is to improve community understanding of	National health insurance fund and other insurance mechanisms

<sup>3</sup> MINISTRY OF HEALTH AND SOCIAL WELFARE undated. Health Sector Strategic Plan 111 June 2009 - June 2015. United Republic of Tanzania.

<sup>4</sup> GOVERNMENT OF UGANDA 2010. The second national health policy. Promoting People's Health to Enhance Socio-economic Development.

<sup>5</sup> GHANA MINISTRY OF HEALTH 2007. National Health Policy. Creating Wealth through Health. Accra.

<b>Country</b>	<b>Different types of organisation deliver health services?</b>	<b>Civil society? Freedom to associate?</b>	<b>Presence of a market in health service provision?</b>
	health policy. Recognises roles of formal and informal sectors.	their rights and responsibilities in relation to health.	enable providers to be reimbursed for care provided. No explicit management of provider market to favour one 'type' of provider over another.
Kenya <sup>6</sup>	Memorandum Of Understanding agreed between private sector & Government. Some service provision facilitated, but mainly for supplies & tax breaks for donations – latter mainly for faith based organisations. Insurance schemes expanding, but mainly only in urban areas.	Objective in health strategy re: public participation in health decision making. 'Social accountability'. Explicitly recognises non state actors. Communities & households explicitly encouraged to participate in management of local health systems.	Aim to establish a national health insurance system. Also, want to promote community based financing mechanisms. Want to eliminate payment at point of use. Want to promote private sector financing of health.
Thailand <sup>7</sup>	Yes, with explicit support to social enterprises in health through the Prime Minister's office.	Set up social enterprise office by Prime Minister decree in 2011 to promote social enterprise delivery of public services. Specific projects at village and community health levels. Explicit involvement of communities in design & management of local health services. Captured in primary health care concepts in health strategy doc. Use Village Health Volunteers (VHV).	Mixed model of public/private facilities. Three insurance schemes.

<sup>6</sup> KENYA MINISTRY OF MEDICAL SERVICES, M. O. P. H. A. S. undated. Kenya Health Policy 2012 – 2030.

<sup>7</sup> BUREAU OF POLICY AND STRATEGY MINISTRY OF PUBLIC HEALTH 2009. Health Policy in Thailand.

All countries considered had plans to deliver a universal health system. As shown in Table 3.1, all five countries were considered as the second case study. Thailand was excluded because of the difficulty of translating documents from Thai into English. Although some documents are available in English, inclusion might mean that it is difficult to manage costs for the project should translation services be required. None of the remaining countries recognised the term social enterprise in health strategies but all have health service delivery organisations which contain the characteristics of social enterprise within an institutional environment which encourages different types of organisations to contest for state contracts to deliver health services.

Whilst Kenya may have been a possibility, there was less detail in health policy documents about private/public policies in health service delivery. It was therefore excluded.

Tanzania, Uganda and Ghana therefore emerged as potential case studies with no distinguishing factors separating them. Each has explicit policies on public/private mix of health service delivery, within a form of market (although the market operates in a very different way to that in the English health system). Each country has policies to promote civil society engagement in health system delivery and management at all levels.

Of the three, academic links with Tanzania made it more practical to conduct the research for the second case study there. There were differences in the way in which each national health system recognises the role of different types of health care delivery organisation and the management of the market, two key considerations for the context within which social enterprises trade. Whilst both countries recognise the value of different types of organisations and both refer to these as 'private sector', policy makers in England explicitly encourage social enterprises to form. In comparison, health policy makers in Tanzania do not manage the institutional context to encourage one form of private enterprise over another. More detailed understanding of the way the health market was designed at a national level in each country was needed as a first step to analysing the relationship between the underpinning principles of social enterprise in each country and policies related to competition and cooperation in the market of health services.

The role of insurance schemes to fund care in Tanzania also allowed further contrasts to be made with the English system. The latter has no insurance component for publicly funded care.

A risk to this project was that neither social enterprise as a term nor its underpinning characteristics were evident in health policy formation in Tanzania. For example, previous research by Mori and Fulgence (2009) had identified that social entrepreneurship was not included in policy making at all. My research approach to the case studies to manage this risk was to develop a timeline which documented evolution of health policy focusing on the development of a universal health system and the role of the private sector and development of a market to inform how the data collection should proceed and whether or not other changes need to be made to the research approach. Because of the difference in approach to the way in which social enterprise was expressed between the two countries, a culturally sensitive analysis of why policy makers do or do not differentiate between the different types of private sector organisation was made. I also tried to identify any local terms used by Tanzanians which might be more appropriate.

### **3.3.3 Research themes**

This study design allowed theory to be generated in an emergent and flexible way. It allowed cross case and within case analysis. Data collection and analysis was structured against three research themes using institutional logic. This thematic approach built on the literature on health system research. (Evans, 2005, Pollitt et al., 2010, Reay and Hinings, 2009, Scott et al., 2000) It reflected the study design in that each national case study was analysed in depth before cross case analysis began. This 'grounded' approach allowed the research themes to be developed inductively as data was collected and analysed during the research process.

The three overall research themes, were drawn from the framework described in Chapter 2. They are:

- Research theme 1. The health system and its socio- political-economic context of social enterprise policy development and implementation.  
This theme drew on the research of Atkinson et al. (2000) on the social

organisation and political culture of health systems to identify what needs to be present to allow social enterprise to emerge. (Kerlin, 2010, 2013). The levels of a health system expressed through institutional logic meta-theory (Thornton et al, 2012) were used which are reflected at different levels of the health system:

- a. Cultural and national context
- b. Institution
- c. Organisation
- d. Individuals

Research theme 2. The meaning and purpose of social enterprise.

Research theme 3. Social change processes in relation to the design and implementation of social enterprise policies in health systems which include the following:

- a. Policy content: may include concrete plans, legislation or instructions. Policy content may also be informal eg a phenomenon or action which happens anyway because of actors interpretation of the social enterprise phenomenon.
- b. Policy development: which actors were involved, why those actors and how were they involved
- c. Policy implementation: when and how policy is implemented and by whom.

The themed approach to data collection and analysis created a structure for ordering the data, recognising that change processes are messy, subject to the influence of different actors.

The research themes informed specific questions to be explored in interviews and guided collection and analysis of documentary evidence in each country. The three research themes are outlined below (Table 3.2). The interview questions were used as a guide and refined as the research progressed.

Table 3.2 Research themes

<b>Socio/ political / economic context of the health system<sup>1</sup></b>	<b>Meaning of social enterprise within a given context<sup>1</sup></b>	<b>Social Change Processes in relation to social enterprise phenomenon<sup>1</sup></b>
<p>Link to research objectives: 3,4<sup>2</sup></p> <p>Which contextual factors affect design and implementation of SE policies and in what way?</p> <p>What benefits were expected from social enterprise policy? For whom?</p> <p>How soon were the changes in the health system expected?</p> <p>Why do actors think there would be improvements in the health system?</p> <p>How were health system related issues/changes (e.g. decentralisation, financing, public-private mix) considered in the development and implementation of social enterprise policy?</p>	<p>Link to research objectives: 1,4<sup>2</sup></p> <p>What is meaning of the term 'social enterprise'<sup>1</sup></p> <p>What are the terms used to describe an organization with social objectives?</p> <p>How are the five aspects of social enterprise (which were identified in the literature review) applied in this context :</p> <p>le Governance, Collective action, Cultural and historical context, Distribution of profits, Relationship to the market</p> <p>Are there any other distinguishing features?</p> <p>Are there other interpretations of the term? By whom?</p> <p>Is social enterprise a new idea in health policy related to social enterprise? If not, why?</p>	<p>Link to research objectives: 2,3,4<sup>2</sup></p> <p>What policies are related to social enterprise and why?</p> <p>In what way does the wider health/societal policy environment influence the process of policy formation in relation to social enterprise?</p> <p>How was the involvement of the private sector, voluntary /community sector considered in relation to the formation of social enterprise policy?</p> <p>How were civil society (lobby) groups able to influence policy and why (i.e. what made it possible for them to influence policy)?</p> <p>Who advised policy makers on the development of the policy? When, why and how?</p>

**Explanatory Notes**

<sup>1</sup> The three themes overlap and will interrelate eg the interpretation of social enterprise in theme 1 will affect consideration of the wider policy processes in theme 2.

<sup>2</sup> Note: all data need to link to a historical period of time in each country

Archival research of documents on health policy, health legislation or media was done in both countries. Recognising that in England I had a richer knowledge and experience to draw on compared to Tanzania, there was a difference in approach between the two countries which meant that I needed to make a judgement about how to interpret the data. I recognised that there may be multiple versions of reality within a national health system as well as between health systems. I deliberately did not form a judgement about whether one version of reality was 'better' than another. Data were structured to reflect meaning and interpretation of social enterprise terms from each actor's perspective. Where appropriate, the influence of individuals who may also behave as institutional entrepreneurs was also captured.

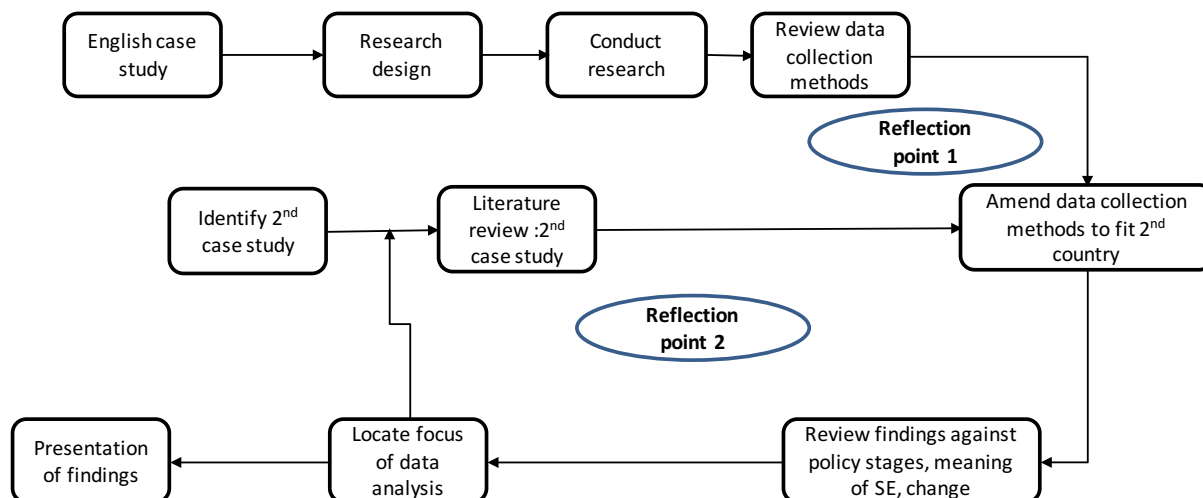
### **3.3.4 Research process**

This process of data collection and analysis was dependant on a number of factors including:

1. Social enterprise emerges as a distinct type of organisation with its own logic, when compared to other organisations delivering health care in the health system in both countries, even if the term 'social enterprise' is not recognised
2. There are identifiable health policies which recognise 'social enterprise' as a distinct type of organisation; and
3. Health system reform actors aim to influence the market, designed and managed by governments (state and market institutional orders) by explicitly recognising or advocating for social enterprises role in health care delivery.

The research process therefore included two 'reflection points' which allowed me to refocus the study design as I developed my understanding of the topic, illustrated in figure 3.3 below.

Figure 3.3 Research process



Each reflection point represented critical decision points in the research process. The first reflection point followed the data collection in England and the literature review of the second health system. At this point the approach to data collection methods was reviewed and compared to my interpretation of the literature review of the health system in the 2<sup>nd</sup> country and then adapted. The second reflection point represents an iterative point in the research process. As my understanding of the health system was less well developed in the 2<sup>nd</sup> case study than that in England, I needed to continually be open to adjusting my approach to data collection as I learnt more about the health system.

At an early stage in my research in Tanzania, it became clear that the idea of social enterprise was not known at a national policy level. I therefore refocused my research on NGOs and policy influencers, because both groups of actors demonstrated either advocacy for social entrepreneurship and / or identified their organisation as entrepreneurial in relation to the health market.

From a research method perspective, therefore, I reviewed the scope of data collection against the research objectives. I decided that the research objectives could be met by refocusing the research onto the collection of data from policy implementer and policy influencers. No changes were made to the interview questions or approach. However, the interviews themselves were more focused than those held in England. I was unsure whether this was because I myself was more focused and experienced as an interviewer or



whether it was because the information collected at interview was more readily available or more limited in scope.

There are a number of practical challenges concerning the collection of data through interviews including the generalizability of the results, the length of time required and resources involved, and the potential difficulty identifying causal relationships (Bennett and Elman, 2006, Easterby – Smith et al., 2008). These were recognised as risks to the project. A number of issues arose during phases 2 and 3 of the research project which needed to be addressed. These included:

- Delay in receiving research approval from Commission for Science and Technology (Costech) in Tanzania. Due to other commitments outside of this research, the project was delayed by one year
- Arranging and then conducting interviews in England was time consuming. In England these interviews needed to be fitted in around my other work commitments. It took six months to complete the interviews in England. In contrast, the Tanzanian interviews were arranged within a short period of time and completed after 2 months.
- The research methodology was amended as learning, particularly in the Tanzanian context, evolved. Not all research themes identified at the beginning of this project were able to be considered in full. These included data on policy processes associated with social enterprise and the socio-political context in relation to the idea of social enterprise. This meant that the comparative analysis was able to be undertaken on the meaning of social enterprise and its associated logic but not on national policy processes. However, interviews with policy implementers in Tanzania revealed a new research theme on the way in which social enterprises engage with the health system and how the design of the health system influences and responds to their presence. This meant that whereas in England analysis of policy processes was directly focused on the implementation of social enterprise policy, in Tanzania, the analysis focused on how the design of the health system (and by implication health system policies) interfaced with the operation of social enterprises. This new focus emerged in Tanzania, and by reviewing the

data collected in England, it enabled comparative analyses to be done on the way in which social enterprise organisational strategies and business models supported social goals. These analyses were then able to identify the criteria for consideration at a national policy level when implementing health system reform strategies associated with social enterprises.

The next section summarises the data collection methods used.

### 3.4 Data collection methods

In both countries, the intention was to collect information through a combination of the four data collection methods: 1) review of documents, electronic and social media, 2) structured interviews with policy actors and 3) observation of policy actors and 4) participant observation. The strengths and weaknesses of each is summarised in Table 3.3 below.

Table 3.3 Sources of Data for the Study

<b>Source of Evidence</b>	<b>Strengths</b>	<b>Weaknesses</b>
1.Documentation eg letters, memoranda, emails, notes, minutes from meetings, policies, news media, social media	Stable and unobtrusive with exact data. Broad coverage over time, related to many events and settings.	May be difficult to retrieve (especially Government documents) and could be biased if collection is incomplete. Documentation for different historical periods may be incomplete or inaccessible.
2. Interviews.	Interviews can be targeted at particular policy actors who may provide insightful, causal inferences. Interviewees responses can be corroborated with each other and other sources of evidence.	Interviewees responses may be biased. Historical periods may be poorly recalled.
3. Direct observations	Formal and informal observations may be made during my day to day work. eg meetings,	This may be time consuming and because I am involved in the development of social enterprises in England, may

Source of Evidence	Strengths	Weaknesses
	creation of networks, use of social and other media.	be biased.
4.Participant Observation	I may assume different roles by participating in social enterprise events to provide data collection opportunities.	This may introduce bias into the research if I align myself too closely with the implementation of social enterprise policy.

All four methods were undertaken, but the volume of material was significantly less in Tanzania than in England. The following sections describe each data collection method in more detail.

### 3.4.1 Documentation

Initially, data collection from documents, social and web based media was undertaken to identify how and when the social enterprise phenomenon emerged and the meanings attached to the phenomenon. A search of the websites of organisations known to be of interest in social enterprise and/or health policy was undertaken using the search term ‘social enterprise’: Department of Health (England), Social Enterprise UK, DFID, British Council, Nuffield Trust, Kings Fund, Ministry of Health and Social Welfare (Tanzania), Health Service Journal, Hansard and Houses of Parliament databases. I did a more general web search using google on the search terms ‘social enterprise’ and ‘health’ with filters for each country, England and Tanzania. These searches were done every 6 months to capture new documents and other material. Documents were selected according to the following criteria:

- written versions of social enterprise policy
- minutes of meetings from committees in relation to social enterprise policy
- newsletter / annual reports of policy actors
- websites of policy actors
- social media discussions on social enterprise
- specialist health service media (in England this is the Health Service Journal) reports on social enterprise

- newspaper reports on social enterprise policy.

I set up alerts on the Kings Fund, Nuffield Trust, Health Service Journal and Monitor websites to track any changes to health policy.

There were some differences in the amount and breadth of data collected in England and Tanzania. Compared to England, where the idea of social enterprise receives significant publicity, there was less published documentation in Tanzania. The table below summarises the volume of data by document type that I collected during the research period:

Table 3.4 Published data collected for research

<b>Source (Collected between 2006 and 2014 in England; 2013 and 2015 Tanzania)</b>	<b>Number of documents</b>	
	<b>England</b>	<b>Tanzania</b>
Department of Health and other government documents	66	20
Social enterprise UK	22	-
Tanzanian social enterprise forum	-	2
Unions	65	
Society values – campaign groups	12	
Social enterprise organisations	46	15
Newspapers (between 1982 and 2014)	52	
Think tanks (inc All Parliamentary Group on Social Enterprise)	28	
For profit organisations eg SERCO, Virgin Health	11	
Donor agencies	0	7
Health service journal (specialist press)	189	
Parliamentary documents eg Hansard, Briefing papers to MPs	18	

I needed some of these publications to undertake my consultancy and interim management contracts. Others, for example, the newspaper and think tank material, I specifically accessed for this research. I also used social media to collect discussions about social enterprise. The Guardian Newspaper had a

social enterprise discussion forum; lobby groups such as 38 degrees also occasionally had discussions about the 'privatisation' of the NHS which mentioned social enterprise. The Health Service Journal, although a specialist publication for NHS managers, always enables discussions and comments about articles.

In Tanzania, I reviewed policy documents and websites of NGO health care delivery organisations, policy organisations and donor agencies. At the time I was doing research, campaigning for the national elections had begun, and there was little coverage in the media on health care system design. Unlike in England, therefore, I did not identify any documentation in the media which I could use in my research.

### **3.4.2 In depth interviews**

I used the framework developed in Chapter 2 to inform a grouping of policy actors to allow for broad role distinctions, acknowledging that these roles may influence actors power to effect change. Actors may be citizens or groups of individuals working together to effect change as 'communities of action'. They may also be health managers or members of policy elites. I developed a distinction between:

- those who make policy (policy makers) and who's focus is at the field (health system) level,
- those who implement policy (policy implementers) who lead social enterprises' engagement with the health system, and
- policy influencers, who lobby for change within the health system.

The ethics committees at Leeds University and Costech in Tanzania reviewed and gave approval for the research to proceed. All interviewees gave their consent to take part in the research.

I purposively sampled policy actors known to be influential in social enterprise policy in England. Gaining access to key actors and documentation was critical to the success of this research. In England, I hold various social enterprise positions in the health system. I therefore had ready access to some interviewees and a large amount of documentation related to health system reform. As I knew some of those interviewed, it was clear that they wanted to

help me personally to do the research so that I could study for my PhD. This personal relationship was instrumental in enabling me to gain access to some of those on my interview list and they also trusted me not to use the information they provided inappropriately. This meant that the interviews started from a shared knowledge base about the context within which we were working, the personalities, actors and relationships.

I aimed to conduct all interviews face to face, but in some cases, this was not practical. In England, two interviews and in Tanzania one interview were held on the telephone.

Data collection in Tanzania was different to that in England. I was not familiar with the Tanzanian socio-political context, nor did I have any personal networks to draw on. The University of Dar Es Salaam kindly agreed to host my research. They provided a range of support including facilitating access to interviewees, reviewing letters of introduction and the data collection approach to make sure it complemented the Tanzanian health system and culture. They provided advice on how to conduct the interviews. I also found a number of Leeds alumni in senior positions in health organisations, all of whom were relevant to my research, wanted to meet me and be interviewed.

I met a group of advocates for social enterprise who had set up a Social Enterprise Forum. They invited me to the Forum meetings as well as sharing their experiences of the issues in the socio-political and economic context of establishing social enterprises as a distinct type of organisation. I also met Cambridge University students who were working with students at the University of Dar Es Salaam to help them set up new businesses. Through both these networks I gained information about health care organisations that they viewed as social enterprises and who would provide valuable information.

Accessing potential interviewees was undertaken slightly differently to England. I started with policy actors who were known to my academic contacts at the University and the Social Enterprise Forum. I then used a snowball technique to identify others by asking the policy actors at the end of the interview who they thought would be useful.

All potential interviewees were invited to take part in the research in the same way in both countries. A letter inviting them to participate in the study with a one page summary of the research was sent to each, followed up by a telephone call or email. If they agreed to an interview, I agreed a date and time with them, and sent them the consent form, which they signed in my presence at the beginning of the interview.

In depth interviews were held with each of the three types of policy actors.

Table 3.5 describes the scope of the interviews in England. The types of policy actors were similar across both countries.

Table 3.5 Policy Actors and scope of data collection in each country

<b>Policy Actor</b>	<b>Scope of data collection in England</b>	<b>Scope of data collection in Tanzania</b>
Health policy makers	All party working group on social enterprise (House of Commons) Social Enterprise policy lead at Department of Health Politicians	Senior civil servants responsible for health policy
Health policy implementers	The actors approached for interview were CEOs of those organisations which hold state funded contracts for the delivery of health services. These included: CEOs of social enterprises in England CEOs of charities holding NHS contracts Private for profit enterprises who	NGO Board level employees whose organisations hold contracts with the State for delivering health care services. <sup>1</sup>

---

<sup>1</sup> In Tanzania, there is a traditional medicine system which works alongside the allopathic focused health system. Interviews with policy makers indicated that different types of traditional medicine are practiced, linked to communities ethnic group. Practitioners are registered individually, and by recommendation from their community. At interview it was not known whether or not these individual practitioners organised themselves into groups to practice. For the purposes of this research, they were therefore excluded from further analysis.

<b>Policy Actor</b>	<b>Scope of data collection in England</b>	<b>Scope of data collection in Tanzania</b>
	use the social enterprise term Two private for profit enterprises were approached to be part of the study, and both refused. Each of them had also held senior policy roles in the Department of Health during the period of study.	
Health policy influencers	Think tanks, unions, professional associations, private sector health care lobbyists, social enterprise and cooperative lobby groups	Professional associations, head offices of networks of faith based health care providers, social enterprise and private sector lobby groups

There was some difference between the two countries in the organisation of the interviews. In England, these were undertaken over a six month period between November 2013 and March 2014. In Tanzania they were done between July and September 2015. Not all potential interviewees agreed to be interviewed, summarised in the table below.

Table 3.6 Number of interviewees approached compared to the number agreeing to interview in England

	<b>England</b>		<b>Tanzania</b>	
<b>Type of actor</b>	<b>Number approached</b>	<b>Number interviewed</b>	<b>Number approached</b>	<b>Number interviewed</b>
Policy maker	14	7 *	7	4
Policy implementer	11	6	8	6 +
Policy influencer	15	7	12	7

\*one of whom was also a policy implementer but for the purposes of this research was classified as a policy maker

+One of these was also a policy influencer. They were classified as an implementer for this research because of the focus taken at interview



Interviewees gave retrospective accounts of policy formation or policy implementation that were relevant to the interviewee. This means that the account may relate to a number of situations, all or some of which were viewed as important context for this research. For example, the account might relate to a particular policy concerning the development of the idea of social enterprise at a national level, equally an account might be an example of how the health system is designed, which affects the operation of a social enterprise.

The interviews for this research needed to be undertaken with an awareness of the political sensitivity of the subject matter. In England, some policy makers approached were unwilling to be interviewed because of confidentiality concerns. Three policy makers and one policy implementer who agreed to be interviewed would not allow quotes to be used from the interviews. All the quotes used in this research were agreed with those interviewed. All interviewees, except one, of those agreeing to the publication of quotes reduced the number of quotes requested and changed the text (but not the meaning). Concern was raised by some that the quotes might enable them to be identified. If this was the case, then we agreed that those quotes would not be published in this research or future publications. In Tanzania seven interviewees agreed to the use of anonymised quotes, each of which was reviewed by them for accuracy.

### **3.4.3 Direct observation and participant observation**

In both countries I was able to employ direct observation techniques, by attending forums for leaders of social enterprises. In England, I attended these in my role as a Director of social enterprises, rather than as a researcher. I balanced these roles by keeping a note of insights or relevant documentation if relevant to my research. I did not include any confidential information I was privy to in this research. These forums included :

- Health and social care forum, run by Social Enterprise UK for social enterprise leaders (2014-2015)
- Member of a national sub committee on financing social enterprises (2009-2010)
- Conferences on social enterprise 2006 to 2015

In 2009/10 I was appointed by the Department of Health to be a social enterprise mentor, supporting CEOs of social enterprises forming in England to manage organisational change. I also held a number of roles as either an interim manager or consultant to social enterprises, which enabled me to observe how the idea of social enterprises was being implemented in different regions in England and types of organisation. Between 2006 and 2015 I worked in Stoke-on-Trent, Birmingham, Bristol, Bedfordshire, Leicestershire, Lancashire and London for 12 health and social care organisations who intended to or had set up social enterprises. This exposure meant that I had practical experience of planning for and the ongoing management of social enterprise generating an enormous amount of data. If I used any of this experience in this research, I obtained permission from the CEO or Chair of the social enterprise concerned.

### **3.5 Data analysis**

I begin this section with an overview of the analytical procedure I followed. To clarify how I have applied the procedures, I provide an example under each research theme of how the data were analysed with reference to the relevant section in the results chapters. I conclude this section with a discussion on how I believe the analysis contributes to theory building, what I have learnt from the process and approaches I might consider adopting in the future given the lessons learnt. All documents, interview recordings and transcripts were stored electronically on the university server and password protected laptop to prevent unauthorised access.

#### **3.5.1 Overview of analytical procedure**

Having read the literature which record the various debates that have taken place extolling the virtues of both content analysis and grounded theory approaches, I recognised that in fact what existed was not two polar extremes but rather, a continuum of practice. I believe that the approach I took in terms of the way I interrogated the data, developed themes and categories and presented the findings, was closer to grounded theory than to content analysis. (Easterby-Smith et al, 2015). The steps I followed and the insights gleaned through the reflective process applied to the data to present the findings was

the means by which I was able to theorise. This process also required gaining an understanding of the cultural and historical dimensions of each of the case studies. Charmaz (2014) has described some of the issues that international researchers who have used grounded theory in their research practice in countries or cultures outside of the UK and North America need to consider when undertaking cross cultural research. In this research, I was particularly careful to build into my analytical approach the different cultural interpretations of the terms used to describe social enterprise and, where appropriate, that the categories developed had a common meaning across both sets of data in each country. However, I also recognised that much research had already been undertaken on the meaning of social enterprise. My approach to analysis aimed to combine this overall grounded analytic approach with some content analysis, (by using some terms or ideas from the literature review) when analysing the meaning of social enterprise. (Hsieh and Shannon, 2005; Flick, 2009) . I attempted to keep the approach as inductive as possible in order to allow new categories and therefore interpretations of the data to be developed. When reading and reflecting on the breadth of data I collected, I feel that by taking this analytical approach it allowed me to build in my personal reflections and experience.

I analysed the data in two stages, within which there were many iterations of the data analysis. These were:

1. Analysis of the data after completion of the in depth interviews in England
2. Analysis of the data from England and Tanzania following completion of the in depth interviews in Tanzania.

As already indicated, the iterative process I used, drew on my reading and understanding of both content analysis and grounded theory but I also read about and incorporated aspects of narrative analytical procedures within the overall grounded analysis approach. This continual review of the data, using the three different analytical procedures meant that I tried to work critically with the material to reflect on interpretations of the data without bias, not necessarily following the concepts of actors. (Stake, 2007) One important illustration of this is that it was not until all the information had been collected and I was in the

process of writing up this research that I was able to place the Right to Request policy in England correctly ie as one policy initiative rather than, as I had interpreted it in earlier conceptualisations, as an ongoing policy. This decision was partly informed by the process of triangulation and corroboration to support the interpretation of the data. It became clearer over time, in policy documentation, that health policy had evolved to focus on mutuals rather than social enterprises. This distinction became important, not just for interpreting the meaning of social enterprise, but also to the analysis of the health system context.

Nvivo was used for analysing the content of the interview transcripts and documents that were collected in England. Interviews from both countries were transcribed word for word in NVivo. However, by stage 2 in the data analysis, given the small number of in depth interviews, I realised that I did not need the data management functionality offered by NVivo. Further, NVivo did not allow time series to be easily developed. Whilst it was possible to do by coding each interview transcript or section of transcript into time defined sets, with such a small number of interviews it was easier to organise the data manually. Some high level coding of the data collected in England, was undertaken in Nvivo and interview transcript sections and documentation organised into themes. It was quicker and more accurate to then examine the detail within each themed group, rather than to continue with detailed coding in Nvivo. I therefore stopped using NVivo after the first stage.

It was important to locate the historical and socio-political context when using all three analytical procedures. This was a fundamental requirement of institutional logic meta-theory. It framed the social enterprise policy process, to provide insight into health system reform processes and underpinning theories. This meant that all the analysis was contextualised to identify historical trends in each health system. For example, I aligned the content of legislation or health policies referenced by interviewees with their views on time and socio-political contexts when non state managed organisations were introduced into each health system (eg Figures 6.1 and 6.2).

Time periods were created by organising the data sources into sets. Analysis of the documentation over time informed identification of path dependency and

causal complexity underpinning decisions made by actors when introducing social enterprise as a strategy in health system reform. For example, Figure 6.2 was developed by analysing the policy documents in England to review when and how the term 'social enterprise' began to be used in health policy and what the key policy priorities were at each period in time. This was then compared with the interview transcripts to create a timeline which documented when different policies associated with the introduction of private health care provider organisations and the market was introduced. This analysis underpinned Chapter 6 on the introduction of social enterprise into the health system in England.

### **3.5.2 How analytical steps were followed**

At each stage of analysis, I set out to follow the seven step process suggested for a grounded analytical approach that is suggested by Easterby-Smith et al (2015, pg 192):

- Step 1. Familiarisation
- Step 2. Reflection
- Step 3. Open coding
- Step 4. Conceptualisation
- Step 5. Focused re-coding
- Step 6. Linking
- Step 7. Re-evaluation

Finding this useful, I decided to follow the same analytical process for each theme being examined. At the beginning of each stage in the research, Step 1, I read through each interview transcript to familiarise myself with the data and to reflect on patterns and meanings. In stage 2, I also reviewed the statistics on the socio political and economic context of each country from published policy documents, agencies such as the Office for National Statistics in the UK and WHO. Stage 2 involved a more detailed analysis of the data. This was because the data from Tanzania challenged my conceptual framework in the following areas: the meaning of social enterprise and organisations strategies to achieve social value, health systems strengthening to support the development of social enterprises and business planning. As the research proceeded, I developed new insights. As these emerged, I added them to the analytical process.

At the end of each stage, I wrote a short report which summarised the research results from the interviews. I emailed the report to each interviewee seeking comment via email. In this way, I tried to check my interpretations of the data with those I interviewed. One of the interviewees in England raised concerns about the definition of social enterprise as she felt strongly that the meaning related to employee ownership. I noted her argument for consideration in the next stage of analysis. I decided that when compared to other interviewees that her views did not justify considering employee ownership as a core characteristic but could be adequately represented as a non core characteristic of social enterprise. Her strength of feeling reflected the political tensions present in the debate. None of those in Tanzania raised any matters of accuracy or commented on the content.

There were differences in the analytical procedures I followed in each research theme due to both context and my own learning. Some examples of the types of analysis when analysing the different themes and how these differed are illustrated below.

Research theme: Socio political and economic context of the health system.

In this theme, an early process I adopted was to align health priorities with each policy implementer organisation's scope of services, the results presented in section 4.3.

At step 3, I reviewed the latest published national health strategy document and identified health priority areas in each country. I made a list of priorities. I then reviewed each organisation's website, documenting the scope of services provided, noting the services on the table against each priority area. Step 4 involved reflecting on the two lists. Of interest to this research was the breadth of services provided by some of the policy implementers' organisations, which I used later on in the analysis when I developed my conceptualisation of the social determinants of health and social purpose.

For the purposes of the analysis of health priorities, step 5 involved a review of how I had categorised services against national health priorities. There were no changes required. I then reviewed the policy implementer interview transcripts against each health policy priority to identify if they specifically mentioned the

service at interview as an opportunity for the social enterprise. These were noted against each health priority. Any services which were not national health priorities were noted separately and used in the analysis of the social determinants of health below.

The services mentioned at interview were added to the table (step 6) with the description of how the interviewees viewed these as opportunities.

#### Research theme: Meaning of social enterprise

When interpreting the meaning of social enterprise to produce the results presented in sections 5.2 and 5.5, I used two different approaches to coding. In step 2, I used codes derived from the literature to do an initial content analysis of each interview eg using terms 'social enterprise', 'mutual', 'charity', 'social', 'community'. Then, in step 3, I analysed the interview transcripts using open coding to identify other terms which might have been used to describe not for profit organisations. Themes were collected together and when found in another transcript, it became a category. I derived four categories which included faith, non governmental organisation, not for profit and for profit. The sections of the interview transcripts that related to questions on the meaning of social enterprise were sorted into a matrix by interviewee and type of interviewee in each country (step 4). In step 5, new categories were defined by reviewing how interviewees describe the meaning of social enterprise. Seven new categories were developed. To complete the table, in step 6 I counted the number of interviewee responses against each category and used this count to identify the core and non core characteristics of social enterprise. These characteristics were linked with the institutional categories found in the institutional order community to identify the underpinning logic behind the meanings of the terms.

From the analysis above, social value became a core characteristic of social enterprise. I reflected on the policy implementer interviewees in Tanzania, all of whom were very clear about how their social purpose aligned with the social determinants of health. I developed three new categories which related to types of social enterprise: holistic, health care and lifestyle social enterprises. I started with step 3 and reviewed interviews transcripts and coded any sections which referred to social value. I conceptualised these transcripts by sorting all those

sections of the interviews which mentioned social value into a separate excel spreadsheet, by interviewee by country. I noted on a table which organisations' social value reflected a social determinant of health, allowing for more than one social determinant of health to be identified per organisation. In Step 5, I re-coded these organisations into three client groups. I linked, step 6, the new client grouping and went back to Step 5 to review from the organisations websites and interview transcripts what organisational strategies were followed. These were noted against each client group by organisation. Step 7 then involved constructing a table which showed each policy implementer, their client group, their social purpose and organisational strategies. I then anonymized and summarized the data for presentation in section 5.7 in this thesis.

I feel that this iterative approach to the data analysis, allowed me to develop new insights as the research progressed. It could not have been done in one linear process. Taking this grounded approach with an iterative process of analysis and reflection allowed me to develop this new idea, which has not been attempted before in health systems research.

#### Research theme: Social change processes

Policy actors used storytelling to advocate for or respond to social enterprise policies in England. From my analysis of policy processes related to social enterprise in England, it was evident that storytelling was used by several policy actors to illustrate their perspectives on the policy. I therefore thought it was important to undertake a narrative analysis of interview transcripts, politicians speeches and policy documents to find out how people created and used stories to argue for or against social enterprise policies. Story telling also emerged as an important way for policy actors to advocate for change in England and in Tanzania. It also helped me to order ideas and events into the appropriate historical time period.

My approach to narrative analysis focused on how policy actors express their vision and goals as a management tool for change (Lawler, 2002). I followed the four stages of analysis described by Easterby-Smith et al (2015, pg 208) ie selection, analysis of the narrative, re-contextualisation and interpretation/ evaluation. I was interested in analysing what was said by whom and in what



context. From the interviews I identified two documents (Hewitt and Unite) as being important. These were analysed to provide insight into how the idea of social enterprise was 'sold' to (in the case of Hewitt) or resisted (in the case of Unite) by policy actors. These authors used storytelling to advocate for their perspective on the implications of the policy, contextualised in relation to time and interpreted in relation to their ideological stance on the introduction of social enterprise. The results of these analyses are presented in sections 7.2.4 and 7.2.5.

Further analysis of the interview transcripts from England was undertaken, using narrative analysis to interpret how stories were used by interviewees to illustrate their views on the reasons for the policy and how the change was managed. Where appropriate, excerpts of these stories were presented as quotes in Chapters 6 and 7. The interview transcripts were also analysed to identify if different interviewees used narratives to advocate for social enterprise. In both countries policy implementers used storytelling to describe social innovations their social enterprises had facilitated. Some of the quotes in sections 7.3, 7.4.2 and 7.4.3 illustrate this.

If I had restricted my analysis to a single procedure (eg grounded or content analysis), I would have missed an exciting opportunity to develop my understanding of how storytelling was used to effect or challenge change. Greater understanding of this process, gained through my use of narrative analysis techniques, enabled me, as a practitioner, to consider how it might be used to advocate for developing the evidence base of the value social enterprises offer health systems.

There was much personal learning from undertaking this research and inevitably, I would make several changes to the research methodology if I were to repeat this study. The data collection process was inefficient. Much of the data I collected was not used, for example, I collected conversations and articles from journalists and social media about social enterprise. From my experience of analysing the data for this project, I have a better understanding of the relationship between data collected and how the data analysis process builds theory. The use of the research themes worked well. I was surprised at how clear the results were when the data were analysed by research theme. In

retrospect the analysis within each theme could have been developed more at the beginning of the study. However, this was the first time I had used qualitative research analytical procedures and needed to 'try out' how different procedures could be used on my research data. In the future I will be able to build on this experience to plan more thoroughly how these techniques can be applied. My periods of reflection were also critical to allow me to think inductively and creatively about the data, rather than taking a mechanistic approach to the data analysis. Next time I will feel more confident about focusing the scope of data collection, and building into my approach more periods of reflection. It was during these reflective moments in the research process that I made the theoretical links between the results and the development of theory.

Following these two stages of analysis, I reviewed the results to review how far I had met all the objectives for the research and addressed each of the research questions. The next section describes how I built on the analysis to develop theory.

### **3.5.3 Theory building**

I approached data collection and analysis continuously so that new concepts, variables and relationships could emerge. (Eisenhardt, 1989, Eisenhardt and Graebner, 2007) In this way, I iteratively evolved the constructs until I felt that the results from the analysis and the theoretical implications had been fully developed. In this process, I kept up to date with the academic literature on health system reform and social enterprise, as research in this area began to be published. Conflicting results between England and Tanzania were used constructively to build theory. I tried to 'unfreeze' my thinking (Eisenhardt, 1989 pg 546), by selecting research themes to examine within group similarities with intergroup differences, exploring the similarities and differences between each case study and then developing new categories and concepts.

Eisenhardt (1989) suggests that tying together underlying phenomena which would not normally be associated with each other should result in theories with stronger internal validity, wider generalizability and higher conceptual level. The resulting theory is more likely to be empirically valid. I approached this challenge by bringing together the management and health policy research

approaches. The two disciplines are different in a number of ways. Health policy research recognises the multi disciplinary nature of the subject, and broadly focuses on power, structure and processes. Management research concentrates on the nature and consequences of managerial actions in organisations and business research is more likely to focus on the determinants of corporate performance. (Easterby Smith et al, 2012). Gilson (2012) highlights the importance of qualitative studies in health system analysis to derive analytical generalisations which enable comparisons between countries and contexts over time, and in patterns of behaviour or features in the context that influence policy change. My approach to theory building has been to build on these two disciplines, combining the health system approach to context with the management and business focus on organisations. This research methodology therefore attempts to bring the two approaches together to build on or develop new theories about health system change. It recognises the role of power in the actions of actors, but also the role organisational actors play in shaping and making sense of the health system context.

The case study approach drew on analysis of historical context, helping to create order from the considerable data generated from this research approach and to identify patterns. (Gummesson, 2000). Whilst no two sets of circumstances are identical, I used this historical perspective to help me to compare the two health systems. It helped formulate my strategic thinking behind the three discussion themes.

In this way, I built from the research results, to identify any additional learning and implications to inform the discussion chapter. Three discussion themes emerged. Construction of the logic model to inform the meaning of social enterprise was done using core and non core characteristics drawn from the results presented in Chapter 5. I was able to identify the common meanings across both countries (the 'core characteristics'), which could then be distinguished from local perspectives of the idea of social enterprise ('non core characteristics'). The second theme was the relationship between organisational strategies, business models and achieving a social mission. New models for aligning business models with the social purpose of the organisation

and organisational strategy were drawn from the results in Chapters 5 and 7. The proposed approach to business planning describes how they can be applied by social enterprise practitioners. The third theme was the relative importance of health system context in comparative research of implementation of social enterprise in health systems. The diagnostic tool which was developed in the discussion chapter drew on all the results. It brings together learning from social enterprise leaders and influencers in both countries, and policy makers in England, all of whom recognised that health system context was important, influencing social entrepreneurs strategies for social change and health care delivery.

### **3.6 Role of the researcher**

As a consultant and senior manager in health systems planning and implementation, I had experience of managing change within organisations and in health systems at regional and national levels. I was aware of the important role of management agency in both influencing the development of health policy and in its implementation. In my various roles, I had worked with Boards to manage risk, plan for strategic change and develop ways of demonstrating the impact of social enterprises. However, I was unprepared for the gap in research on the dynamic relationship between the institutional environment and organisations, particularly when organisations, as in my case, were viewed by some policy actors as having a distinct logic. This section describes how I brought together the practitioner and research perspectives in my approach to this research, including the benefits my experience brought to this research project and also the personal challenges. Further detail on the impact of this research on my personal practice is provided in Annex A.

As I work in the field of social enterprise in England, it was pragmatic to choose England as one of the case studies. The social reality and knowledge obtained for this research was, at least in part, influenced by my own subjective context in both time and place. As the study proceeded and particularly when I visited Tanzania, I became increasingly aware of this. I tried to distinguish between reflection and dialogue/action ie as a researcher, I tried to maintain my distance and develop concepts and theories about social enterprise in health systems

whilst as a consultant I needed to intervene to deliver project outcomes or business objectives.

In this study, over a number of years, I was also a policy actor, drawing on my experience and involvement of social enterprise in England to support government policy makers to implement social enterprises in the NHS in England. I have held various policy implementation roles as interim CEO of new social enterprises delivering health care services and these different roles again have enabled me to see social enterprise from different perspectives.

As a consequence I have built this autoethnographic perspective into the study design and shown where my knowledge and understanding changed as the study progressed. In this way, I became both the subject and object of the research. This learning occurred at the very beginning of the research. As a consultant, I have been used to looking for solutions. The research process has helped me focus on wider understanding prior to acting. I took a reflexive stance, both belonging 'inside' the research as well as observing from the 'outside' (Hayes, K, 2012)

The advantage of recognising and building on my role and experience as a consultant is that in England I had better access than others to interviewees and information about social enterprise context. Those I interviewed in England shared my experiences in setting up social enterprise. Some were peers with common interests and outlook as my own. These shared experiences need to be recognised, perhaps more approximating ideas of 'collective ethnography' (Cohen et al, 2009). In this way the relationship between myself and interviewees reflected a continuing dynamic between us, which is present even today after the research has been completed. I have come to see that collective understanding as a consequence of my research is the first step to real change based on a common purpose. Those who I interviewed in England continue to be supportive and interested in the outcomes of this research, facilitating dissemination of results. Through my intervention they became more aware of the issues facing them, their own views, how they were formed and how they might be changed. This experience suggests that the relationship goes beyond the interaction between the interviewer and interviewee from a shared knowledge and understanding developed from historical interactions (Garton

and Copland, 2010) to include a perspective on the future dynamic of the relationship as well. In this way it could be possible that the process of doing research and my research findings initiated change. (Gummesson, 2000)

As a researcher and consultant I was also acting as a change agent. This required a trusted relationship between me and decision makers, which depends in part on my preunderstanding and professionalism. (Gummesson, 2000). I recognised that the act of entering into dialogue with policy actors may influence their knowledge and interpretation of social enterprise phenomenon. In Tanzania, the relationship between myself and the interviewees was as a peer interviewing a peer. We were jointly constructing meaning (Garton and Copland, 2010) by exploring definitions, outlooks and inter cultural differences in interpretations of terms. In Tanzania the interview contents became increasingly disruptive to my preconceived ideas of social enterprise. This critical reflexivity, described by Hayes (2012), was important for the development of the theories arising from this research project.

This personal, autoethnographic perspective to my research complemented the concepts of institutional logic meta theory. Using the institutional logic orders and the change processes to guide my thinking it challenged my own cultural and experiential perspectives on social enterprise. In this way I allowed for the differences between individuals, between individuals in different countries and the way the meaning of social enterprise has developed in each country over time. It assumed that :

- socially constructed realities emerge over time and may be objectified and sometimes contested. Different realities, created by human action and interpretation, may co-exist, be contested and fragmented; (Cunliffe, 2011)
- construction of reality is a process with inter related actions, elements, structures and system which are context dependant (Cunliffe, 2011)
- cultural differences in the social construction of reality can be discerned by comparing why and how policy actors in different national health systems use the idea of social enterprise.

The autoethnographic aspect to this research influenced the methodology by recognising my role and experience as a practitioner in socially constructing meaning in each health system. That actors (including myself as researcher and consultant) aim to change the underpinning logics of a health system to further their social missions to effect change in societies. The approach to 'case' was fundamental to this research approach and will be considered in the next.

### **3.7 Study Limitations**

This study has been scoped to enable it to be completed within the timescales and resources of a PhD. If more resources were available, more case studies could have been undertaken. The results of this study provide a starting point for further research. By undertaking research across two contrasting case studies the framework(s) developed from this study can be tested in other domestic health systems in further studies. Limiting the case study selection criteria to English speaking countries was pragmatic, reflecting the resources available. Further studies can be undertaken in the future using the framework(s) developed from this study to apply the learning to non English speaking communities in different cultural contexts.

The conceptual challenge of applying social enterprise within a health system context remains throughout this study. The lack of consensus on the meaning of social enterprise and the lack of clarity on the conceptualisation of a health system offers opportunities for this research to contribute to the ongoing debate amongst researchers and policy makers on what these terms mean in different contexts. Rather than considering these conceptual challenges as a limitation, I would argue that they offer scope for innovation in the research that is undertaken and for policy actors to design culturally and historically specific improvements to domestic health systems.

Preparation for this research project indicated that very little previous research had been undertaken on the relationships between health system reform and social enterprise. There was also no research that I was aware of which compared case studies in health systems in low to middle income countries and a high income country. This introduced several methodological challenges:

1. Taking a social constructionist approach to this research meant that my understanding of the subject area was shaped by who I interviewed, the authors of the documents I read for this study, and my own experiences and culture. I was conscious in Tanzania that my idea of what social enterprise means in a health system was shaped by my experience in England. When policy makers in Tanzania said they had no knowledge of the term, the task was to uncover how they interpreted the closest construct to social enterprise which was the idea of 'not for profit' organisations. I was looking for coherence between my culturally determined idea of social enterprise and the Tanzanian idea of not for profit organisations. Whilst it is acknowledged in this methodological approach that the observer is part of what is being observed, the degree of objectivity of myself as a researcher and practitioner may be questioned.
2. The validity of the results of this research need to be tested within Tanzania, England and others. A significant quantity of 'data' was generated, and some selection needed to be done to explore the patterns of interest to me as a researcher. Others will have different areas of interest.
3. The theoretical abstractions are based on just two national health systems. Both the framework for interpreting the meaning of social enterprise and the diagnostic tool were outcomes from this study which need to be tested and refined in different contexts.
4. The reflexive nature of the research based on interviews and experiences are very subjective. As outlined this subjective was partly based on my strengths and weaknesses not just as a researcher but also in my ability to reflect on my own behaviours in the work context. Not all of the change projects I was involved in that were related to social enterprise go smoothly. This emotional aspect my work needed to be managed by me to achieve results in the work place. I tried to control for alternative explanations of results, and analysis was undoubtedly influenced to some degree by my personal outlook on the work at hand, this research project and obtaining data.



5. Whilst this research methodology enabled an understanding of processes and meaning, and allowed both data and experiences to generate theory, it was very time consuming. At times it felt unfocussed and risky as ultimately, my personal goals were clear. Studying for a PhD is not a trivial undertaking.

Nevertheless, despite these limitations, this research study is the first of its kind. There were advantages in taking a phenomenon such as the idea of social enterprise rather than a programme or single policy area. This approach to the study scope allowed the research to focus on the logic of the phenomenon and how this was expressed in different ways throughout the whole health system at different levels including a type of organisation, health system environment, as well as actor agency.

### **3.8 Conclusions and summary**

The framework developed in Chapter 2 guided the research methodology. From the literature review, I identified three characteristics of social enterprise. These were used as a starting point to define the meaning of social enterprise. The study design allowed for further characteristics to be identified. Recognising that the emergence of social enterprise as a phenomenon in health system reform may be related to and impacted by other health policies. The socio-political and economic context of a national health system acknowledged the different structural layers of a health system and how these might influence the dynamic of the health system in relation to social enterprise. (De Savigny and Adam, 2009)

Data were collected using four data collection methods. These were the review of documentation, interviews, participant observation and observation of policy actors. A grounded analysis approach was supplemented with content and narrative analytical procedures where appropriate. Data were ordered into a timeline of events for each case study which shaped the analysis of the sequence of events linked to the emergence of the social enterprise phenomenon in each country.

Explanatory theories in one country were developed and explored in relation to the other country to develop theories for change. However, this methodology was not without problems. Ensuring the scope of the research is focused on the research question was critical to the success of this project. This iterative approach meant that the research methodology was risky in that time and resources limit the extent to which new data collection could be undertaken if analysis of the Tanzanian data suggests a different data collection topic was required in England. However, these risks were managed and can be used to inform future research studies in health system reform.

Chapters 4 to 7 present the results of the research. I start in Chapter 4, by comparing the resource base in England and Tanzania, comparing both health policy and resource context in each country before illustrating how social entrepreneurs interviewed for this study developed their organisational strategies in relation to the resource context. Chapter 5 presents the different meanings attributed to the term social enterprise, comparing each country. It identifies core and non core characteristics of social enterprise and concludes with a proposed grouping of organisations social purpose against two criteria: the social determinants of health and client group. Chapter 6 explores the reasons why policy makers choose to invite privately managed companies to deliver health care services. Chapter 7 considers social change, the purpose of social enterprise, from the perspectives of social entrepreneurs acting as institutional entrepreneurs who advocate for changes to the health system.

## **Chapter 4 Comparing the resource base in England and Tanzania: social enterprise context**

### **4.1 Introduction**

The case study design for this research required two contrasting health systems where resources differ. This chapter compares the health system vision and priorities in England and Tanzania, locating these within the demographic and other resource context. This initial section is followed by a short description of the scope of state funding in each health system (4.3) and how this links with health system reforms described by interviewees and found in policy documents. Section 4.4 describes how this resource context influences social entrepreneurs actions in designing their investment strategies (section 4.4.1) and human resource capacity building (section 4.4.2). The chapter concludes by bringing together the results presented in this chapter to summarise how the role of governments and the institutional logic of the state influences both the social enterprise context and their resource opportunities.

### **4.2 Health system vision and priorities in England and Tanzania**

The quotes below describe the vision for health in both countries.

England:

‘Everyone has greater control of their health and their wellbeing, supported to live longer, healthier lives by delivering high quality health and care services that are compassionate, inclusive and constantly-improving’. (NHS England, 2016b)

Tanzania:

‘The vision of the Government is to have a healthy society, with improved social wellbeing that will contribute effectively to personal and national development. The mission is to provide basic health services in accordance to geographical conditions, which are of acceptable standards, affordable and sustainable. The health services will focus on those most at risk and will satisfy the needs of the citizens in order to increase the lifespan of all Tanzanians’. (Ministry of Health and Social Welfare, undated pg 17)

Both England and Tanzania aim to provide a universal health care service to all their citizens. The scope of health care includes prevention and wellbeing as well as curative services, thereby addressing the broader social context within which people live. In Tanzania health care is viewed as playing a key role in national development. Vision 2025<sup>2</sup> (Tanzania, 1999) sees the private sector as: “an engine of growth for building a strong, productive and renewing economy”, and “unleashing the power of the private sector for economic growth and other social purposes”. NHS England has a specific mandate for furthering economic growth by supporting people with health conditions to remain in or find work. (NHS England, 2012 pg 6 para 12)

There is a significant difference in the resource base of the two countries. This observation from a policy implementer illustrates the importance of the resource environment in relation to planning organisational strategy and the influence of the state.

‘I went to India on a social enterprise tour about 6 years ago now. The thing that struck me was... they were working to 30, 40, 50 year business plans & [reference to an organisation] was working to a 200 year business plan. That's the difference. We can't stick to a business plan for longer than a few weeks. The policy environment doesn't help because governments are working to too short a time span, so they don't want a commitment to the long term.’ *Policy implementer England*

For the purposes of this research I have compared the two countries from a range of perspectives, each of which has relevance to the analysis and interpretation of the data in this study. The statistics I draw from are those identified by Kerlin (2013), (described in section 2.4.3) as being important in influencing social enterprise models. A definition of the statistics used can be found in Annex B.

Firstly, the statistics demonstrate how the demographic profile of each country links to their respective health policy priorities. Adult literacy, for example, influences the nature of engagement health organisations with the general

---

<sup>2</sup> Following elections in Tanzania in 2015, significant changes are being made by the new President. A new National Action Plan is being prepared, which at the time of writing this thesis had not been released (January 2016)

population particularly in areas such as health promotion and participation in decision making at all levels.

The statistics presented in the table below demonstrates the scale of the health challenge in Tanzania.

Table 4.1 Demographic statistics for England and Tanzania

Indicator	England	Tanzania
Population	64.16m (UK: 2014 estimate) (1)	44.93m (2012) (8)
Life Expectancy at birth (England and Wales)	79.3 (males) 83 (females) (2011 to 2013) (2)	61 years (2012) (8)
Fertility rate, total (births per woman)	1.85 (2013) (3)	5.5 (9)
Adolescent fertility (15 to 19 years)	26 per 1000 (3)	81 per 1000 (9)
Annual population growth rate	0.6% (2014) (4)	3.2% (2014) (4)
Infant mortality rate	3.9 per 1000 births (2014) (5)	45 per 1000 births (2012) (8)
Maternal mortality rate	10 deaths per 100,000 women giving birth (6)	432 deaths per 100,000 live births (2012) (8)
Adult literacy (15 years +)	99% (7)	78% (2012) (8)

(1) (Office for National Statistics, 2015)

(2) (Office for National Statistics, 2014)

(3) (Office for National Statistics, 2013)

(4) (World Bank, 2016)

(5) (Office for National Statistics, 2015)

(6) (Knight, 2014)

(7) (Literacy Trust, 2011)

(8) (United Republic of Tanzania, 2014)

(9) (United Republic of Tanzania, 2015)

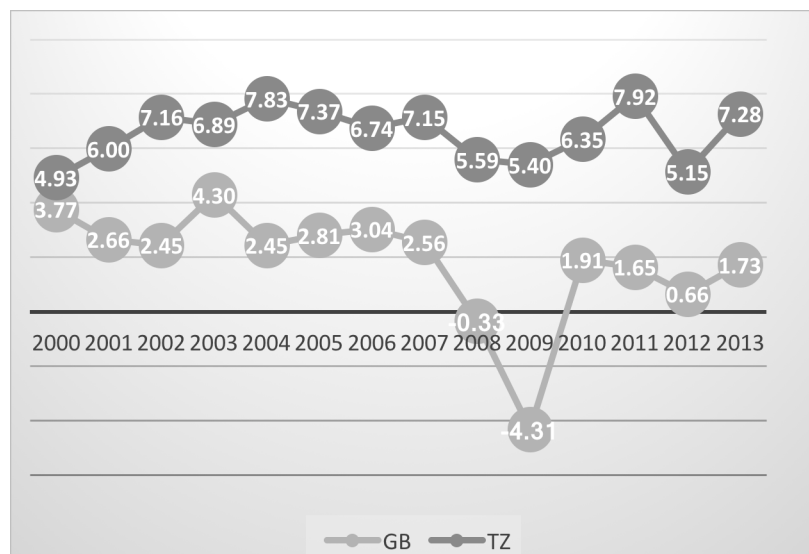
Tanzania, compared to England has two thirds of the population of England and significantly lower life expectancy at birth. The fertility rate is over three times that in England, measured by total births per woman and adolescent fertility.

Infant and maternal mortality rate is high. Adult literacy, at 78% of the population aged over 15 years is lower than in England.

A comparison of selected economic data is relevant to this research. In both countries the State manages the health system and access to government funding for delivery of care. The overall 'health' of the economy is a factor in the availability of government resources to deliver health services. Figure 4.1 below illustrates the annual percentage growth rate of GDP in each country.

Figure 4.1 Annual Percentage growth rate of GDP.

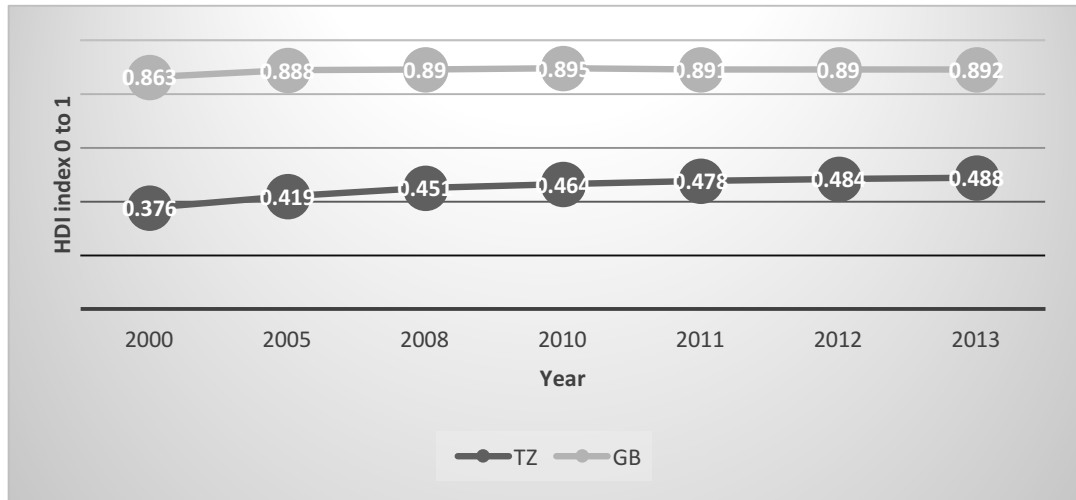
GB (Great Britain) and Tanzania(World Bank, 2014a)



Growth of GDP demonstrates that the Tanzanian economy is growing faster than the UK economy but GDP per capita is very different. In 2013, it was US \$694.77 in Tanzania compared to US \$41748.47 in the UK.

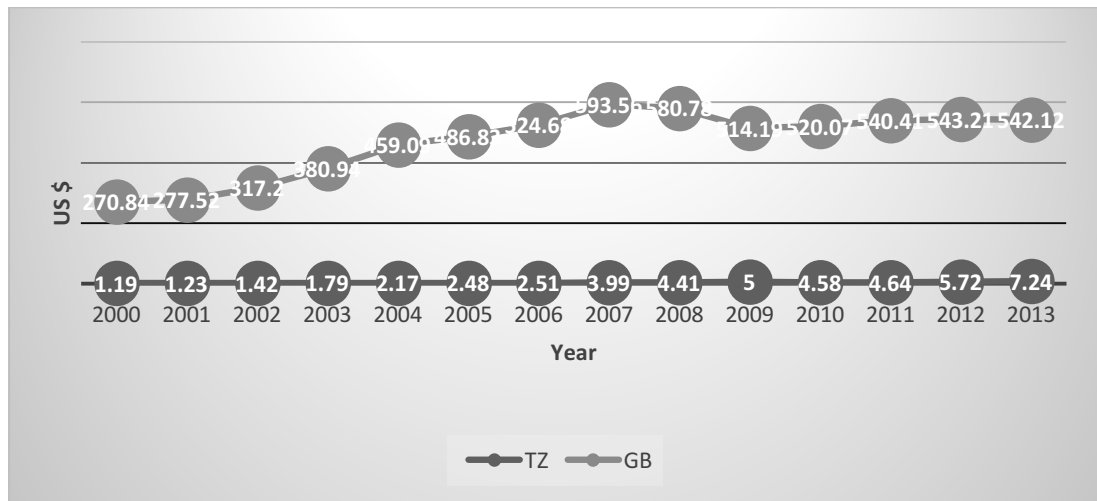
Measures of household consumption and the human development index (HDI) indicate the health service organisations context and links to national health priorities and opportunities to make a social impact. The human development index (Figure 4.2) shows that although the UK is higher it is increasing in Tanzania.

Figure 4.2 Human Development Index (points): Great Britain (GB) and Tanzania (United Nations, 2014)



Government expenditure in both countries is growing, albeit that Tanzania is starting from a lower base. (Figure 4.3)

Figure 4.3 Government expenditure (billions US\$) Great Britain (GB) and Tanzania (World Bank, 2014b)



Health services are labour intensive and require high numbers of educated staff. The unemployment rate is much lower in Tanzania than in the UK, but the age dependency ratio is higher. In 2011, Tanzania spent a slightly lower proportion of its GDP on education (4.62% , 2010) than England (5.75%) (World Bank, 2012).

Research reviewed in Chapter 2.4 indicated that perceptions of the quality of public services, the civil service and degree of independence from political

pressures, quality of policy and the extent to which citizens are able to participate in selecting governments, freedom of expression, association and a free media is an important context for social enterprises. Government effectiveness and perceptions of voice and accountability are relatively stronger in the UK than in Tanzania, where it is relatively weak but improving. Both countries demonstrated reasonably high levels of freedom of expression, which was identified by Kerlin (2013) as an important condition for the emergence of social enterprise.

Within this resource context, health spend per capita in England rose significantly up to 2007, then declined between 2007 and 2013. (Figure 4.4) In comparison to Tanzania, health spend per capita starts from a much lower base. In 2013 it was \$49 per capita compared to England's \$3598 per capita. However, in comparison to England health spend per capita has increased by a multiple of four over the same period from 2000 to 2013.

Figure 4.4. Health spend per capita: UK and Tanzania (World Bank, 2014c)

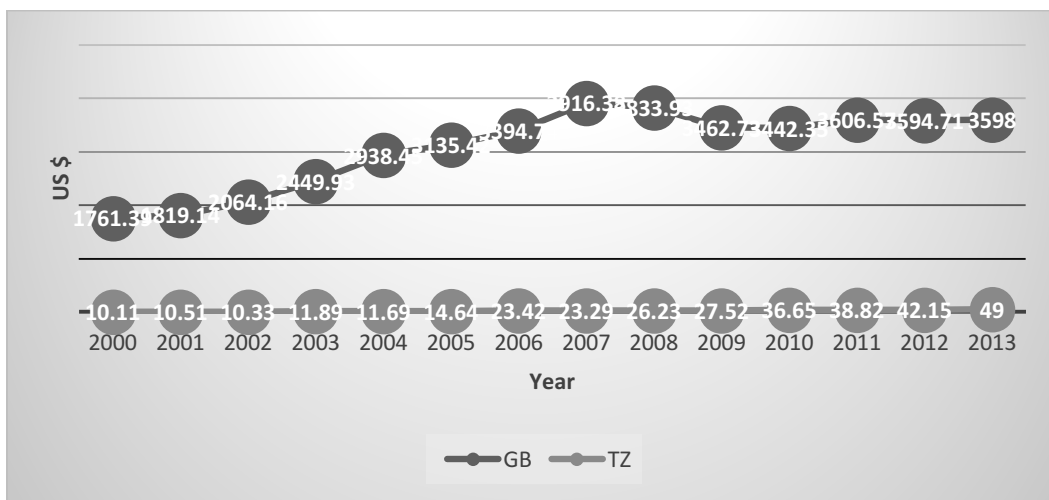


Table 4.2 below summarises the health priorities in each country.



Table 4.2 Health priorities: England and Tanzania

Health priority	England	Tanzania
Children fully vaccinated by 12 months of age (children aged 12 to 23 months)		
BCG		99% (2012) (1)
DPT1		99% (2012) (1)
DPT3		92% (2012) (1)
Polio 3		90% (2012) (1)
MCV		97% (2012) (1)
HepB 3		92% (2012) (1)
Hib3		92% (2012) (1)
Newborns protected against tetanus		88% (2012) (1)
Diphtheria, Tetanus, Pertussis, Polio and Haemophilus influenza type b	94.3% (2) (2013-14)	
MMR	92.7% (2) (2013-14)	
TB incidence	17 per 100,000 (inc TB+HIV) (3)	172 per 100,000 (inc TB + HIV) (2013) (7)
Malaria mortality rate (per 100,000 population)		21 (2009) (8)
HIV prevalence of population	2.8 per 1000 aged 15 to 59 (2013) (4)	5.1% (2012) (1) (Adult prevalence)
Diabetes prevalence	6% (age 17+) 2013 (5)	8% age 20-79 years (9)
Smoking prevalence (%)		
Youth	10.2 (6)	10.6 (6)
Adult	19.2 (6)	23.9 (male), 1.3 (female) (6)

(1) (Unicef, 2012)

(2) (Health and Social Care Information Centre, 2014)

(3) (World Health Organisation, 2014a)

- (4) (Yin et al., 2014)
- (5) (Gatineau et al., 2014)
- (6) (World Health Organisation, 2013)
- (7) (World Health Organisation, 2014b)
- (8) (World Health Organisation, 2010)
- (9) (International Diabetes Federation Africa, 2014)

Tanzania has significant challenges to address the high infectious disease burden of the population (malaria, HIV, TB). Access to clean drinking water is a core public health goal as it relates to the burden of infectious disease and infant mortality. Whilst in England the whole population has access to clean drinking water, in Tanzania only 77.9% of the urban population and 44% of the rural population had access to drinking water in 2012. (WHO/UNICEF, 2013) The management of chronic disease, illustrated by the diabetes prevalence in the adult population in both countries is comparable, although the overall burden is higher in England because of its older age profile.

Each country specifies priorities for action. In England, the 5 year health priorities are:

- prevention of health risks: alcohol, obesity, smoking,
- give patient greater control over their care,
- NHS to break down barriers between GPs and hospitals, physical and mental health, health and social care, more care delivered locally with some in specialist centres,
- new care delivery models to be chosen locally, improve efficiency
- manage population risk by predicting risk of hospital admission. (NHS England, 2014a, NHS England, 2015)

Malaria is the major cause of morbidity and mortality in Tanzania. (World Health Organisation, 2010) Access to health care services in general and effective service delivery are problematic, reflected in the high maternal mortality rate and high infant mortality rate. (United Republic of Tanzania, 2014) Tanzania faces a considerable HIV/AIDS epidemic with an adult (15–49 years) prevalence of approximately 5.1 percent in 2012. Approximately 74 percent of its population live in rural areas (United Republic of Tanzania, 2014) which introduces substantial barriers in the adequate provision of national health services.

Specifically the Government aims to

- Reduce morbidity and mortality in order to increase the lifespan of all Tanzanians by providing quality health care;
- Ensure that basic health services are available and accessible;
- Prevent and control communicable and non- communicable diseases;
- Sensitise the citizens about the preventable diseases;
- Create awareness to individual citizen on his/her responsibility on his/her health and health of the family;
- Improve partnership between public sector, private sector, religious institutions, civil society and community in provision of health services
- Plan, train, and increase the number of competent health staff;
- Identify and maintain the infrastructures and medical equipment; and
- Review and evaluate health policy, guidelines, laws and standards for provision of health services.

(Ministry of Health and Social Welfare, undated pg 17)

Each health priority offers opportunities for social enterprises to obtain recognition (and funding) for delivery of government targets, summarised in Table 4.3.

Table 4.3 Comparison of health priorities and opportunities for social enterprises

(Number of policy implementers identifying health priority in their organisational strategy)

<b>Health Priority</b>	<b>England</b>	<b>Tanzania</b>	<b>Link to research findings: opportunities for social entrepreneurs</b>
Immunisation coverage	Yes (3)	Yes (5)	Enhance immunisation coverage to population
Infectious disease			Support government targets by changing behaviour, improving access to preventive products and services, improving timeliness of diagnosis and tailoring health care interventions to vulnerable populations to improve uptake of treatment. In the English group a wide range of services fell into this group for example, mental health, learning disabilities, diabetes management, rehabilitation. Reflecting the ageing population, the English group also
<i>TB</i>	Partial (1)	Yes (3)	
<i>Malaria</i>	No	Yes (4)	
<i>HIV/Aids</i>	Yes (1)	Yes (5)	

<b>Health Priority</b>	<b>England</b>	<b>Tanzania</b>	<b>Link to research findings: opportunities for social entrepreneurs</b>
Long term conditions	Yes (all)	Emerging (3)	covered some social care services for older people. In Tanzania, the interviewees managed a broader range of services from specialist hospital and community health care services to prevention (eg sexual health). The emphasis in Tanzania for preventive services was focused on preventing infectious disease (eg by improving sanitation, screening) rather than preventable lifestyle diseases associated with smoking, alcohol or obesity.
Prevention			
<i>Smoking</i>	Yes (3)	Yes (0)	
<i>Alcohol</i>	Yes (3)	Yes (0)	
<i>Obesity</i>	Yes (6)	Emerging (0)	
Improve quality and access to care	Yes (all)	Yes (all)	Use of profits to improve access to care, use innovative techniques to deliver high quality care
Redesign care	Yes (all)	No (all)	Use freedom from state management to develop innovative care models potentially in partnership with other sectors (eg social care, education, lifestyle industries). May also use cultural strategies to redesign care between staff and patients and within the organisation. This focus on redesign of care models is not found in Tanzania at a national policy level, but was found in all the policy implementers organisations.
Strengthen primary care	Yes (3)	Yes (5)	Improve access to and/or capacity of primary care
Achieve financial sustainability	Yes (all)	Yes (all)	Access financial investment to invest in change, use flexibilities from independence of state control to access different funding opportunities, use profits to strengthen financial viability of organisation, manage financial risk.

Analysis of the scope of services provided by each policy implementer's organisation demonstrated that all included quality and access to care, redesign of care models and achieving financial sustainability in their organisational strategies. Reflecting the social mission of the organisation, some, but not all were addressing one or more of the national health priorities. These results demonstrate that the interviewees in this study reflected the health priorities in

the health care services (but not prevention) provided by their organisations, which, in turn complemented the national health priorities in each country. There was an emphasis on services to address infectious disease in the Tanzanian group but less focus in this group on prevention (smoking, obesity, alcohol) of long term conditions.

### **4.3 Scope of state funded health care**

Neither country specifically defines what care will be provided to whom in their health strategies. The closest the English strategy comes to defining the scope of health care funded by its collective insurance system is in its use of the term 'comprehensive', the specification of the locations of care ie primary care, community health services and hospital care and its focus on certain population groups such as those with mental illness or learning disabilities. The underlying assumption in the English strategies is that all health care will be available for the population free at the point of care. What is not explicit is the underpinning role of NICE in providing evidence based guidance and advice (National Institute of Clinical Excellence, 2016) and commissioners in managing the scope of care that is purchased. In England, health care will be free at the point of care only where it is commissioned. In this context, decision making (within limited state defined budgets) balances the demands of national and local health priorities with those of a 'comprehensive' health care system. In practice, this means that almost all care (except that requiring highly specialised care and/or that for which there is not enough evidence to justify funding such as some new pharmaceutical products) is funded by the state. Care which requires co-payments by individuals, for example, dental or optical services, is agreed through national legislation. The tension balancing public expectation with state funding is described by one of the interviewees for this study:

'The general public understands that money is limited. There is an acceptance that you can't have everything all the time. In the end, the general public wants access to an ambulance quickly when they're ill, they want to see a doctor in a reasonable period of time, not wait too long for admission to a hospital, and free prescriptions when they need it. The principle of a free health service is important but there is a reality about it. Not everything can be afforded on current budgets though I would like to think that taxation could rise to assist people with very rare illnesses who could be treated.' *Policy maker, England*

For example, charities, such as MacMillan which specialise in cancer and end of life care have always complemented NHS funded services with other sources of funding. End of life services in some regions have been wholly or part funded by charity fund raising activities, rather than NHS funding. (NHS England, 2014b)

In Tanzania, a commitment is made to provide a 'basic' health care service with users of state funded health services often required to make a co-payment towards the cost of care. In Tanzania a significant proportion of health funding comes from external sources ie the resources may come from international organizations, other countries through bilateral arrangements, or foreign nongovernmental organizations. These resources are part of total health expenditure. In 2013, the World Bank estimates that 33.2% of health funding came from sources outside of the country (although this was lower than the 2011 and 2012 figures : 40.3% & 38.5%) (World Bank, 2013)

This review of the two health systems demonstrate the logic of this State view on the scope of health care. Referring back to Chapter 2.2, the state, through its funding rules redistributes resources to increase community good which has implications for health care delivery organisations operating in each country. The state uses its bureaucratic power to design the funding rules to effect health system reform. In England 5 policy makers interviewed suggested that funding systems changes allow investment in innovation or the expansion of services in the private sector. In Tanzania, 5 policy implementers and 2 policy influencers suggested that these changes had implications for innovation or expansion of services. Buse et al. (2012) have identified types of health system reform. Of these the following reforms were evident from interviews and policy documents reviewed in both Tanzania and England:

- Liberalising laws on private providers
- Creating purchasing agencies
- Introducing contractual relationships and management agreements between purchasers and providers
- Decentralising health services
- Encouraging competition and diversity of types of providers

- Increasing patient choice of where treatment is provided and nature of care
- Paying providers for performance.

The resource context, the type of health system reforms adopted by policy actors has implications for social entrepreneurs delivering health care which will be discussed in the next section.

#### **4.4 Implications of resource context for social entrepreneurs**

Through its bureaucratic control of the design of the health system, it can be inferred that government also influences the rules governing institutions in the health system. In England, for example, three policy implementers illustrated how their organisations required funding from sources outside of the NHS budget, allowing them to redesign services, and negotiate for contracts with local commissioners. These funding strategies were either used to address the needs of vulnerable people with complex health and social care needs or prevent ill health. The former emphasised empowerment and poverty reduction. In Tanzania various strategies were used by social entrepreneurs to address health equity challenges.

In both countries some social entrepreneurs interviewed for this study enhanced state funding to address state health priorities either by securing additional resources or by redesigning services. The funding strategies adopted were different in the two countries, reflecting in part the rules in each health system which provided opportunities or restricted options available to social entrepreneurs. This section continues by examining two aspects of the structural and resource challenges in the health system in England and Tanzania, investment and human resource capacity building.

##### **4.4.1 Securing investment to fund the growth of social enterprise**

In both England and Tanzania responding to the limitations of state funding systems emerged, through the interviews, as an important change strategy for policy actors. Table 4.4 below summarises potential sources of investment across both countries, separating out types of organisation

Table 4.4 Options to attract investment<sup>1</sup>

	<b>State owned (Public)</b>	<b>Organisations with a social mission (Private not for profit)</b>	<b>Cooperatives (Either Private not for profit or for profit depending on presence or not of social mission)</b>	<b>Public Companies (Private for profit, no clear social mission)</b>	<b>Private Companies (Private for profit, no clear social mission)</b>
Market investment options	State	State	State	State	State
		Specialist investors – ethical capital			
		Private investors	Private investors	Private investors	Private investors
		Share issues <sup>2</sup>	Share issues <sup>2</sup>	Share issues <sup>2</sup>	Share issues <sup>2</sup>
Accountability to	Taxpayers	Community of interest through social mission	Community of interest through social mission	Shareholders	Shareholders
Return on investment measurement	Achieve population health targets	Social impact	Cultural engagement and control, belonging, influence	Shareholder value	Shareholder value

<sup>1</sup> A distinction is made in this table between organisations with a social mission and cooperatives as they measure their return on investment in different ways. They are presented in this table as a blended logic of corporation and community.

<sup>2</sup> If company structured to hold shares – excludes charities, and some company forms eg companies limited by guarantee which do not have share ownership



In table 4.4 the state may provide investment capital in the form of grants or loans. In England specialist government investment vehicles exist such as SIB (<http://www.sibgroup.org.uk>) which use state or other funding (eg charity funding) to invest in health initiatives, although all types of organisation may secure investment from private investors, the state or share issues. As described in Chapter 2, and I argue in the next chapter, of importance in considering the logic of social enterprise, only organisations with a social mission measure their return on investment through their social impact. Each type of organisation is accountable to funders in different ways. The state is accountable to its taxpayers to achieve population health targets. Public and private companies are accountable, in law, to their shareholders for realising a financial return for their shareholders, rather than any social goal. Cooperatives are in an ambiguous position. If they have a social mission, then they can legitimately be held to account for achieving a social impact to their community of interest. However, as will be discussed in Chapter 5, not all cooperatives may be held to account for realising social impact. They may be established for the financial benefit of their members, which may weaken their social accountability to a wider community of interest or be non-existent.

In England five policy makers referenced various investment vehicles which were set up at a national level to allow social enterprises to access investment monies to support the transition from a state managed organisation to an independent social enterprise. These included the Social Enterprise Innovation Fund and Mutual Fund. These funds built on already tested central government models, such as the Future Builders Fund, which were managed by bodies at arm's length from government control. The latest of these is the Social Investment Business Group <http://www.sibgroup.org.uk/> which supports investment in social businesses using government, endowment capital and its own funds to support charities and social enterprises to create social change. The Social Investment Business is a social enterprise and specialist fund manager, aiming to strengthen civil society organisations through its investments. Viable, non bankable projects may be supported.

This kind of national funding infrastructure is not available in Tanzania. The implications of this were illustrated by one policy implementer:

'We have a private department but the demand from those wanting to pay TSh50,000 is so great we can't accommodate them. We have a Board resolution which allows us to go up to 30% private 60% public. Now we are 18% private, the rest is public. We want to expand our private services because the demand and need is there. We have a name, credibility. So we wanted a loan from our bank to expand our space, because we believe in it. The private will be able to pay for itself but the bank didn't understand why we wanted a loan, suggested fund raising, but [our organisation] challenged their assumption about whether funders were available for private services. None of our donors understand it. We argued we would be able to generate income to invest it back into other services. Then we can reduce donor funding. But this isn't well understood.' *Policy implementer, Tanzania*

Social enterprises in Tanzania delivering health services adopted different investment strategies. In the example below, the social enterprise leader illustrated how, by identifying a gap in the market, undertaking specialist training overseas and then offering a service to private patients who could pay, by advocating for change at a national level, they were able to then offer a publicly funded service when public funding models changed.

'You can be a model, so if you are successful in one then others will copy. For example, with HIV we were the first hospital to offer antiretroviral therapy in the whole country. I am an endocrinologist, because very few physicians we had to multitask, so I trained in North West University in Chicago at a centre of excellence for HIV. I started a HIV clinic here. It was private, it wasn't free, very few people could afford treatment. The criticism I had was that I was only treating those who could afford it. But ethically, if there is a treatment and someone can pay for that treatment, I am not the one to deny that treatment. But then later on that model was expanded, free access to drugs .. Some of the patients we had in 1995 are still in my clinic.' *Policy Implementer, Tanzania*

Of those interviewed:

- 4 providers adopted redistribution strategies, which subsidise the cost of care to those least able to afford it, supported by differential charging schemes based on ability to pay
- 2 providers explicitly redistributed resources from urban to rural localities to achieve specific health priorities

- 2 providers adopted empowerment and poverty reduction strategies by reinvesting financial surplus or applying for project funding (often through donors) which complements health funding.

In Tanzania access to health care is influenced by the ability to pay and choice of provider. Unlike in England, funding rules in the health system allowed redistribution strategies (from rich to poor) in poverty reduction strategies. Patient choice allowed these policy implementers to design services targeted at those able to pay to release investment for services to deliver to those unable to pay. Agreements for receipt of state funding were negotiated with the state through public private partnership mechanisms at regional and national levels.

It may be concluded from this section that securing investment to grow social enterprises may be limited by the way an organisation is structured, how it measures its value (through the return on investment) and ease of access to investment funding. Governments may choose to facilitate investment for social enterprises by establishing specific funds from which social enterprises can draw upon for growth. In this way, governments can use their bureaucratic domination of the health system to redistribute funds to support social enterprise. This government strategy was seen in England but not in Tanzania. Social enterprises in Tanzania had difficulty accessing investment from banks, reportedly because the decision makers in banks did not understand the new logic of emerging business models being designed by social entrepreneurs. As is illustrated in this section, social entrepreneurs in Tanzania and the UK use a range of strategies to grow their businesses, from securing funding for service delivery outside the health sector to using their surplus to invest in health services which meet their social objectives.

#### **4.4.2 Building human resource capacity in social enterprises**

A second challenging area was capacity building. Section 2.4.2 in the literature review drew on the importance of organisational culture which, it is argued by some, is one of the defining criteria of social enterprises. The interviews in both countries demonstrated this, but in different ways. In England, the capacity of actors in the health system needed to be built particularly to enhance the competencies of social enterprise leaders to engage with a market and manage social enterprises outside of direct control of the NHS management hierarchy in

a more commercial environment. In an evaluation of the right to request policy, this support system was viewed as critical to establishing these new organisations outside of NHS management control. (Anderson et al., 2011) In Tanzania shortages of clinical staff were also a challenge but offered opportunities for social enterprises to deliver additional social value to the health system.

In Tanzania, according to the HSSP111, total staffing of the health sector stands at 35% of total need (pg 29). Staffing shortages are found in all disciplines. Rural areas have more shortages than urban areas. Three policy implementers interviewed for this study and one policy influencer had embraced this challenge as part of their organisation's social mission either by incorporating continuous professional development programmes into their delivery models and/or addressing the absolute shortage of clinical staff by improving access to specialist clinical services.

In this example, the policy influencer at PRINMAT describes how the social enterprise has chosen to invest in the professional development of maternity staff in state managed facilities, to improve the quality of referrals to their specialist services.

'Yes we see ourselves as part of the system. The big challenge is getting the referral right. The team in maternal newborn childcare is setting up a referral system, we want the women to continue to go to government facilities and not jump the queue. If you have no complications, you should be delivering at health centres/PRINMAT facility but women go to regional centres. When we started we found a lot of health centres empty, so staff were not experienced. We helped build the capacity, training them, moral and confidence of the staff and now 3 years on the centres are performing well, they are busy. We have built up the capacity of these 22 sites.' *Policy influencer Tanzania*

In this example, PRINMAT used its position as a membership organisation to influence the partnership culture of private midwives to improve clinical care for the system as a whole.

In England a range of support was provided to NHS staff wishing to form independent organisations, social enterprises, including 'how to' literature (see for example Directorate of Commissioning and System Management (2008)

A forum, managed by the Social Enterprise Coalition was established to support those forming social enterprises, all of whom participated. This was a peer to peer support group. Experts were invited to advise the group from time to time on key issues. Access to funding to manage the change was available to NHS teams, once approved for entry onto the right to request programme. This funding could be used to bring in technical experts (eg lawyers, accountants) to support business planning, backfill NHS staff to create the capacity to lead the team through the change and negotiate the transition with stakeholders such as the unions and contracts with commissioners. More formal training was available through the School of Social Entrepreneurs <https://www.the-sse.org/our-courses/> and other academic providers to support the new leaders of these social enterprises to develop their skills. Some aspiring social enterprise leaders enrolled on a bespoke course at the Skoll Centre for Social Entrepreneurship in Oxford designed to support NHS staff wishing to form social enterprises. <http://www.sbs.ox.ac.uk/faculty-research/skoll>.

Social entrepreneurs respond to resource challenges in the health system by using their social missions to meet national health priorities. In England, the government invested in cultural change programmes to support teams leaving the NHS to develop the skills to become social entrepreneurs. In Tanzania, the example illustrated in this section demonstrated how a membership organisation used its position in the health system to not only increase capacity and skills of the state managed health system but also to instil a culture of partnership working to achieve its social purpose amongst its membership base.

#### **4.5 Implications of the resource base for social enterprise logic**

Institutional logic considers the cultural and national context important when analysing a field. This aspect of institutional logic was reviewed in chapters 2.3 and 2.2. Using institutional logic as a guide to interpreting these results, the logic of the state in relation to the health system emerges as an important context for social enterprise. At the beginning of this chapter, the different resource base of the two countries was compared. Despite having different

demographic and economic resources, both countries aim to deliver a state funded health service, using governments bureaucratic power to redistribute resources to meet the health needs of its populations. Both countries demonstrated reasonably high levels of freedom of expression, which, in section 2.4.3 was identified as an important condition for the emergence of social enterprise.

The differing resource base in the two countries offer opportunities for entrepreneurs to develop their business models and grow the size of their organisations. Investment structures are an important aspect of organisational strategy, but not the only contextual factor. Cultural and structural constraints and enablers such as the knowledge and skills of investors about social enterprise businesses and the actors leading policy development and implementation were also important. Contrasting systems to support growth, capacity and capability were able to be evidenced in both countries.

Social enterprises use strategies to both secure funding to grow their organisations and achieve their social purpose. This chapter demonstrates that the scope of health services provided by the social enterprise leaders interviewed for this study, complemented national health priorities. Further, social entrepreneurs adopted strategies to secure additional funding to develop health services, beyond that provided by the state. These funding strategies were influenced by the rules governing financial institutions, the structure of the social enterprise and the way they measure return on investment by achieving a social purpose. However, the lack of investment opportunities for social enterprises in Tanzania created barriers to social enterprise growth.

Institutional context therefore emerged as important. It allowed certain investment strategies to be followed, but not others. In England and Tanzania social enterprises used investment to support national health priorities, health equity strategies, health services redesign or the introduction of services which were not funded by the state.

## **Chapter 5 Meaning of Social Enterprise in England and Tanzania**

### **5.1 Introduction**

This chapter's focus is on the use and interpretation of the term across England and Tanzania against the logic of the institutional orders described by Thornton et al. (2012) Section 5.2 describes the definitions and characteristics of the term social enterprise in the two countries. It separates the core characteristics which emerged from the analysis of interviews from the non core characteristics. Section 5.3 then focuses on the particular uses of the terms social enterprise and mutual in England followed by the use of the term in Tanzania in section 5.4. Using the institutional categories described in Chapter 2.2 to guide the analysis, these characteristics of the term social enterprise are then analysed in relation to the institutional order 'community' in section 5.5. This analysis is expanded in section 5.6 to illustrate how social enterprises can also exhibit characteristics found in the institutional orders: profession, corporation and religion. Section 5.7 builds from Chapter 4, describing how social enterprises enhance state health service capacity, helping to achieve health priorities for the population. It demonstrates how the social purpose of organisations can be aligned with the social determinants of health by identifying three types of social enterprise. Section 5.8 presents ways in which the market is designed in England to recognise social value.

### **5.2 The term social enterprise: definitions and characteristics**

Various definitions of the term social enterprise are available in England.

These include the following:

Department of Trade and Industry: 'a social enterprise is a business with primarily 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' (Department of Trade and Industry, 2002 page 13)

The Social Enterprise Mark goes further with an explicit reference to limiting profits for personal gain:

‘awarded to credible social enterprises that can prove they operate with the central aim of using income and profits to maximise positive social and/or environmental impact, taking precedent over a requirement to maximise personal profits for owners and shareholders.’ (Social Enterprise Mark)

The European Union definition also emphasises innovation and entrepreneurship, transparent and ethically responsible governance within a culture of engagement. Of interest to this research is that the definition recognises that some social enterprises may be structured to link their social mission to their ownership or method of organisation which is implicitly rejected by the Social Enterprise Mark. The definition is:

‘A social enterprise is an operator in the social economy whose main objective is to have a social impact rather than make a profit for their owners or shareholders. It operates by providing goods and services for the market in an entrepreneurial and innovative fashion and uses its profits primarily to achieve social objectives. It is managed in an open and responsible manner and, in particular, involves employees, consumers and stakeholders affected by its commercial activities.’ (European Union)

The EU definition allows cooperatives and other organisations which recognise a role for stakeholder control. In this way it incorporates ideas of civil society but explicitly integrates these principles to describe the types of business which might be viewed as social enterprises including:

- ‘Those for who the social or societal objective of the common good is the reason for the commercial activity, often in the form of a high level of social innovation.
- Those where profits are mainly reinvested with a view to achieving this social objective.
- Those where the method of organisation or ownership system reflects the enterprise's mission, using democratic or participatory principles or focusing on social justice.’(European Union)

Both the UK and EU definitions recognise that social enterprise may be constituted using many different legal forms.

The table below presents the number of those interviewed by interviewee type who recognised the term social enterprise.



Table 5.1 Number of interviewees recognising the term social enterprise

	England			Tanzania		
	P. mak	P. imp	P. inf	P. mak	P. imp	P. inf
<b>Number recognising the term social enterprise</b>	7 (7)	6 (6)	7 (7)	0 (4)	5 (6)	5 (7)

(Numbers in brackets are total number interviewed)

The social enterprise term was recognised by all those interviewed in England.

In Tanzania none of the policy makers interviewed recognised the term. In Tanzania 5 of the 7 policy influencers interviewed recognised the term and five of the six policy implementers recognised the term.

The table below summarises the perceived characteristics of social enterprises by those interviewed. Those not recognising the term in Tanzania were excluded.

Table 5.2 Perceived characteristics of social enterprises in each country

Characteristic	England			Tanzania	
	P. mak	P. imp	P. inf	P. imp (n=5)	P. inf (n=5)
Purpose of the organisation social mission	7	6 ( )	7	5	5
Use surplus to further social mission	6	6	7	5	5
Trading in market, entrepreneurial outlook	7	6	7	5	5
Staff ownership	2	2	1	0	0
Culture – involving staff	5	6	4	0	0
Culture – involving patients	4	6	4	0	0
Contribute to development of communities	0	6	4	5	5

( ) defined as quality of care by two respondents

From this table three core characteristics of social enterprise emerged which were common to all those who recognised the term in both countries. However, other characteristics were also perceived to be important. The rest of this section analyses these results in more depth, focusing first on the core characteristics of social enterprise, followed by the non core characteristics.

### 5.2.1 Core characteristics of social enterprise

The three criteria that all interviewees recognised across both countries included:

1. Purpose of the organisation defined by a social mission
2. Use surplus to further the organisation's social mission
3. Actors in the organisation demonstrating an entrepreneurial outlook when trading in a market.

In England these perceptions followed the DTI definition of a social enterprise (Department of Trade and Industry, 2002) . Whilst 5 of the policy influencers in Tanzania had heard of social enterprise, only three felt able to define it. However, in the discussion at interview, all five identified the same three criteria summarised in the table above.

The integration of the three characteristics social mission, use of surplus and trading in a market with an entrepreneurial outlook is illustrated by this policy implementer from Tanzania:

‘Social business... there is a social part and a business part. We run our organisation as a profitable business. It should be self running, generating enough income to be sustainable and generate some profit to improve and expand the services. Social means injecting back profits into the social to give back to the community’ *Policy implementer, Tanzania*

In both countries interviewees separated the social purpose from personal gain, illustrated in this quote from a Tanzanian policy influencer:

To me the difference is always the purpose of what you are doing but the means might be the same but the point should be why did you start did you start to make a lot of money for your own gain or were you starting to resolve a certain social issue or create a social impact... to me that is how we differentiate *Policy influencer, Tanzania*

Use of surplus to further a social mission were two important characteristics which distinguished social enterprises from organisations which use their surplus for corporate social responsibility. Policy makers and CEOs raised concerns about the role corporate social responsibility plays in shaping government thinking in England:

‘There is a fight going on - within the body politic - the government would quite like the big companies and corporates to say that as long as you're

supporting good things (eg Price Waterhouse Coopers puts investment in SE UK, Lloyds have a deal with the School for Social Entrepreneurs), that this is the definition of social enterprise..... There is no doubt at all that some of the social enterprise mutual initiatives that this government have taken have been trojan horses for privatisation because they are very resistant to asset locks.' *Policy maker, England*

In both countries all interviewees recognised that any number of organisational forms may be used. Of importance in England was the common understanding across policy makers, policy implementers and policy influencers of social purpose linked to service redesign illustrated by this quote from one of the policy makers interviewed:

'Clarity about social purpose is essential. Creating social value is equally crucial. As policy makers, we need to enable organisations and their staff, together with users and carers to redesign services creatively to deliver sustainable, personalised care and support' *Policy maker, England*

This link with service redesign was not explicit in the interviews held in Tanzania. However innovation was mentioned by one policy implementer in Tanzania. Two policy makers in England also emphasised the importance of social enterprises demonstrating innovation, for the benefit of society.

The emphasis on the market and the accompanying entrepreneurial outlook was mentioned by all those interviewed in England and all those who recognised the term in Tanzania. In both England and Tanzania interviewees raised the difference in outlook required to lead a social enterprise compared to a donor or grant funded NGO. See for example, this quote from a policy influencer in England:

'On voluntary and community organisations : one of the first pieces of work I commissioned was an evaluation of the extent to which members are socially entrepreneurial or enterprising. Not the term social enterprise so much that the notion even back then (approx. 2003) there was a need to think about how to diversify income. It was much more about do you see yourself as an enterprising organisation rather than a social enterprise. Organisations characterised as entrepreneurial were looking at least to the horizon if not beyond..... the notion of being enterprising - seeing opportunities, how you can meet them, whilst at the same time, especially for charities with clearly set charitable objectives, that they keep their eyes on their mission.' *Policy influencer, England*

Entrepreneurial outlook was viewed as a form of innovation from two perspectives. The first perspective was to generate income, the second in how profits are used to make a social impact to further the organisation's social purpose.

A distinction was made for analysis purposes between adoption of business ideas such as marketing techniques or management systems found in 'for profit' organisations. All those interviewed, except for one interviewee in Tanzania, made a distinction between these business ideas and the meaning of social enterprise. The discussion with the interviewee in Tanzania, illustrated in Box 5.1 below, is illustrative. Despite several questions, the respondent didn't equate the adoption of commercial business models to achieve social objectives with a strategic approach to achieve the sustainability of the organisation ie to remove itself from dependence on donor funding.

*Box 5.1 Business principles and Social Enterprise Characteristics: Interview discussion*

In Tanzania, one policy implementer, equated adoption of business principles (marketing and franchising) with social enterprise. This discussion was challenging for me, as I had to be very careful not to impose my own interpretation of the terms on the respondent. Key points in interview:

- Use of the term 'social marketing' to mean that the organisation adopted marketing techniques and processes used in business to achieve social objectives
- Use of the term 'social franchising' to mean that the organisation adopts commercial franchising models to achieve social objectives
- Both viewed as synonymous with the term social enterprise ie social enterprise is adoption of commercial techniques, processes to achieve social objectives.

'We are a social enterprise, a personal view, by using the word social marketing, we really mean social enterprise. The words social marketing put aside the word marketing and use social enterprise ... We are using marketing techniques. We are not making a profit. So we are 100% a social enterprise, not for profit. .... Social marketing uses the commercial principles, techniques to achieve social good. With social franchising, we are using the same franchising models as the commercial.' *Policy implementer, (Tanzania)*

A key characteristic of social enterprise, implicit in all interviews in England and the other health care delivery organisations recognising themselves as social enterprises in Tanzania was that they were transitioning or had already transitioned to participate in a market for health care services in order for their organisation to become sustainable and that the process of transitioning involved adopting business principles. In Tanzania this was an explicit strategy adopted by organisations to reduce dependence on donor funding. This organisational strategy was also referred to by interviewees in England who lobbied for and adopted this strategy to reduce historical dependence on grants during the 1990s. For me, this distinction between adoption of business ideas and the creation of a sustainable organisational strategy challenged an implicit assumption on my part. I had assumed that adoption of business ideas to achieve social objectives implied that an organisation was also planning to achieve a sustainable social enterprise organisation which was independent of donor or grant funding. This distinction was mentioned by one of the interviewees in England as a fundamental issue, but which I did not fully appreciate at the time.

‘[Meaning of social enterprise] Its about seeing the opportunities and being entrepreneurial and it doesn't necessarily mean being business like although there might be business like processes you adopt but doesn't necessarily mean being like a business. You have to be careful about being too business like, as we might lose our distinctiveness . Its about recognising the need to be current, to accept there is a diversity of income streams, being entrepreneurial and having social objectives. Its clear many charities would fit into that description.’ *Policy influencer, England*

I concluded therefore that entrepreneurial outlook, is not a sufficient characteristic by itself unless it is tied to sustainable business strategies. Adoption of business ideas such as marketing or business processes are not a defining characteristic.

Comparing these results with research summarised in section 2.4.1, these characteristics meet all the economic criteria described by Defourny and Nyssens (2008, pg 5) and one of their social criteria: an explicit aim to benefit the community. Implied in these interviews is limited profit distribution, a second

social criterion identified by Defourny and Nyssens (2008). Of interest amongst this group of policy implementers was that no one mentioned it at interview. This could be because none of the social enterprises in Tanzania had a shareholding structure. In England those with a shareholding structure had all written into their constitution an explicit clause that no dividends would be paid, or, if set up as a CIC, employees would not be eligible for a dividend as they had not invested capital in the organisation.

### **5.2.2 Other characteristics of social enterprise**

Table 5.2 presented the numbers of interviewees who viewed contribution to the development of communities as an important feature of social enterprises. Arguments for a community perspective were favoured by policy implementers in both countries all of whom viewed it as an important characteristic of social enterprise. Four of the seven policy influencers in England and five in Tanzania also viewed it as important. The idea of community will be analysed from three perspectives, the community benefit with its associated asset lock, in terms of geography and from an employee and/or patient perspective.

Preservation of assets for community benefit through an asset lock was perceived to be important by some of those interviewed in England but was not mentioned by interviewees at all in Tanzania. In England, the new community interest company organisational form was viewed by interviewees as important because it included an asset lock in its constitution which is enforced by legislation. However, asset locks are found in other organisation forms (eg charities, community benefit societies) and are not exclusive to community interest companies. Whilst an important consideration, I therefore classified an asset lock as a non core characteristic of social enterprise.

The importance of space was tied to the localism political agenda by one policy maker.

‘Social enterprise can deliver better outcomes than a commercially-based organisation because it tends to be geographically based, in places where people running a social enterprise are the same people who will achieve the outcomes for the people they are working with’.

*Policy maker, England*

Other social enterprise leaders emphasised the importance of building relationships within communities to achieve social impact and deliver care in different ways.

‘the collective... its the whole thing.. its about finding ways to benefit everybody in the round.. ... so that the local printer, the people who support the local restaurateurs who make sandwiches for your meetings, its everybody.. you have this responsibility to develop a rich community because lets face it ..... there's not going to be enough to meet people's needs so we have to do something to build resilience’  
*Policy Implementer, England*

The idea of community could therefore be a community of interest which may be bound by geography.

The idea of a community of interest extended to the difficult and sometimes conflicting views on staff engagement as a defining characteristic of social enterprise. In Table 5.2 staff engagement in the context of social enterprise was found in England but not in Tanzania. It took two perspectives. The first was staff ownership, the second was staff involvement. Those viewing staff ownership as an important characteristic of social enterprise were in the minority: only two policy makers, two policy implementers and one policy influencer viewed it as a characteristic of social enterprise. Many more interviewees viewed social enterprises as demonstrating a culture of staff engagement. Of these five were policy makers, six were policy implementers and four were policy influencers. Almost the same numbers viewed patient engagement as an important feature of social enterprises. 15 of those interviewed in England considered that social enterprises had better ways of creating a culture which engages staff than other types of organisations, some arguing that this is because they have the flexibility to provide financial incentives to staff based on performance.

This culture of staff engagement was mentioned by one policy implementer in Tanzania, but in the context of improving staff performance by increasing their understanding of why there had been a recent increase in fees associated with moving to a more commercial model (to reinvest in achieving their social mission). In this example staff engagement was not viewed as a distinguishing characteristic of its transition to a social enterprise, but as good management

practice. Neither staff ownership nor staff engagement were mentioned by interviewees in Tanzania as a defining characteristic of social enterprise.

Concern was expressed by one CEO in England that staff engagement should not be done at the expense of a social mission.

*'We are a community benefit society, not a staff benefit society'*

*Policy implementer, England*

In England the health policies which guided the emergence of social enterprise in England were important in framing the meaning of the term. However a review of the three White Papers, *Our Health Our Care Our Say*, *High Quality Care for All*, *Equity and Excellence*, (Department of Health, 2006, Department of Health, 2008, Department of Health, 2010) which were published between 2006 and 2010 revealed that it was not until 2010 that social enterprises were explicitly linked with employee engagement.

*'Our ambition is to create the largest and most vibrant social enterprise sector in the world. .... As all NHS trusts become foundation trusts, staff will have an opportunity to transform their organisations into employee-led social enterprises that they themselves control, freeing them to use their front-line experience to structure services around what works best for patients.'* (Department of Health, 2010 Para 4.21 pg 46)

However, the expectation for employee engagement was clear in Patricia Hewitt's pamphlet on social enterprise, published in 2006. This view was reinforced by journalists in the specialist press (see for example, Helen Mooney in the *Health Service Journal* (Mooney, 2006)) in relation to staff membership of social enterprise organisations. One interviewee strongly argued that employees as owners of social enterprises could effect improvements to care.

*'We spent a lot of time developing a vision with employees about what people wanted. There is huge frustration that the NHS reinvents itself every few years. Patient care doesn't seem to improve, and the employees get lost in it all. People working in PCTs hadn't a clue who they were really working for which impacts upon employee loyalty and patient care. So for us, it was about developing a sustainable model which values employees. If we get that right we will get the patient focus right. Its why we were interested in employee ownership model.'* *Policy implementer, England*

Social enterprises were viewed as offering better patient engagement. Table 5.2 shows that this was found in all three categories of interviewee in England



but not in Tanzania. Ways of engaging patients in England varied. Two policy implementers described how they tailored their service to take a holistic (ie multi system) approach to individual need. Another described how they worked with patients and their families to improve health literacy to enable them to manage long term conditions more effectively. In all cases, the examples were presented as a result of change in culture: for those who had delivered their service in the NHS this was a different model; for those who had never been managed by the NHS this had always been a distinguishing feature of their approach.

When compared to the breadth of definitions outlined in Chapter 2.4, social enterprises demonstrated many features of 'hybrid' organisations (Battilana and Lee, 2014; Doherty et al, 2014). In England, organisational culture was viewed as important in relation to staff/patient engagement which was seen as distinct from an entrepreneurial culture within the organisation. The latter I described as a core characteristic of social enterprise. In Tanzania, interviewees descriptions in section 5.2.1 described how they adopted 'business principles' which I decided did not represent a core characteristic but can be viewed as a non core characteristic, and therefore a hybridisation of logic, which I will explore in more depth in section 5.5.

### **5.2.3 Core and non core characteristics of social enterprises**

The results suggest that there are core characteristics of social enterprise which cross national boundaries. The idea of community was an important feature of social enterprise and its meaning varied in different contexts. It could be viewed as a community of interest by employees or patients, in geographical terms or represent ideological beliefs about, for example, the preservation of assets. The emphasis in England on staff and patient engagement is important and will be further analysed in the next section in relation to the political context in which the terms are used.

## **5.3 Political definitions of the term social enterprise in England**

The Coalition's White Paper Equity and Excellence, (Department of Health, 2010) has, as one of its aims to:

‘create the largest social enterprise sector in the world by increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises.’ (Department of Health, 2010)

There were some high profile requirements. For example, the NHS and Social Care Act 2012, (UK Government, 2012a para 183(2)) required Local Governments to set up Health Watch in the form of a social enterprise in each Local Authority area. However, despite the use of the term, in England it was felt by some interviewees that from 2010 onwards the term ‘social enterprise’ had become subsumed into the term ‘mutual’<sup>12</sup>. The quotes below from those who raised this during interview reflect the frustration many feel<sup>13</sup>.

‘If the crash hadn't happened in 2008 [after which ] governments tried to look in desperation for solutions. Social enterprises were able to fill that void. Not strong now. Employee owned association going from strength to strength and has ministers' ear. If Francis Maude walked through that door now we'd be talking about us as a mutual not a social enterprise. We never use that term now. Hazel was a strong advocate. Milburn didn't get it but wasn't against. Denham got it. Dobson got it. Those connected to the Coop party got it. Strongest minister was Norman Lamb. Even when in opposition he is the only politician who could stand a platform for half an hour with no notes who could talk intelligently & passionately about social enterprise. Even Norman stopped using that language and used the mutual language.’ *Policy implementer (England)*

‘Traditionally you think of social enterprise as no shareholders, profits used to impact upon community - social value stuff – with variety in the governance/ownership model. I wouldn't disagree with any of that. I think the current government has a different idea for it than the previous government, probably from what the sector itself would say, especially the cooperative movement. Lansley himself .... said Foundation Trusts should be outside government control with their own objectives - no social - just enterprise. Away from government is the key thing. Peter Holbrook at SE UK lodged various complaints about it. We weren't alone in being concerned.’ *Policy influencer, England*

---

<sup>12</sup> The term mutual has a specific meaning in England: ‘the organisation is owned by, and run for, the benefit of its members, who are actively and directly involved in the business – whether its employees, suppliers, or the community or consumers it serves, rather than being owned and controlled by outside investors’ DEPARTMENT FOR BUSINESS INNOVATIONS & SKILLS. 2011. *Guide to mutual ownership models* [Online]. Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/31678/11-1401-guide-mutual-ownership-models.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/31678/11-1401-guide-mutual-ownership-models.pdf) [Accessed 8/1/16].

<sup>13</sup> Reference is made in this quote to various English politicians. Annex B contains a list of all politicians referenced by interviewees and their roles.

Their concerns were well founded. Following these interviews, Chris Ham, CEO of the Kings Fund, published the results of his working group's research on the positive relationship between quality of care and staff engagement. (Ham, 2014) The Department of Health subsequently focused on exploring how Foundation Trusts might benefit by moving to a model of organisation which valued staff engagement. Building on Chris Ham's report (Ham, 2014) Francis Maude, Minister for the Cabinet Office and Norman Lamb, Minister of State for Care and Support, invited Foundation Trusts in a letter dated 28<sup>th</sup> July 2014 to apply for a pathfinder programme to explore the opportunity to form staff owned mutuals (Maude and Lamb, 2014). In their letter to Foundation Trust CEOs, the social enterprises which had been formed between 2006 and 2010 were reframed as 'mutuals' which, they argued, had achieved better patient care through creating a more engaged and empowered workforce. The original emphasis on social mission was all but lost. This reflects a confusion between the social aims of an organisation and its means, an important distinction illustrated by this interviewee:

'Can have a social aim and a social means. Cooperative democratic models emphasise the means; important because a number of benefits.... Social enterprise mark tried to rule out other organisational forms in favour of a more philanthropic model ie business - role is to generate profits, how you use those profits for social benefit or social good, ruled out the idea that you might trade out profits to benefit those involved in the business.' Cooperatives are a form of social enterprise that are distinctive for members with a democratic model ..... *Policy influencer, England*

This tension between democratic forms of control and social purpose is illustrated below:

'Social enterprise should be controlled in the interests of the communities they serve. Attempt to say social enterprise could be wholly investor owned ... we disagree with that... our position is that the control of the social enterprise should be held by no-one or in the interests of the people who's mission it says it supports.' *Social Enterprise UK*

This blurring of the terms mutual and social enterprise reflects political tension between advocates of social enterprise and mutuals. This research therefore supports the findings of others, reviewed in Chapter 2.4.4. The social enterprise term can be used as a political tool to support political agendas. As illustrated in England, by conflating the two terms, social enterprise and mutual,

not only resulted in loss (or at least a lessening in importance) of the criteria of social mission, but also demonstrates how important the historical context is when interpreting meaning.

#### **5.4 Awareness of the term and ‘fit’ with health policy in Tanzania**

An operational tension is found in Tanzania in the distinction between ‘not for profit’ and ‘for profit’ companies. Whilst clear in legislation in Tanzania, the distinction is unclear in the context of social enterprise. All those interviewed who had needed to argue for ‘social enterprises’ to be classified as ‘not for profit’ had been successful. They argued the following points:

1. There is a problem with the general level of awareness of social enterprise as an idea.

‘I think first of all the challenge is on understanding the concept of SE. Most of the NGOs don’t count themselves as SE, although you may find some of them behaving like social enterprises, according to how you define it. But no one counts themselves as social entrepreneurs and there are few social enterprise in Tanzania. Most of them are actually relying on donor funds directly. If there are no donor funds, they die. Most of them are not involving business models in their projects or programmes. There are a few doing so but very few.’ *Policy influencer, Tanzania*

2. The institutional environment does not provide a way for social enterprises to be classified easily into ‘for profit’ or ‘not for profit’ status. Challenges included recognition of the meaning of the term social entrepreneurship by company registration and revenue authorities.

‘When I was training, some of my students started their own projects and when they went to register the company they were sometimes rejected simply because they mentioned social entrepreneurship in their papers. They were told that we are not here for entrepreneurship so you should remove these from your name.’ *Policy influencer, Tanzania*

But registration of a social business as a not for profit NGO had not been a problem for an NGO calling itself a social business.

‘I have heard that the certificate of compliance is now provided because last week I went to the business registration agents & I was told that because we wanted to register a not for profit company that I can register it but go to the NGO offices to get the certificate of compliance. So I think that is happening but for sure in our systems there is no recognition

of social entrepreneurship as it is.... but ..... according to how the system is you can still register and come up with those kind of certificates to operate.' *Policy influencer, Tanzania*

As shown at the beginning of this chapter, social enterprise is not a recognised term in health policy in Tanzania. If the three common characteristics of social enterprise across the two countries are taken, it can be argued that policy makers are missing an opportunity to recognise the role that social enterprises could play in achieving national health priorities. The ambiguity in classification systems between not for profit and for profit organisations in relation to social enterprise means that profit making enterprises which reinvest their surplus to achieve social objectives need to justify to government authorities why they should be treated as a not for profit organisation to receive the benefits, such as tax benefits, enjoyed by not for profit organisations.

'If we want to establish a private clinic and we register it differently for social enterprise, we would have to pay 100% tax, everything like a corporate. But then the whole idea goes. There is no clear understanding. The moment I register it differently then I have to pay taxes, I'm not exempted. You are either a charity or a private organisation. There is no middle ground with a different registration. I think the solution will be at policy level, that they recognise social initiatives, that the business model built in which is aimed at social good.'

*Policy implementer (Tanzania)*

Lack of clarity in Tanzania, found in the institutional context of the meaning of social enterprise shows that social enterprises do not neatly fit into existing legislative descriptions of 'for profit' and 'not for profit' organisations. The fact that social enterprise leaders mentioned it as an issue, and were able to give concrete examples of situations when they had been concerned that their trading activities might result in a change in their status to 'for profit' enterprises suggests social enterprise is emerging as a new type of organisation in Tanzania.

Four organisations in Tanzania did not identify their organisations as social enterprises. However, using the core characteristics described in section 5.2.1 they do meet the criteria of a social enterprise. One of these was both a health care delivery organisation and lobby group. The others were lobby groups. All three lobby groups demonstrated a social mission in the core purpose of their

organisation, used any surplus to achieve that social mission and engaged in the health market.

All the lobby groups were engaging in the health market to secure commercial contracts to deliver health services or to provide infrastructure support to their constituency. Of interest in this research is the way in which one lobby group used its role as a membership organisation to demonstrate its social entrepreneurial outlook. This organisation had enhanced its infrastructure support by negotiating and managing a financial investment fund for members of their organisation wishing to set up or expand their health care organisations. Another had successfully bid for the provision of capacity building support to citizens to enable participation in health care delivery and planning structures.

Whilst policy makers may not recognise the term social enterprise, it may be argued therefore that in the Tanzanian context, 'not for profit' organisations are already making the transition. All leaders of health care delivery organisations and some policy influencers interviewed in this study were growing their health care businesses by negotiating or bidding for new health contracts with the state, developing new commercial health care services and using their profits to invest in achieving their social purpose. These results provide further support for the idea of social enterprise as a 'hybrid' organisation. (Battilana and Lee, 2014). In Tanzania, social enterprises are challenging the historical interpretations of the terms 'for profit' and 'not for profit', which are built into legislation.

The next section analyses the results concerning the meaning of social enterprise against the logic of the community order in institutional logic. If social enterprise expresses a separate community logic to other institutional orders, then health system actors may be able to develop health policies which leverage their unique characteristics.

## **5.5 Aligning social enterprise with a community logic**

As described in the preceding sections, common defining characteristics across the two countries were able to be identified. These were:

1. Purpose of the organisation defined by a social mission

2. Use of surplus to further the organisation's social mission
3. Trading in a market which includes actors in the organisation demonstrating a social entrepreneurial outlook.

I argued in the preceding sections of this chapter that social enterprise is an emerging term in Tanzania. In England, I suggested that it is a politically contested term with the term 'mutual' replacing the term 'social enterprise' after 2010. In England, but not in Tanzania, I argued that politicians have blended the term social enterprise with the term 'mutual' to mean various forms of employee control and to further their own political agendas.

The institutional logic framework through its various logic categories, offers an opportunity to explore whether the community institutional order can be used to distinguish social enterprise from other forms of organisation. Table 5.3 below compares the categories of the community institutional order described by Thornton et al (2012) with the interviewee responses. Those aspects of the logic categories specific to Tanzania but not England are identified separately.

Table 5.3 Analysis of Community Logic Categories with Interviewee responses

Y-Axis	X-Axis: Institutional orders: England and Tanzania – Community Logic of Social Enterprise <i>Anything in italics are the results from my research</i> Text which is not in italics is taken from Thornton et al (2012) framework	
Categories	Community Logic	<i>From one or more interviewees on social enterprise relationship with a health system</i>
<b>Root metaphor</b>	Common boundary <i>(community of interest)</i>	<i>A service</i> <i>A client group</i> <i>A geographical area</i> <i>A nation</i> <i>International (Tanzania only)</i>
<b>Sources of legitimacy</b>	Unity of will. Belief in trust & reciprocity	<i>Freedom to act in interests of community, be accountable to the community</i> <i>Social value, quality of care, empowerment</i>

<b>Sources of authority</b>	Commitment to community values & ideology	<i>Responsiveness to community of interest</i>
<b>Sources of identity</b>	Emotional connection. Ego-satisfaction & reputation	<i>Less evident in this research</i>
<b>Basis of norms</b>	Group membership	<i>The social enterprise leaders interviewed for this research demonstrated a logic which was more aligned to the corporation, rather than this description of community</i>
<b>Basis of attention</b>	Personal investment in group	<i>As for the basis of norms above.</i>
<b>Basis of strategy</b>	Increase status & honor of members & practices	<i>By allowing communities of interest to influence or lead services delivered ('empowerment') either through organizational strategy or service models Quality of services</i>
<b>Informal control mechanisms</b>	Visibility of actions	<i>Community cohesion through partnerships, visible support to community of interest Evidence of effectiveness</i>
<b>Economic system</b>	Cooperative capitalism	<i>Based on this alignment of the research results against the different logic categories, this does reflect the overall logic of the economic system. Social enterprises' focus on communities of interest, tied to achieving social value for its community is reflected in each logic category. The sources of identity, focus on common community rather than individual, ego focused goals.</i>

A comparison of the community logic described by Thornton et al (2012) with the interviewees responses suggest that they are not quite aligned. Social enterprises have an emphasis on social value and organisational social mission which is a narrower theme running through each of the categories. Social enterprise in Tanzania also had a stronger international logic in their root metaphor, identity and basis of norms.



Social mission and the link between this and social value emerged in the results as one of the important core characteristics of social enterprise. In terms of the logic categories in this table, it links not only to a source of legitimacy, but also to the root metaphor. Sources of authority, in terms of responsiveness to the community of interest defines how the social value is measured ie by linking the root metaphor with the social mission. Social enterprise leaders in England identified themselves as social entrepreneurs and separate from NHS managers and leaders in the for profit commercial health sector. In both England and Tanzania, the basis of attention is their personal investment in the group, where the surplus from trading activities is reinvested for the benefit of those communities of interest expressed in the organisation's social mission. Innovation and patient or staff engagement is a strategic focus, not necessarily to increase the status and honour of members and practices (as suggested by Thornton et al, 2012 ) but to allow communities of interest to influence or lead services.

The next section analyses the results from the perspectives of the other institutional orders religion, corporation and profession. It illustrates the results in relation to two types organisation. The first integrates its community logic with those of religion, profession and corporation. The second integrated the community logic with profession.

## **5.6 The institutional orders of religion, corporation and profession**

In Tanzania not for profit organisations play an important role in the health care delivery system. Many of these not for profit organisations are founded on religious principles; their social mission is based upon their faith. This section of the analysis refines the alignment of social enterprise with the logic underpinning community by exploring how social enterprises in Tanzania reflected the other logic of the institutional orders, religion, corporation and profession in their organisation. The first section draws on publicly available documentation from the Christian Social Science Commission (CSSC) in its role shaping the health system, and the Kilimanjaro Christian Medical Centre (KCMC) providing an organisational perspective. The second analysis draws

on the functions and scope of a membership organisation with a professional logic, PRINMAT.

### **5.6.1 CSSC and Kilimanjaro Christian Medical Centre (KCMC)**

The CSSC own and manage about 42 percent of health services at hospital level in Tanzania (56 percent in the rural areas) and more than 10 per cent of education services (Christian Social Services Commission, undated). It was formed in 1993 by the Tanzania Episcopal Conference (TEC) and Christian Council of Tanzania (CCT). It facilitates social services provided by member churches. The KCMC is a zonal referral and teaching hospital. It provides the following five functions:

1. To provide the public high quality of health care services
2. To provide to the public super-specialized health care services
3. To serve as a centre of excellence for certain specific diseases that can be utilized by local stakeholders for the development, optimization or implementation of medical interventions and health policies.
4. To conduct clinical research
5. To train different levels of health cadres (Kilimanjaro Christian Medical Centre, 2015 pg 9)

A comparison of the missions of each organisation is illustrated below:

CSSC:

‘Support the delivery of social services by church institutions in Tanzania through collaboration and partnership, advocacy, lobbying, capacity building and selected interventions, with the compassion and love of Christ.’ (Christian Social Services Commission, undated)

Kilimanjaro Christian Medical Centre:

“To render God’s healing services to set mankind free from the bondage of sickness, suffering and sin”, “To reflect Christ’s character of love, mercy, compassion and faithfulness in the course of fulfilling the call to care and heal the sick” and “To share God’s grace and love through the power of the Holy Spirit in the course of treating and caring for the sick”.(Kilimanjaro Christian Medical Centre, 2015 pg 5)

Within a Christian ethos:

‘We pray to Almighty God, to continue giving KCMC staff good health, courage and love so that they continue to serve with humility and dignity for the benefit of patients, students and visitors who come to KCMC.’

Prof R M Olomi ACTING: EXECUTIVE DIRECTOR, KCMC AND

EXECUTIVE SECRETARY, GSF (Kilimanjaro Christian Medical Centre, 2015 Forward pg 2)

Those interviewed for this research made the following observations of faith based health care organisations in Tanzania:

1. The scope of health care provided is bounded by faith. Some services such as family planning services to those who are not married are therefore not provided.
2. There was a perception by some policy makers and influencers that faith based health care delivery organisations have strong financial systems underpinning their operations, which ensure their financial survival. Systems require patients, in certain cases, to make a co-payment for care. Money is claimed back from the state for care provided under the service agreements with local and national governments
3. The meaning of 'not for profit' when charges were being made to patients which were perceived to be higher than some 'for profit' organisations.

The predominance of faith based organisations in Tanzania introduces a separate logic. In relation to the institutional order of religion, the legitimacy of the CSSC and KCMC is provided by faith and sacredness. The church's authority of the CSSC and KCMC is illustrated by their governance structure. At CSSC church representatives, the bishops, govern the CSSC and are its source of authority. At KCMC The Good Samaritan Foundation (GSF) Board of Trustees are the source of authority.

However, KCMC also demonstrates many aspects of the corporation. The strategic plan for the Kilimanjaro Christian Medical Centre demonstrates one or more of characteristics of the other logic categories found in the institutional orders Community, Religion, Market, Profession and Corporation. (Kilimanjaro Christian Medical Centre, 2015) . For example, KCMC measures its performance on the basis of the quality of the care provided, its financial viability and their market share. Its strategic plan demonstrates the challenge balancing the delivery of high quality health care services in a competitive environment with the need to incorporate up to date international scientific and technological developments. In its market position it acknowledges its responsibility to

contribute to national strategies to attain health related Millenium Development Goals. (Kilimanjaro Christian Medical Centre, 2015 pg 10 para 3.2) In the context of the national environment, entrepreneurship is seen as an important strategy to achieve its goals:

‘KCMC community needs to acquire and develop entrepreneurship skills so as to be able to mobilize resources to cover the budget deficit and meet its recurrent and capital development budget’ (Kilimanjaro Christian Medical Centre, 2015 pg 10 para 3.3)

However, both organisations also demonstrate features of the corporation. Bureaucratic roles such as Executive Director, Heads of Department at KCMC and at CSSC provide identity. In institutional logic categories, the basis of norms are employees and status in hierarchy the basis of attention.

KCMC’s strategy is to increase its size and diversification. It aims to remain competitive by devising novel ways of conducting its business, building good relationships with all key stakeholders/ and the surrounding communities. (Kilimanjaro Christian Medical Centre, 2015 para 3.4.8 pg 14) However, as at CSSC, the delivery of health care services and achieving excellent clinical services, requires strong clinical leadership, demonstrating the importance of the professional institutional order.

‘The competitive environment with which the Hospital operates demands quality performance in its core function of patient care. In order to ensure quality delivery of services the hospital needs to improve its specialist patient care. This strategic objective is geared towards achieving this goal.’ (First strategic objective, Improved Quality of Clinical Services: (Kilimanjaro Christian Medical Centre, 2015 pg 22)

KCMC’s strategic plan brings together the clinical perspective for excellence with the market. For example, clinical threats include KCMC’s unpreparedness for internal competition e.g. East African Community (Kilimanjaro Christian Medical Centre, 2015 pg 16) and the establishment of private hospitals offering health services. (Kilimanjaro Christian Medical Centre, 2015 pg 18). One of its key growth and sustainability strategies is to attract funds for specialized and unique services, thereby differentiating itself in the health care market (Kilimanjaro Christian Medical Centre, 2015 pg 18). The plan also identifies one of the opportunities for growth being a ready market for projects if operated on a commercial basis (Kilimanjaro Christian Medical Centre, 2015 pg 19). The

financial section of the strategic plan identifies the opportunity to attract loans for investment. Its status as a not for profit organisation, with various tax exemptions, is viewed as critical to maintaining cash flow. (Kilimanjaro Christian Medical Centre, 2015 pg 19)

Drawing on the analysis of the CCSC and KCMC roles, plans, purpose and values, the table below demonstrates how the idea of institutional orders might be applied in this context. In this table, not all cells need to be completed. It is the combination of different logic categories across each institutional order which gives the organisations their distinctive characteristics.

Table 5.4 Application of institutional orders and categories of institutional logic to case studies

<b>Y-Axis</b>	<b>X-Axis: Institutional orders</b>				
<b>Categories</b>	<b>Community</b>	<b>Religion</b>	<b>Market</b>	<b>Profession</b>	<b>Corporation</b>
<b>Root metaphor</b>	Health and social care services to Tanzanian people	Temple as bank	Transaction	Profession as relational network	Corporation as hierarchy
<b>Sources of legitimacy</b>	Freedom to act in the interests of those Tanzanians needing care	Importance of faith & sacredness in economy & society		Personal expertise	Market position of firm
<b>Sources of authority</b>	Commitment to community values & ideology – responsive to patient need	Priesthood charisma		Professional association	Board of directors. Top management
<b>Sources of identity</b>		Association with deities		Association with quality of craft. Personal reputation	Bureaucratic roles
<b>Basis of norms</b>		Membership in congregation		Membership in guild & association	Employment in firm
<b>Basis of attention</b>			Status in market	Status in profession	Status in hierarchy
<b>Basis of strategy</b>	Quality of services		Increase efficiency profit	Increase in personal reputation	Increase size & diversification of firm
<b>Informal control mechanisms</b>	Evidence of effectiveness. Cohesion through Christian network of health care facilities	Worship of calling	Industry analysts	Celebrity professionals	Organisation culture

Drawing on section 5.2 at the beginning of this chapter and table 5.3, the core characteristics of a social enterprise can be found in their root metaphor. The community of interest is the health and social care services provided to Tanzanians. They are also free to act in the interests of Tanzanians using their services, demonstrating their accountability to the community (via their contract with the government) through their social value and quality of care. Their status in the market is reflected through their market share. CSSC aims to grow the number of their faith based facilities in Tanzania. KCMC aims to grow their hospital. There are also non core characteristics of social enterprise. This community and market focus is managed within a professional logic which can conflict with those of the market and community. Clinical professional logic, for example, derives its authority not from the organisation's community of interest but from clinical colleagues, creating identity through personal reputation and their status in their profession. This professional logic may, in turn, conflict with the bureaucracy of a corporation, where a hierarchy with a Board of Directors, is reinforced by bureaucratic roles with its associated status and employee/employer power relations. These non core characteristics described in section 5.2 are blended with faith. The power of faith leaders in legitimising the purpose of both organisations is demonstrable where the church is also funding and/or negotiating with the state health care delivery services.

Each of the institutional logic categories demonstrates a blending of different and potentially competing logics at organisational and health system levels. The root metaphor in the example above, is a combination of religion, market, profession and corporation logic categories. Sources of authority logic category is a combination of community, religion, profession and corporation. This finding reflects previous research that social enterprises can be viewed as hybrid organisations ((Doherty et al., 2014, Battilana and Lee, 2014). Applying the framework of institutional logic provides an interpretation of how the logic associated with different institutional orders might be combined in different ways.

### 5.6.2 PRINMAT: an example of Professional and Community Institutional Orders

The literature review outlined other health system research which analyses the changing logic over time between the professions and other institutional orders. In relation to this research, two policy implementers in England emphasised the role of the clinical professions in influencing the quality of care and respect for professions as an important component of their culture. In Tanzania, one policy influencer, who represented a professional group, and whose membership organisation demonstrated the core characteristics of a social enterprise provides a useful example of how a professional logic might be reflected in the logic categories without the logic of the corporation.

Private Midwives and Nurses Association of Tanzania (PRINMAT) [Box 5.2] is an example of a Tanzanian organisation which combines professional logic with social value. Its organisational purpose includes clear social objectives and it derives its authority as a professional association. Quality of care is important. Quality of care was supported through, for example, a system of competition on performance amongst members. A performance based funding mechanisms was in place for 6

#### *Box 5.2 PRINMAT*

A non governmental, not for profit organisation. Its mission is to: 'reducing morbidity and mortality of underserved community through provision of quality, general sexual/reproductive and child health services and mobilizing community. PRINMAT does so to compliment Government efforts. In achieving this mission, PRINMAT will adhere to Human rights and professionalism.' (Prinmat, undated)

PRINMAT is organised as a professional network of qualified independent midwives and nurses.

It has membership from midwives in 22 regions of Tanzania who run 85 nursing homes

years with the support of a donor agency. The table below summarises how the organisation brings together the professional logic with social value in a market. (Table 5.5)



Table 5.5 Combining Professional logic with social value

Institutional orders	Examples
Profession <ul style="list-style-type: none"> <li>- Manage clinical risk</li> <li>- Improve health outcomes</li> </ul>	Clear and rapid referral criteria to ensure high risk pregnancies are referred to specialist facilities
Market <ul style="list-style-type: none"> <li>- Provide high quality service to encourage people to use service again</li> <li>- Focus on customer service, respect confidentiality</li> </ul>	Confidentiality, friendliness, respect, customer focus
Health system - State	Reduce workload of the district hospital by appropriate referral of high risk pregnancies, reducing costs to health system  Integrate private midwife service with other health care organisations, so part of whole health system, not separate entity
Social determinants of health – multi system change - Community	Through empowerment to encourage women to take responsibility for their health, education, food, nutrition, broader socioeconomic circumstances

Of interest in applying the institutional logic framework is that none of the logic categories of the corporation were evident at PRINMAT. Similar professional network organisations were not interviewed in England for this research, however, they do exist in the English health system. For example GPs and Dentists in England are organised around a professional logic. The majority (a specialist medical accountant suggests it might be in the region of 95% ) of GP practices are partnerships of GPs, who work together across a region as a professional network to deliver care to a geographically defined population. Social enterprise core characteristics may be found together with corporation, profession and religion institutional orders. Examples of different combinations of the categories within the institutional orders can be found in organisations delivering health care services in Tanzania and England. A combination of

social value, social purpose with one or more logics from other institutional orders therefore describe the underpinning logic of social enterprise.

Against the institutional logic framework and with the refinements proposed from this study, it can be argued that the principles underpinning social enterprise contain a distinct logic and are responsive to a market logic in health care services. The next section will explore the interaction between the logic of a social enterprise's social mission, its basis of strategy and client group in more detail.

## **5.7 Integrating the social mission with social determinants of health**

The idea of social enterprise lends itself to different ways of designing organisational culture, structures and processes within the organisation and between the organisation and the health field to further a social mission. The results suggest that this might allow flexible business models to be designed.

‘Social enterprise will potentially be seen as a solution, because its the idea that its a looser structure. You can try to get integrated care under a social enterprise umbrella....social enterprise can support fundamental integration - structures - not just organisational structure, funding systems, the systems underpinning the structure. ‘ *Policy influencer, England*

As described in Chapter 2, the WHO has published a framework which categorises the social determinants of health across four dimensions.(World Health Organisation, 2008a) For the purposes of analysis, each of the policy implementer interviewees in this research was allocated a number. The organisations' social mission, as described by the interviewee (policy implementer) was aligned with the WHO's social determinants of health categories. The alignment is illustrated below.

Table 5.6 Alignment of social mission with social determinants of health

Organisation	Socio economic and political context	Material circumstances Social cohesion Psychosocial factors Behaviours Biological factors	Social position	Health care system
England				
1	Y	Y		Y
2		Y		Y
3	Y	Y	Y	Y
4	Y	Y	Y	Y
5	Y	Y	Y	Y
6		Y		Y
Tanzania				
1		Y		Y
2		Y		Y
3		Y		
4		Y		Y
5	Y	Y		Y
6	Y	Y	Y	Y

From this analysis, it can be seen that each organisation was addressing one or more aspects of the WHO's social determinants of health framework. When compared to the organisation's target client group, a different pattern emerged.

Table 5.7 Alignment of Social enterprises client groups with their social mission

<b>Client group targeted in social mission</b>	<b>England</b>	<b>Tanzania</b>
Vulnerable people with complex health and social care where interventions are made across multiple sectors (Group A: Holistic)	1, 2, 4	6
Clients with health needs who may also require social care interventions or advocacy in the health system (Group B: Health care)	3, 6	1, 2, 4, 5
Clients with an interest in investing in their health and wellbeing (Group C: Lifestyle )	5	3

I will argue in sections 5.7.1 to 5.7.3 that organisations in each of the three groups shared similar strategies for achieving their social mission. However, the social determinants of health by themselves did not result in any obvious grouping of organisations. Each group of social enterprises will be described in more depth below.

### **5.7.1 Holistic social enterprises (Group A)**

In Group A social enterprises in England aimed to achieve their social mission by designing interventions tailored to the whole needs of an individual client. I have called these 'holistic' social enterprises. Long term strategies aimed to secure funding from different sectors, for example, two of these organisations secured funding from housing and employment as well as health and social care. Leaders of these organisations believed that multiple funding sources enabled them to improve daily living conditions for users more than they could with health funding alone.

'We do have a social care contract alongside our primary care contract. If you are working with all the drug users or whatever else, a primary care intervention isn't going to solve the problem. All we ask is that its put together with social care. If we get that right, there will be savings elsewhere. .... If you want to cut costs you have to recognise that your most complex people cost you lots of money and working differently with them will save money, but not necessarily your budget.' *CEO of social enterprise, England*

In Tanzania, the organisation had a strategy to build capacity for people living in marginalised communities. Areas covered including how to start a village

community bank, how to secure public funding for community projects, how to track resources to ensure that they reach the intended target.

All four organisations took a long term view of community engagement. Two of the social enterprises in England actively implemented partnerships with schools, using their position in the health market to influence health behaviours of children and their families. One of these also worked with refugee families who had children at the school to enable them to engage with the English school system effectively. They aimed to influence the social position of the children by improving their educational achievements and their future employment prospects.

### **5.7.2 Health care social enterprises (Group B)**

Organisations in Group B focused more narrowly on delivering health care services. I have called these 'Health care social enterprises' In these cases social care was still an important component of the care provided, but was more narrowly defined than in Group A. For example, both social enterprises in England falling into this group deliver community health services and include within their service philosophy the principle of embedding patients control over their own health. In that many of these patients experience long term health conditions, the aim is to stop health conditions becoming more complicated, rather than curing them.

Both organisations were actively developing partnerships with other service delivery organisations to develop more integrated care models which cross health and social care services. Like social enterprises in Group A, both social enterprises in the English Group B category, managed social care contracts as well as health care contracts, but unlike Group A not housing, education or employment contracts. Care models focused on integrated health/social care and working in partnership with others to address the broader health or social care needs of their clients.

In Tanzania social enterprises in Group B also delivered health care services. Unlike in England, they delivered specialist and general hospital services as well as community health services. These organisations demonstrated a

number of organisational strategies which contrasted with those found in the English group. These include:

- Building the capacity of the state managed health system, to improve the quality of referrals to their service and to confirm their position as a provider of specialist services (organisation 2) or to provide specialist services in regions where skills in state managed facilities are not available (organisations 4,5)
- Building into their service model the empowerment of women (organisations 2, 4, 5)
- Implementing new clinical services for those able to pay whilst advocating for public funding for those unable to pay (organisation 1)

### **5.7.3 Lifestyle social enterprises (Group C)**

In Group C both organisations in England<sup>14</sup> and Tanzania focused on achieving lifestyle changes. I have called these ‘Lifestyle’ social enterprises. In the English organisation, funding for the full range of services was obtained from the self insured, those privately insured, employers or the NHS, reflecting the company philosophy of not being dependent on government contracts. In contrast to the English organisation, the Tanzanian organisation aimed to create behaviour change in targeted populations (health care consumers and health care professionals) by building delivery channels for subsidised health products and services. The organisation actively engaged with government to influence changes to legislation and/or to promote the uptake of its products.

In this group (C), whilst both are social enterprises, the English organisation engages with the social determinants of health through its behavioural change lifestyle programmes for those able to pay. In contrast, the Tanzanian organisation takes a broader approach to behavioural change by addressing the systemic challenges at all levels in the health system including influencing

---

<sup>14</sup> In England, the organisation had a group structure. One of these groups aimed to maximise health and wellbeing of its customers and engage citizens by providing lifestyle services to those able to invest in their own health. The scope of services in the remaining company groups included specialist hospital care, general hospital and community health services.

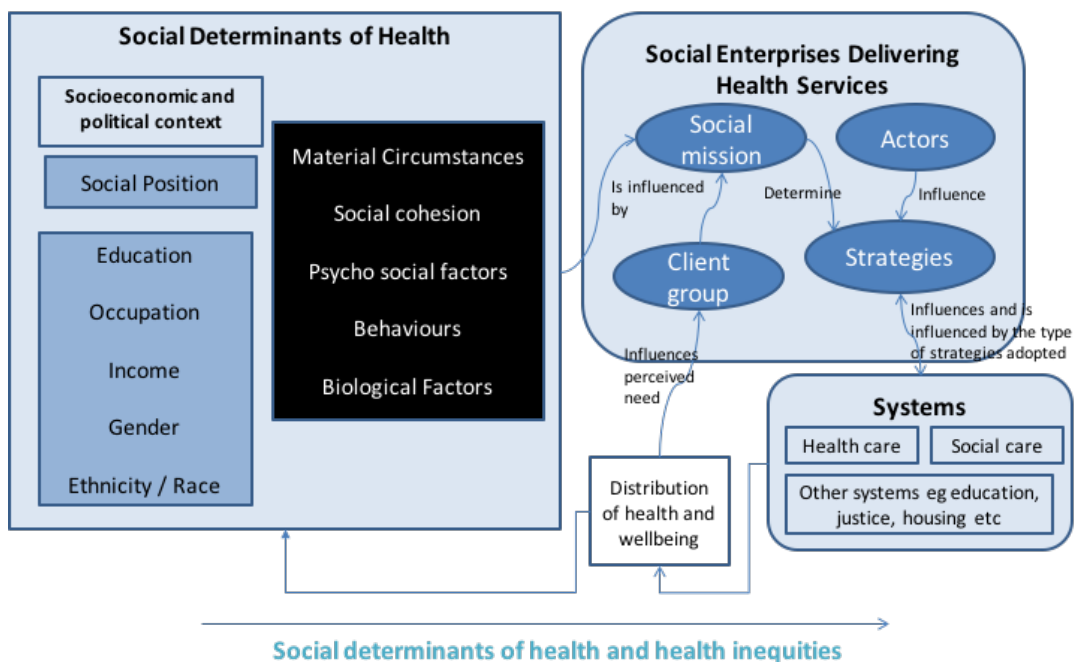
government policy and legislation, commercial distribution of health products and retail models.

#### 5.7.4 Using the social determinants of health and organisational strategies to effect social change

The results in this section suggest that the social mission of a social enterprise cannot be decoupled from its organisational strategies and client group. A social mission can be categorised by the five social determinants of health in the social determinants of health framework. When linked to client group and organisational strategy, the three groups emerge.

The health system design and other systems, particularly social care, influence the strategies pursued by organisations aiming to achieve a social mission. The client group and the social mission adopted by the organisation is influenced by the perceived need for change in the distribution of health and wellbeing. Actors from within and outside the organisation will influence the strategies adopted. These actors and the outcome of the strategies pursued influence system design. Building on the WHO Social determinants of health framework, (World Health Organisation, 2008a) this dynamic is illustrated below in figure 5.1.

Figure 5.1 Aligning social enterprise with social determinants of health conceptual framework



(World Health Organisation, 2008a Fig 4.1 pg 43 (adapted))

The social determinants of health include the socioeconomic and political context as well as the material-cultural-psycho-social factors found in individuals. The social mission of a social enterprise is influenced by these social determinants of health and client group needs. The distribution of health and wellbeing influences perceived needs of the client, for example whether organisational strategies which address employment or housing should be followed as well as health care.

Taking the WHO's social determinant of health framework as a starting point, the results from this study suggest that actors with an interest in social enterprise delivering health services integrated their social mission and organisational strategies to achieve improvements in one or more social determinants of health experienced by their client group. Other systems may be tightly coupled (Group A: holistic) or loosely coupled (Group B: health care) by integrating funding sources or through other mechanisms such as partnerships between organisations. Social entrepreneurs, by combining social enterprise organisational strategies and systems context, aim to influence the distribution of health and well being interventions in a population, to address the perceived needs of their client group and the broader social determinants of health of the population. These results build on previous research. In Chapter 2.5.2, Roy (2014) found only five studies linking the social determinants of health with social enterprise. The results presented here go further, demonstrating not only that a link with a social enterprise's social mission can be made, but that also, there is a relationship between the social mission and the organisational strategies used to meet need. The implications of this finding for social enterprises' business planning approach, will be discussed in more detail in the concluding chapter.

The next section explores how the logic of a market in health care services is related to social entrepreneurs organisational strategies. It builds from the review of research in section 2.5.3.

## **5.8 Using social value in health care markets**

As a market mechanism the idea of social value and the way in which social enterprises demonstrate social value needs further development if the concept



is to be embedded as a currency (ie payment formula for health care interventions) for health services. However, if the market currency is price and quality of care, social enterprises are left with no recognition of their social impact in the market. In this context, a separation needs to be made between social impact at an organisational level (as in the previous section of this chapter) and the social impact at a service level. Whilst the two are not mutually exclusive, in England, commissioning is undertaken for services. Organisational impact in terms of the social impact of the organisation's strategies as a whole is not built into commissioning mechanisms. The commissioning system in England is designed so that organisational type is not taken into consideration.(Monitor, 2013)

The investment in social enterprises in England was done without investment in market mechanisms to allow competition in social impact. A recent publication identified 75 different ways of measuring social value (Lord Young, 2015). Whilst social enterprise as an organisational type could be introduced into the market, there were no agreed system or currencies to measure their differentiation via social impact.<sup>15</sup>

---

<sup>15</sup> For example, the SROI Network provides a range of information and tools. SOCIAL RETURN ON INVESTMENT NETWORK. undated. Available: [www.thesroinetwork.org](http://www.thesroinetwork.org) [Accessed 18/1/16.], CABINET OFFICE 2009. A Guide to Social Return on Investment. NEW ECONOMICS FOUNDATION 2011. Small Slices of a Bigger Pie-Attribution in SROI. 2011, New Philanthropy Capital: Social Return on Investment- Position Paper. ..LEIGHTON, D. & WOOD, C. 2010. Measuring Social Value: the gap between policy and practice. DEMOS.

*Box 5.3 Legislation: The Public Services (Social Value) Act 2012*

The Social Value Act (2012) was advocated by social entrepreneurs and lobby groups such as Social enterprise UK as way of building social value into the operation of the market for health care services funded by the state.

It aimed to:

‘require public authorities to have regard to economic, social and environmental well-being in connection with public services contracts; and for connected purposes.’

A recent review of the Social Value Act (Lord Young, 2015), whilst finding commissioning examples where the deployment of social value had led to some successes also found the following barriers:

1. Awareness and take-up of the Act is a mixed picture.
2. Varying understanding of how to apply the Act can lead to inconsistent practice, particularly around:
  - knowing how to define social value and how and when to include it during the procurement process
  - applying social value within a legal framework and procurement rules
  - clarifying its use in pre-procurement.
3. Measurement of social value is not yet fully developed.

The Social Value Act (UK Government, 2012b) (Box 5.3) was a first step towards this but has had little impact on the operation of the market.

In England, recognition of social value was confused further by the role of volunteers in delivering social value. One policy implementer interviewed for this research, described how some health care commissioners confuse social value with volunteering believing that use of volunteers reduces the overall cost of the service.

‘Some commissioners think that if you're a social enterprise you can make money for yourself so they don't have to pay so much. We see [volunteering] as added value because we're giving people skills, contributing to the community, building confidence so they can move into work. Their [commissioners] view is that we'll pay half the service because half of it is free.’ *Policy implementer, England*

For this client group, in a Group A: Holistic social enterprise, the role of volunteers in service delivery was completely misunderstood by some commissioners, yet others recognised the complexity in terms of system

changes (structural, cultural, behaviour) required to improve recognised that if they wanted innovation, they paid for the design and then the delivery of the service.

‘So they are using commissioning as a way of saying we want something different to what we've got as opposed to saying what's the cheapest’.  
*Policy implementer, England*

A lack of understanding of complexity was further confused by different ways of defining social value. The SE UK guide to the Social Value Act defines social value as:

“Social value” is a way of thinking about how scarce resources are allocated and used. It involves looking beyond the price of each individual contract and looking at what the collective benefit to a community is when a public body chooses to award a contract.

Social value asks the question: ‘If £1 is spent on the delivery of services, can that same £1 be used, to also produce a wider benefit to the community?’ (Social Enterprise UK, 2012b)

Reviewing the social mission of the organisations whose leaders were interviewed for this research demonstrated that a social mission of an organisation may be focused quite narrowly on simply the delivery of health and social care. Measurement of social value, therefore, may not ‘fit well’ with social enterprises that are primarily focused on employee benefit rather than to achieve broader social benefit. The community interest company regulator, for example, established to oversee the social purpose of community interest companies, one form of organisation adopted by some social enterprises, uses the community interest test to establish whether a community interest company is operating for the benefit of the community. The guidance specifically excludes companies set up for the benefit of employees (Office of the Regulator of Community Interest Companies, 2013 Chapter 4) However, the guidance also describes ‘community’ in broad terms to include the delivery of health and social care services, rather than social value in the terms of the Social Value Act.

Arguably, lack of precise meaning of the terms social mission and social value allow variation in the institutional field (the health system) through interpretation and experimentation, allowing ideas and organisational strategies to evolve over time. The results from this research in relation to the logic of the market

will be explored in more depth in the next chapter. From an organisational perspective, the introduction of terms into the health care market, which include the ill defined 'social' are contested and, as illustrated with the review of the impact of the Public Services (Social Value) 2012 act, (UK Government, 2012b) the intended impact can be diluted. Aligning social value with achieving change in the social determinants of health of target populations may be a way of embedding the concept into commissioning mechanisms at a service level and will be considered in the concluding chapter.

## **5.9 Conclusions**

In this chapter, the core characteristics of a social enterprise can be found in both countries. These are: social mission, reinvestment of surplus to contribute to achieving an organisation's social mission and trading for a profit within an entrepreneurial outlook. Other non core characteristics may be present. For example, adoption of employee ownership may be found in social enterprises in England but not in Tanzania. This blend of characteristics supports other research (Battlana and Lee, 2014, Doherty et al, 2014) which demonstrates that social enterprises can be viewed as hybrid organisations drawing on different organisational structures and cultures to blend logics in the development of organisational strategies to achieve their social mission.

There is a benefit in leaving the definition loose from a structural perspective (ie not linking it to a specific organisational form) as this enables a variety of business (including structural and cultural) strategies to be adopted to generate income to further the social mission. The three characteristics of social enterprise can be found in combination with other institutional orders including religion, profession and corporation. This finding suggests that this blending of logic is not fixed but flexible across social enterprises operating within the health care delivery system.

In England and Tanzania the meaning of the term social enterprise needs to be contextualised within the broader context of 'not for profit' organisations. In England the three core characteristics of social enterprises could equally be applied to charities, voluntary and community organisations. In Tanzania there is no similar debate in relation to the meaning of social enterprise by policy

makers. Those arguing that social enterprise is a separate type of organisation, argue on the basis of entrepreneurial outlook, and that its social purpose and reinvesting of profits to achieve that social purpose place it within the broader definition of 'not for profit'. However, social enterprise is not found in Tanzania's health policy. It may be anticipated that this lack of clarity concerning the meaning of social enterprise may emerge in the future as 'not for profit' organisations refocus their business models on income generating, sustainable models, independent of donor funds.

Aligning the social purpose of the organisation and their client groups with the WHO's social determinants of health framework (World Health Organisation, 2008a), three groups of social enterprise were identified. These were: Group A, holistic social enterprises, Group B, health care social enterprises and Group C, lifestyle social enterprises. These results begin to fill a recognised gap in the research, highlighted by Roy (2014) on the alignment of social enterprises' social purpose with the social determinants of health. The type of classification system developed from this research, goes some way towards differentiating those social enterprises managing complexity across multiple systems (including health) from those with narrower (in systemic terms) approaches to their business scope.

Recognising that social enterprises do have a distinct logic through its three core characteristics, they are privately managed organisations in a market based health system. The next chapter therefore compares why and how each health system is designed to allow privately managed organisations to receive state funding to deliver health care services.

## **Chapter 6 Rationale for and process of introducing social enterprise**

### **6.1 Introduction**

Health services may be state funded, privately funded or a mixture of both. Each health system enables the involvement of private providers in delivery of state funded health services. This chapter draws on the three change processes described in institutional logic theory in the introduction to section 2.5, ie the actions of institutional entrepreneurs, structural overlap and event sequencing.

Section 6.2 presents interviewees views on the benefits private providers bring to a health system. These results provide the context for the rest of the chapter.

In Section 6.3, the analysis contextualises this public/private mix of organisations in relation to the history of each health system and the development of a state managed market in health services. Application of the first change process, event sequencing of health policies, demonstrates how introduction of private sector organisations is historically contingent on the socio political context of the time and previous policy decisions. This section also examines the logic of the market in health services, compared to the ideal description of the institutional order described by Thornton et al (2012) and presented in Chapter 2.2.

The period between 2006 and 2010 in England is then examined to analyse why NHS managed staff were offered the opportunity to establish their own social enterprises. This section (6.4) illustrates how institutional entrepreneurs, the second change process, influenced the development of social enterprise policy in England. It also demonstrates how their actions were bound by their historical context. Event sequencing and the actions of institutional entrepreneurs are bound together.

Building on the learning from the English case study and the analysis of the health system context in Chapter 4, section 6.5 draws together the data from the interviews in England and Tanzania to analyse how social enterprises'

respond to structural challenges in the composition of the health systems field. In this section, I focus on the third process, structural overlap to explore how social entrepreneurs develop their organisational strategies in support of health priorities, enabling them to receive state funding whilst also achieving their social mission.

## 6.2 Why have privately managed organisations in health systems

Albeit starting from different resource bases, both countries health strategies recognise the role of different types of organisation (public/private) in achieving their goals. In England and Tanzania policy makers have introduced a state designed and managed market in health services which allows organisations which are not managed by the state, such as social enterprises, to receive state funding. By introducing market mechanisms to redistribute state resources, policy makers interviewed in both countries suggested that privately managed organisations will bring benefits to the health system not found in state managed organisations.

Table 6.1 presents the arguments made by policy makers for involvement of the private sector. Five of the six arguments in both countries were the same.

Table 6.1 Explanations for private sector provision of Health Services

<b>Arguments for involvement of the private sector by interviewee</b>	<b>England (number)</b>	<b>Tanzania (number)</b>
Innovation	4	2
Choice of provider	1	2
Enhance capacity of the health system	2	3
Access to new expertise	1	1
Employment	0	1
Transfer financial risk from public to private sector	1	1

Social enterprises, as non state providers of care, may therefore need to demonstrate one or more of these characteristics. Each of these arguments will be considered briefly below.

### **6.2.1 Innovation**

The private sector in England was mentioned as being more innovative than publicly managed organisations by four of the policy makers interviewed. One of these, however, was clear that this was not always the case by giving examples of private sector organisations which in his view were not innovative. These policy makers viewed innovation in terms of new care models which challenged the status quo. They cited examples of initiatives such as the Independent Sector Treatment Centre (ISTC) policy which was widely viewed as challenging clinicians entrenched care models resulting in more efficient and productive service delivery.

In Tanzania policy makers gave two examples of innovation that private sector providers might introduce. The first was the example of one aspect of the PSI (Population Services International, 2016) business model where the NGO builds commercial relationships with retailers and wholesalers to distribute subsidised health care products. The objective of the business strategy is to reduce the prevalence of HIV/AIDS in the population. The second was leveraging experience from the private sector to introduce more efficient management systems.

In England policy makers valued new ways of expanding business models to cover large geographical areas thus enabling more communities to benefit from innovation. The literature review for this thesis refers to this scaling up of social enterprise as one important aspect of innovation to achieve social transformation. (Anderson, 2014, Yunus et al., 2010). Issues of scale were not mentioned by any of the policy makers in Tanzania, possibly because there are already examples of private organisations, including not for profit organisations working nationally or regionally. In England, there were clearly tensions between scale and the social mission of some organisations who tied their organisations strategies to a small geographical area such as a town or neighbourhood. In this example below, the policy influencer illustrates the



difficulties scaling up a social enterprise model which achieves its social mission by creating strong links in a community:

'I don't think it means big is always the solution... there's something about scaling out. How do you bring a range of providers in an area together to give a more consistent person centred service.... Example of a neighbourhood: recognise there are many different communities. By scaling we need to bring all the factors to bear looking at provision across a place so a person from a community, whatever their characteristics, can get the right service from an organisation ie scaling across an area, recognising diversity. Won't necessary be able to transfer what works in [one area to another]. *Policy influencer, England*

The same policy influencer expressed concern about the motivations of policy makers.

I don't think this is what it means to policy makers - who think bigger because its cheaper, easier to manage (transaction costs appear to be smaller) but if people get missed because they don't fit the conceptualised model then people drop through the net, and appear somewhere else eg A&E.' *Policy influencer, England*

In this example, a social enterprise leader in England highlights the challenges between working within a planned health economy with strong national rules and the lack of local flexibility to influence the design of regional operating environments.

'No government yet has the balance right between localism and central control. They give with one hand and take away with other eg everything is local but then more regulators than ever, who don't speak to each other then cause us problems. Things like we were guaranteed 3 year contracts and then 6 months later they invented AQP. Then 40% of my contract could have been out to the world if my commissioners had felt like it. Contracts aren't worth the paper they are written on. Have to do the dance otherwise you risk isolating yourself which isn't good business. So increasingly we get sucked into behaving like everyone else - sucked into that centralised control .... we all end up starting to look the same again which was why we came out.' *Policy implementer, England*

Of those interviewed in England, 19 mentioned the importance of civil society in the discussion on social enterprise. In their descriptions of the idea of community, interviewees mentioned the importance of geography in relation to building local relationships to tailor services to the needs of local populations to deliver better outcomes.

'Social enterprise can deliver better outcomes than a commercially-based organisation because it tends to be geographically based, in places where people running a social enterprise are the same people

who will achieve the outcomes for the people they are working with.’  
*Policy maker, England*

Five of the policy makers I interviewed spent time describing how social enterprises delivering health and social care services had been able to design more innovative care models. What was not clear from this research is whether the social enterprise leaders who chose to form social enterprises were more entrepreneurial than their colleagues who stayed in the NHS. One of those interviewed, for example, described how throughout his 20 year career, he had always challenged the status quo. Two policy implementers led charities which had never been managed by the NHS, although both had worked intensively with NHS policy makers and commissioners at national and local levels to influence change.

5 policy implementers in England emphasised that innovation is driven by the culture of partnerships and cooperation at a regional level, rather than competition in the market place. For example, some social enterprise leaders offered specialist services to defined populations such as learning disabilities, mental health, vulnerable people with complex problems or a broad range of health care services delivered within a strong lifestyle/preventative framework. These social enterprises, delivering specialist services, were not geographically focused in their organisational strategies, but were geographically focused in their service delivery models, tailoring their business and care models according to local partnership arrangements.

Related to innovation, was the comment by two policy makers in Tanzania that the private sector was able to introduce new medical technologies faster than state managed organisations. In this way, the private sector was viewed as enhancing the capacity of the health system as a whole.

Innovation was perceived by policy makers in both countries to include care models, business models, scale and adoption of new technology. However, there was frustration by policy implementers in England that an overly controlling state limited leaders' ability to plan for the long term.

### **6.2.2 Choice**

In England, health policies explicitly include a commitment to allow patients choice of health care provider. In this context, private provider organisations

were seen as integral to patient choice within an NHS branded delivery system ie that all providers delivering state (NHS) funded services could use the NHS brand in addition to their own.

In Tanzania one policy maker suggested that private providers offered the government the opportunity to distance themselves from the provision of controversial health services, such as sexual health services. Private providers also offer the growing middle class in Tanzania opportunities to pay for services such as enhanced hotel services or faster access to treatment. Faith based organisations also give Tanzanians an opportunity to use providers which are aligned with their religious beliefs, particularly in urban centres where many different health facilities offer similar services.

Health system rules are an important influence on business model design. Enhanced hotel services are 'allowed' in the NHS but not faster access to state funded health services (as in Tanzania). Ability to co-pay for state services leads to opportunities for different business models to be designed in Tanzania.

### **6.2.3 Capacity**

In England the private sector was also viewed by one policy maker as having a role in enhancing capacity of the health system:

- it complements state provision by allowing patients to fund their own care
- through alternative funding sources (eg personal health insurance)
- providing an opportunity to enhance public provision when demand for services exceeds supply in state managed facilities. This latter point is linked to the choice agenda above but this interviewee clearly views that private provision needs to be offered in a state managed, national insurance system.

'The private sector can do things in the health service and do them well. There is an argument for saying that if there was only state provision it would not cope with demand, so if people can afford to pay after they've paid their taxes then why not? However, there is a consequence of this for private sector provision because we have to be very careful about market failure - if you had the NHS as a market-driven system only it would fail. It couldn't possibly deliver what it has to deliver. The principle of a Beveridge-based national insurance system where we insure

ourselves as well as others still matters to me. That is one of the great things about this country. We are all in the same system instead of a diverse system.' *Policy maker England*

In Tanzania three of the four policy makers suggested that the private sector can enhance the capacity of the health system as a whole. For example one policy maker felt that immunisation targets for the population could not have been achieved without private sector engagement which allowed them to achieve national immunisation coverage at a rate which is comparable with England. This policy maker made the same point as the English policy maker in terms of the state's role in ensuring the whole population has access to health care services of a certain quality.

#### **6.2.4 Expertise**

The private sector was also viewed as having access to different management and specialist expertise to those in the state management health system. The limitations of the role of the state and the importance of devolution to experts in service provision was a view held by one of the policy makers in England:

'The state has very heavy overheads and is only as good as the people running it. Equally, a council is only as good as the officers you have, what they know and the resources they have. Often people who do know a lot about a very specific area are in the voluntary/third sector because they have an expertise - for example, homelessness. A council may have one or two officers and may run social housing but may find it difficult to provide all the services a homeless person might need – so, the state needs to be supported by third sector organisations. Some housing associations are so good at what they do you would not need a council to run it'. *Policy maker England*

One policy maker in Tanzania emphasised the role played by the private sector in applying their expertise to change lifestyles, describing a range of opportunities such as use of social marketing techniques, leveraging expertise in gyms and other sports facilities to promote exercise. Another policy maker also mentioned the role the private sector played in training for both clinical and non clinical roles.

#### **6.2.5 Employment**

One policy maker in Tanzania suggested that the private sector also played a role in enhancing employment of the general population through both its private

health care facilities and infrastructure investment (eg medical equipment, pharmaceutical, facilities).

None of the policy makers in England viewed employment by the private sector making a contribution to country development. However, private sector market reports in England claim private sector employment to be an important factor in national economic development. (Laing and Buisson, 2011)

### **6.2.6 Reducing financial risk for the state**

Balancing the financial risk between state and private providers was viewed as an important component of English policy by one policy maker. Although only mentioned by one of those interviewed, various financial instruments such as payment by results have been introduced into the health care market for state funded services over the previous decade. Whilst applicable to all providers (state managed or private) linking performance to payments and therefore managing financial risk for the state, is an important part of the financial policies underpinning the health market in England.

One policy maker in Tanzania described the different views on the purpose of private public partnerships. On the one hand, the Ministry of Finance considers large initiatives where the financial risk is shared between the state and the private partner. However, many private public partnerships in health are viewed as outsourcing ie where the government funds services provided in a private health establishment and on a much smaller scale, with the state retaining all the financial risk under current financing models. In Tanzania, one policy maker said that there are no commissioning mechanisms to balance financial risk as in England.

### **6.2.7 Challenges for social enterprise**

Policy makers perceptions of the benefits of privately managed organisations present challenges for social entrepreneurs. None of the policy makers explicitly referenced social innovation, which was one of the change themes identified in the review of research in Chapter 2.5.2. Rather, the benefits of privately managed organisations are viewed in relation to the opportunities found in a market of health services which allow consumers choice of provider through competition, for example that arising from different care models. Capacity of the health system is recognised as limited in both England and

Tanzania in terms of access to some services, delivery of some national performance targets and expertise. Social entrepreneurs therefore need to demonstrate these benefits. In both countries private organisations are embedded into the operations of the health system in a number of defined ways and is the focus of the next section.

### **6.3 How private organisations are embedded in health systems**

The scope of the role of the private sector in receiving state funding to deliver health care services is limited in England, but not in Tanzania. Market structures and processes differ between the two countries. State defined market structures and processes shape engagement of the private sector. The importance of policy actors, who influence decision making at a national level also cannot be ignored. The overall purpose of this section is to illustrate how important an analysis of event sequencing in policy development, (one of the change processes identified in institutional logic meta-theory) is to interpreting how private organisations are embedded in the health systems in England and Tanzania. I start by comparing the size of the private sector in England and Tanzania (section 6.3.1). I then draw on the two change themes developed in Chapter 2.5.1 and 2.5.3. The first section 6.3.2 focuses on the historical contingency of health system changes, and illustrates how event sequencing is important to interpreting change. The second, section 6.3.3 examines the introduction of a market logic into the health system. Drawing on the summary of research presented in 2.5.3, together with the results from this analysis, I propose a way of reframing the market institutional order.

#### **6.3.1 Relative contribution of privately managed organisations**

In England, there are no clear definitions available for classifying non state managed providers so it was difficult to obtain accurate statistics. However, the Nuffield Trust estimate that in 2011/12 NHS funded care provided by non NHS providers was £8.7 billion of £105 billion total funding (8.2% of NHS budget). Services commissioned included general and acute hospital care, mental health, community and learning difficulties services. Care was provided by private, voluntary and local authority providers.(Arora et al., 2013 pg 4) In 2011/12, 12% of care was purchased from secondary care providers, less than

1% was spent on the voluntary sector, and 'others' was 3.7% (Arora et al., 2013 pg 15).

In contrast to England, Tanzanian government policy does not specify organisational types to the detail followed by the British Government. Instead, it has focused on making a distinction between 'not for profit' organisations and 'for profit' organisations. Historically, Tanzanian private health providers (particularly Faith Based Organisations) have played a significant role in expanding service delivery and providing supportive functions such as pharmaceutical dispensing and laboratory diagnostics (White et al., 2013). The table below illustrates the types of facility providing health care in Tanzania. Private 'not for Profit' facilities account for 13.6% of the total health care facilities providing care. (Quoted in (White et al., 2013 pg 41)

Table 6.2 Total Number of Facilities in Tanzania by Facility Type and % of Total Health Expenditure by Facility Type

<b>Facility Type</b>	<b>Government</b>	<b>Parastatal</b>	<b>PNFP</b>	<b>PFP</b>	<b>Total</b>
Hospitals	95	8	101	36	240
Health Centers	434	10	134	55	633
Dispensaries	3,889	168	625	787	5,469
<b>Total</b>	<b>4,418</b>	<b>186</b>	<b>860</b>	<b>878</b>	<b>6,342</b>
<b>Percent of Total</b>	<b>69.6%</b>	<b>3.0%</b>	<b>13.6%</b>	<b>13.8%</b>	<b>100.0%</b>
<b>% of total health expenditure<sup>16</sup></b>	<b>46.6%</b>		<b>13.5%</b>	<b>7.6%</b>	<b>67.7%</b>

Aside from public facilities, the 'Private Not for Profit' sector is the second largest group offering health and support services in Tanzania. It includes Faith Based Organisations, charitable not-for-profit organizations, NGOs, and community-based organizations. Of these, the Faith Based Organisations, are most prominent in terms of total infrastructure, number of staff, and geographic reach (White et al., 2013), particularly in rural areas, where they may be the

---

<sup>16</sup> Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation. (World Bank)

only health care provider. (White et al., 2013 pg 11) In Tanzania there has been a partnership between Faith Based Organisations and State at policy and service delivery levels since 1967. Faith Based organisations have a recognised place in the health system as ‘designated facilities’ – particularly in rural areas where state managed health care organisations are not present.

Authoritative market reports, such as that by Laing and Buisson in England (Laing and Buisson, 2011) equate social enterprise with employee owned companies, rather than organisations which demonstrated the three core characteristics identified in this research. For example, Laing and Buisson (2011) profiled the company Circle as follows:

‘Circle is a social enterprise co-founded, co-run and co- owned by clinicians. As such, the consultants and healthcare professionals who work for Circle own the facilities they work in and are empowered to put patients first in everything they do.’ (Laing and Buisson, 2011)

Inaccurate classifications of social enterprise contribute to different interpretations of the term and therefore their role in the health system and how they contribute to health priorities. In Tanzania, in contrast to England the contribution of ‘for profit’ and ‘not for profit’ organisations are explicit in policy documents although interpretation of terms is often contested.

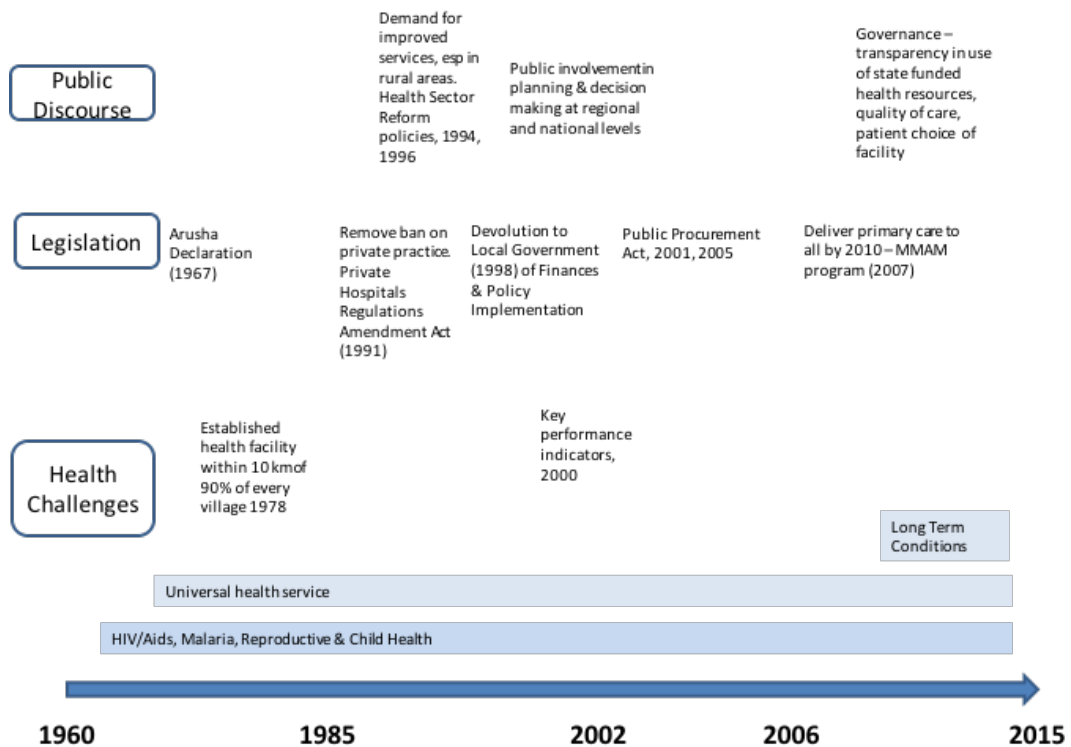
### **6.3.2 Historical contingency in the role of the private sector in health care systems**

In both countries, the state has used legislation or policy initiatives to change the balance of contribution of the private sector in delivering health care services. However, each country has used each mechanism differently.

In Tanzania distinct legislation over 45 years has reduced or expanded the role of private health care organisations in health care delivery. These changes are summarised in figure 6.1 below.



Figure 6.1 Tanzania: Legislation over time and health policy challenges



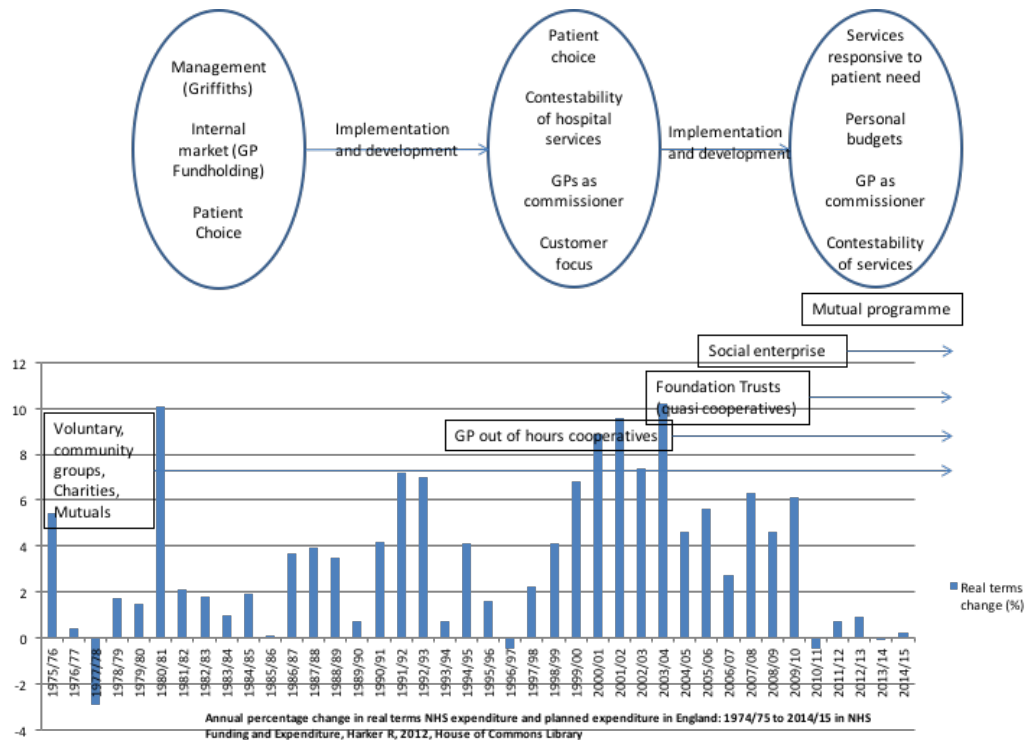
The first of these is The Arusha Declaration (TANU, 1967) when a commitment to provide a universal health care system in Tanzania was made. This legislation also banned private sector delivery of health services although in practice, public sector services were delivered in partnership with Faith Based Organisations. The principle of excluding private for profit enterprises in health care delivery was reinforced in 1977 with the Private Hospitals Act (United Republic of Tanzania, 1977) which banned all Private For Profit hospitals. Of importance for this research was that it made exceptions to those hospitals operating with a social purpose:

- ‘An organisation shall only be eligible for approval under this section if-
- (a) it has as its objects the advancement of religion; or
  - (b) it has been established for the promotion of the welfare of workers or peasants; or
  - (c) it is engaged in the advancement of any other' public purpose' (United Republic of Tanzania, 1977 6.2)

The Private Hospital Regulations Amendment Act, 1991 (Tanzania, 1991) re-established private medical and dental services. (pg 19) This move coincided with the introduction of a market based economy (although the market was not extended to the health sector at this time). It was followed by the Health Sector Reform policies of 1994 and 1996 and a Health Sector Reform Program and Action Plan for 1992–2002. In these strategies and programmes, partnership with the private sector was identified as one of six strategies to reform and modernize the health sector. (White et al., 2013 pg 19) It also included the devolution of all planning and delivery of health services to local government authorities in 1998. (COWI, 2007) The Public Procurement Act of 2001, (updated in 2005) provided the regulatory basis for the Tanzanian government to outsource public services to private operators including procedures to respond to solicited and unsolicited proposals for Public Private Partnerships (PPP). (White et al., 2013 pg 19)

In England, even the 1946 NHS Act, which absorbed voluntary hospitals into the state managed and funded NHS did not explicitly limit private sector organisations from receiving state funds to deliver health care services although in practice most hospitals and other health care providers organisations came under state management. (1946) Subsequent legislation focused on extending decision making freedoms of state managed organisations ie decentralising management of NHS organisations. For example, the NHS Act 2012 (UK Government, 2012a) extended the power of NHS Foundation Trusts to earn non NHS income, thus building on previous legislation which allowed greater independence of NHS Trusts from state control, through Foundation Trust Status (2003). At the same time, expansion of privately managed organisations delivering state funded health services in England has not been achieved through changing legislation but by policy initiatives which expand the market to allow competition for health care services contracts. The diagram below illustrates how private sector involvement of organisations with a social mission or democratic structure has been reflected in policy changes over time in England.

Figure 6.2 Emerging democratic organisations or organisations with a social mission between 1975 and 2015 in England



In England not for profit organisations such as voluntary organisations, community groups, charities and mutuels have always been present in the health system, albeit with varying levels of involvement. They complement state funded health care provision for the privately insured (or self payers) population but also deliver and sometimes fund health care services on behalf of state funders. Since the 1990s, health policy makers have also explicitly permitted state managed organisations and/or teams to move outside of state management. These included the quasi-independent Foundation Trusts in 2003, Social Enterprises in 2006 and Mutuels in 2010. The underpinning logic behind these different types of organisation has been fluid and politically contested. For example, Foundation Trusts were built on cooperative principles of engagement with local communities, allowing community representatives to influence Trust policy through membership schemes (Department of Health, 2005). However, this community empowerment aspect of their constitution was diluted significantly on implementation (Brettingham, 2005) and they have never been completely independent of state control (Milburn et al., 2014).

Policy makers interviewed for this research said that the significant increase in NHS funding between 1998 and 2010 was, in part, invested in enhancing the capacity of commissioners to manage local markets in health care delivery. It was also used to support NHS teams interested in forming social enterprises to make the transition into a corporate operating environment. Most of this investment coincided with the Pathfinder and Right to Request initiatives to externalise community health services into social enterprises. Similar opportunities offered to hospital staff resulted in very low uptake. At this point investment in supporting the change was significantly decreased.

To complement the legislative framework, the role of private organisations in each health system is clearly defined. In both health systems the state retains responsibility for monitoring and regulation, data and evidence and commissioning services, whilst allowing private providers involvement and management in health care delivery, prevention of ill health services, education providers and others such as diagnostic services and capital developments.<sup>17</sup>

The next section will review how the market is designed in both countries to enable private organisations, like social enterprises, to participate in health delivery. It focuses on the logic behind the design rather than its structure and processes.

### **6.3.3 Market Logic**

In this section, I build from the presentation of the results in section 5.8 on the attempts made in England to build social value into health markets. Initiatives such as the Public Services (Social Value) act (UK Government, 2012b) were shown to have limited impact on the operation of the market in health care services.

In England the historical evolution of the market in health care is not new:

‘In the health context its [social enterprise] about delivering services in a better way, better value than the public sector or the private sector can. The provision of health care in the UK has always had a diversity of suppliers eg trade unions running hospitals, mutuals, Benenden, Bupa.

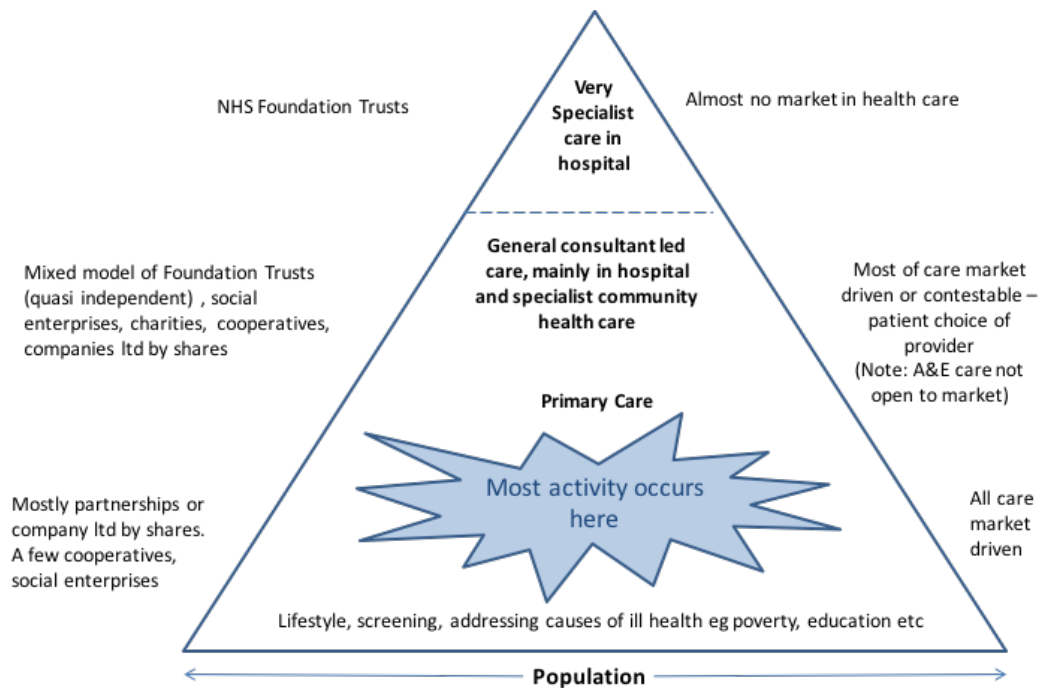
---

<sup>17</sup> For the purposes of this research, I am excluding ‘others’ and provision of education services from further analysis.

It's not a new idea that organisations other than the State can provide health care. On that basis ... [policy is] a progression of growth of different ways of supplying health and social care'. *Policy maker, England*

The diagram below illustrates which health care services are subject to competition in the NHS.<sup>18</sup>

Figure 6.3 Overview of the NHS Market



The diagram illustrates that almost no market exists for certain services, such as very specialised services or Accident & Emergency Services. There is, however, a market in most general consultant led care in hospital services, community health services, and primary care (including prevention). A broad range of non state managed organisations (excluding Foundation Trusts which are quasi-independent) including social enterprises, charities, cooperatives, partnerships and companies limited by shares are contracted to provide health care services.

The logic underpinning the health care market in England demonstrates several differences to the institutional order of market described by (Thornton et al., 2012). Competition and status in the state managed health system in England is

<sup>18</sup> Primary health care services for offenders are subject to competition. Defence medical services not subject to competition

defined by criteria other than share price and includes health criteria such as quality of care, effectiveness, innovation, employer standards and financial robustness. Social enterprises were seen as having an important role to play in the state defined market by all policy makers interviewed.

‘Competition can never be only on price. This is a massive issue for the current government (and any government) which is so driven by price. When you want to maximise the size of a contract things can go wrong because organisations can end up being driven by the bottom line not by social value. This is why social enterprise is so important’. *Policy maker, England*

One social enterprise leader interviewed for this research in Tanzania, emphasised that even in a market where patients pay for services according to ability to pay, in their organisation the care provided is the same to all, regardless of ability to pay.

‘Here, we have standard services and private health care services. You are flying on an aeroplane, 1<sup>st</sup> class, 2<sup>nd</sup> class, same pilot, you all reach the same destination, it is just the hotelier that is different.’ *Policy implementer Tanzania*

In England, experiments with market creation can be found historically, firstly in the commissioning of elective hospital care in the 1980s when GP Fundholders (Carson, 2000) were given a budget to purchase some hospital services. After the demise of this policy, some elective hospital services were again contested and private sector organisations explicitly invited to bid for services through the ISTC (Department of Health, 2000). Three Policy Makers in England suggested that the ISTC policy shaped the views of politicians on the potential of the market for the future:

‘When Labour were in government in early 2000, we were trying to diversify the supply of health care to unlock big problems like the backlog on hip replacements, to challenge the vested interests of consultants and Royal Colleges who were prepared to allow 2 or 3 year waiting lists for hip replacements and one of the ways we challenged was getting the private sector in to buy hip replacements. Those of us interested in coops, mutuals, social enterprises realised there was no reason why people in the health service couldn’t deliver health services through the establishment of Social enterprise. The genesis of that idea really comes from the labour party, government policy on diversity of supply and people like yourself and others who thought this was an opportunity.’ *Policy maker, England*

It was not until 2006, with the Social Enterprise Pathfinder Programme, that policy makers experimented with the market by offering teams employed by the NHS the opportunity to set up their own social enterprises independent of state control. The social enterprise Pathfinder programme offered clinical teams, who were managed by state owned and managed organisations, an organisational vehicle to 'externalise' into organisations of their own. Successful participants in the scheme were awarded contracts to deliver NHS services for 3 to 5 years. This programme is examined in more detail in section 6.4.

Social enterprise leaders interviewed for this research questioned the role of the market in health care delivery.

'I'm not even sure it's the market driving innovation. Why charitable sector has driven innovation is because they haven't been led by politicians and traditionally people recognise people are not getting a good deal, they find other solutions. The charitable sector has always worked with people not getting a good deal from public sector. ... I do believe there should be a public sector. I don't necessarily believe having a market of private sector providers will drive innovation. In fact I don't think it will. I don't think there is any evidence it ever has. I haven't seen any. What they do see is evidence driving down cost and evidence from the social enterprise sector of people innovating. And that is a different thing. ' *Policy implementer, England*

Some unions, eg Unison (2007) supported by academics have also questioned market driven strategies because they argue that the market drives down costs and long term investment

In Tanzania, policy development in relation to the market has focused on PPP structures. In the HSSP III, the MOHSW defines the PPPs as:

"PPPs in health can take a variety of forms with differing degrees of public and private responsibility and risk. They are characterized by the sharing of common objectives, as well as risks and rewards, as might be defined in a contract or manifested through a different arrangement, so as to effectively deliver a service or facility to the public."

(Ministry of Health and Social Welfare, undated pg 33)

One interviewee from a donor agency described the basis for their approach to private sector development in health:

The private sector thinks differently from the government. There is a view that the state is to say 'give me money, give me money'....but in fact it is the way the private sector thinks and plans and are adaptable to

sometimes volatile market places that the government doesn't understand. This is why building these partnerships are very very difficult because the government has a certain mentality and the private sector has a different mentality and those are two different worlds. The private sector has to be market and customer responsive whereas the public sector tends to be more responsible to its politically constituency. The civil service have to respond to that as well so those starting places are different. *Policy influencer, Tanzania*

Regulation of the market in England was devolved to government funded and quasi-independent organisations, such as Monitor and the Cooperation and Competition Authority. In its role as regulator, The Ministry of Health and Social Welfare in Tanzania has a specific role to play in facilitating PPPs. The 2003 Policy explicitly states:

“The Ministry of Health anticipates that a mutually beneficial cooperation of public-private partnerships shall exist among, public, faith-based organizations, NGO, private and informal and civil society sectors in the identification and prioritization of health needs of the population through a joint for a (sic). The partnership will jointly and transparently mobilize and share resources for development and efficient delivery of well-regulated health services while ensuring accountability to the public they serve.” (United Republic of Tanzania, 2003 section 4.3.2).

The regulator of health care organisations in England, Monitor<sup>19</sup> and PPP structures in Tanzania have clear roles, compared in the table below.

Table 6.3 Roles and principles of Monitor and PPP

Monitor	PPP
1) independent NHS foundation trusts are well-led so that they can provide quality care on a sustainable basis 2) essential services are maintained if a provider gets into serious difficulties 3) the NHS payment system promotes quality and efficiency 4) procurement, choice and competition operate in the best interests of patients (Monitor, 2015)	Collaboration and relationship between the public and private sectors, including: 1) mutually beneficial cooperation; 2) jointly and transparently mobilizing and sharing resources; 3) continuing communication, cooperation, coordination, and collaboration; 4) jointly regulating health facilities in both sectors; and 5) promoting health services by private sector organizations. (United Republic of Tanzania, 2003)

<sup>19</sup> A recent restructure in 2015 has incorporated Monitor into a new organisation called NHS Improvement



Historical investment in the development of a market infrastructure including experimentation with state managed markets meant that there was already expertise and capacity for commissioning health services in the NHS.

Experience of developing national payment systems for hospital services based on a national tariff and new payment systems such as Any Qualified Provider meant that commissioning structures and meaningful payment tariffs for some services were already in place but not for others. Payment tariffs for community health services only begun to be piloted in 2015, (Monitor, 2014).

In both countries the state retains responsibility for designing and managing the implementation of market logic. It may be inferred from these results and those presented in section 5.8 that in the state managed markets of England and Tanzania, the market institutional order is best reflected by making a number of changes to the defining institutional categories. In both countries, in the context of the state using market transactions to redistribute resources, the logic of a market needs to reflect the importance of social value, citizen democracy and health impact rather than price. Whilst shareholder activism is viewed as sources of authority and legitimacy in a market, in a state managed health context, the state, citizens and communities of interest are more relevant sources of authority. Whilst share price might be relevant to for profit shareholder based corporations, in the context of social enterprise and health care delivery, health impact, efficiency and social impact are more relevant. Status in the market is defined by local and national commissioners. Whilst efficiency and profit may be important, they are not the only bases of social enterprise's organisational strategies.

#### **6.3.4 The role of event sequencing as a change process**

Event sequencing is therefore an important change process, illustrated in this analysis of the introduction of private organisations into state funded health systems. The analysis presented here demonstrates how health system reform was influenced by historical policies on socio-political change and the introduction of a market. When compared to previous research summarised in Chapters 2.5.1 and 2.5.3, however, this analysis did not find any clear logic in the design of the market to support organisations such as social enterprise

which aimed for social change. Whilst in section 6.3.2, it can be demonstrated that event sequencing in policy formation allowed the gradual introduction of private providers, there was no evidence in section 6.3.3 that the development of the health market was designed to favour social enterprises. It may be inferred from these results that the design of the market in England focused on using health currencies designed to improve the quality of care, rather than social impact. Arguably, in England, the promotion of democratic types of organisation like Foundation Trusts and Cooperatives plus those with a social mission like social enterprises were believed to offer higher performance through their organisational culture alone rather than through the design of the market. In Tanzania, where the introduction of the private providers is undertaken within the context of a clear legislative framework, developed over decades and which separates for profit from not for profit providers, there is also no evidence that the health market is being designed to build on this distinction. The next section will explore why, in one particular historical period in England, clinicians and managers in England were invited to form their own social enterprises. It provides insight into the second change process of institutional logic, the way in which actors use their position as institutional entrepreneurs to change a field. In this case, policy actors, acting as institutional entrepreneurs influenced the agenda in relation to the formulation and implementation of health policies to introduce the idea of social enterprise into the health market.

#### **6.4 NHS managed staff form social enterprises in England**

Unlike in England, in Tanzania there has been no policy to allow employees in state managed health facilities to form their own social enterprises. The question why the British government decided to pursue the idea of social enterprise in England between 2006 and 2010 provides insight into how the socio-political context of health system reforms influenced social enterprise policy development. Building on the previous section, this event sequencing in national health policy development was important context for institutional entrepreneurs advocating for change.

Given the importance of social enterprise in health policy between 2004 and 2010, why were staff managed by the NHS invited to form social enterprises? In

England the key themes which emerged from the interviews are illustrated in the table below.

Table 6.4 Number of interviewees referencing reasons for social enterprises emerging in policy making in England

	<b><i>Policy Maker (Number)</i></b>	<b><i>Policy Influencer (Number)</i></b>	<b><i>Policy Implementer (Number)</i></b>
Values based arguments on social responsibility of social enterprise	6	0	2
More efficient, productive services which improve the quality of care	6	2	5
Emerging from the organic policy making process	5	1	3
Fit with ideological context of the day	4	2	4

There was a consistency in policy makers' beliefs that social enterprises were to be encouraged. They used values based arguments which recognised that social responsibility is built into social enterprises' business purpose and surplus reinvested to further that social mission. This social mission was viewed as aligning with both NHS staff values and society's expectations on the values behind the NHS. Of those interviewed five policy makers explicitly referred to this as a reason (although not the sole reason). Only two policy implementers viewed it as a reason behind its emergence in health policy in 2006 and none of the policy influencers. Of those policy makers which did not emphasise this social responsibility, one considered that social enterprises were staff owned enterprises; in this case the social mission was not viewed as a critical factor. One other policy maker linked social responsibility with an emphasis on the democratic opportunity of social enterprises to engage geographically discrete communities within a broader political ideology of local democracy, 'localism'. It is of note that only two policy implementers and no policy influencers mentioned the social responsibility of social enterprises as a reason for policy interest.

Of equal importance was the view amongst policy makers that social enterprises also offered opportunities for the provision of more efficient, productive services which improve the perceived quality of care. Three policy

makers considered social enterprises as being better able to be innovative, because they are independent of the NHS and therefore free from the perceived stifling bureaucratic management of state control. Five offered arguments based on financial crises. These differed in type, from the shock of the financial crisis in 2008, to the financial consequences of the political commitment to address waiting lists in the 1990s, and the emerging crisis arising from the costs and complexity of delivering care to an ageing population and managing long term conditions. One policy maker also believed that social enterprises (in common with all private sector organisations) could attract funding not open to state providers. This view was also found in Tanzania amongst some of those interviewed. This implies that state funds can be 'topped up' by other sources of funding for services such as co-payments from patients or donations from the public or international donors.

Social enterprises were viewed as offering an opportunity for services to be provided more efficiently and effectively. Two policy makers suggested that the authoritative research by the Cass business school (Lampel J, 2012) on the greater productivity of staff controlled organisations subsequently confirmed this view. This research built on influential Think Tanks, such as the Kings Fund, which had published reports on the opportunity of mutual forms of organisation and social enterprise since 2006. (Lewis et al., 2006, Addicott, 2011, Ham, 2014) One policy maker raised the need to challenge the vested interests of clinical consultants to improve care, raising the ISTC programme as an example of an effective strategy to effect system change by using competition to challenge entrenched practices of powerful clinical groups. This view was balanced by two policy makers who suggested that social enterprises offered clinicians and other staff a bigger say in how services are run. However, social enterprises were not viewed as a solution in themselves. As one policy maker said social enterprises must have good leadership to achieve its objectives.

Some social enterprises are driving and delivering service transformation, but not the majority. Whether they're delivering transformation does not seem to relate to issues of ownership or governance, rather leadership and values – particularly whether there's a strong focus on users' needs. Frankly, it's not worth spinning out services or bringing in new contractors unless this is going to enable

major transformation which improves services and outcomes for patients.  
*Policy maker, England*

One policy maker emphasised that the right culture of staff and patient engagement is also seen in some 'for profit' organisations. In his view, it is not related to type of organisation, whether for profit or not for profit.

One social enterprise leader argued passionately that clinicians in their social enterprise, had been able to be more productive and offer a better quality of care than they had in an NHS organisation, because of the change in culture they had effected as leaders. They equated this change in culture to their organisational form where staff were given shares and therefore some degree of control over company policies and strategic direction. However, improvements in the quality of care were not linked to staff control by other social enterprise leaders, who pointed to a change in culture that they had managed to effect as leaders. In the quote below the social enterprise leader suggests that the act of transitioning out of the NHS was energising rather than the result of any planned local or national policy.

Neither at the time, nor retrospectively can I really see what the clear flow of logic was that drove the policy. However, it has been hugely beneficial for this health community. It was an unintended consequence of policy. As a manager of public sector services you are being swept away by a flood of policy so you pick some things up along the way that might make sense - bits that you can act on that seem a good idea. [Becoming a social enterprise has] given us an energy that wasn't there before. [It has] done good things for a lot of people; things we weren't doing in NHS. *Policy implementer, England*

Those who led organisations which had always been independent of the NHS also argued that the culture in the organisations they led was not linked to staff control, but to a broader philosophy of engagement in the culture of the organisation and its interaction with service users.

I was quite involved in the development [of social enterprise policy]. I went to lots of workshops and discussions, conferences. Before 2006. Rationale: the whole self help self reliance. I have a real belief in that. It's absolutely right. There's something in the drive of social enterprise which is about being innovative, finding new solutions, not being reliant or passive recipients of the service..... It is something we want to promote and other people did as well. *Policy implementer, England*

These different perceptions amongst policy makers and policy implementers on the reasons behind the emergence of social enterprise in health policy, all

suggest that the narratives for change, the framing of the argument and the underpinning theories presented for change will be important areas for consideration in this research. These are analysed in more depth in Chapter 7.

Four policy makers emphasised that these narratives for change cannot be decoupled from the broader political environment of the day. They emphasised that a reduction of direct management of services and embedding the purchaser/provider split in health care services was part of the overall government strategy. Four policy makers emphasised the democratic ideology of the time under New Labour which, they said, took the following forms:

- an emphasis on supporting geographical communities to be self reliant,
- using the democratic process to create more responsive organs of government,
- involving citizens in service design to improve the quality of services,
- broader democratic argument about accountability of the NHS to UK taxpayers for not only the quality of service delivery but also the means of delivery (ie that social enterprises offer a values based alternative to 'for personal profit' organisations and therefore should be supported in the managed NHS market).

Of relevance to this research is the broader legislation in England relating to Community Interest Companies, a new company form, introduced in 2004. (2004) This act specifically includes statutory clauses for companies established as community interest company, including an asset lock which retains assets for the benefits of communities and member control, and clauses to prevent demutualisation and windfall profits being paid to directors and members without checks of mutuality and charitable status. (The CIC Regulator, Undated) It was viewed by health policy makers at the time as a key plank of legislation, which subsequently underpinned NHS policy initiatives to externalise state managed services to social enterprises between 2006 and 2010.

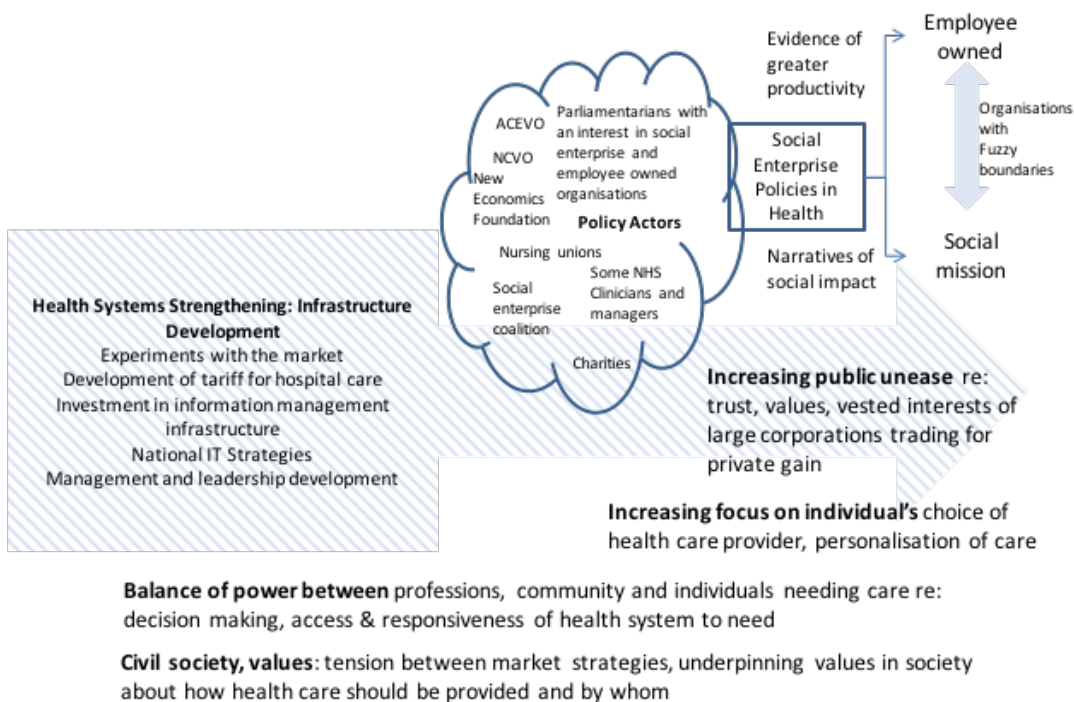
Two policy influencers suggested that the market ideology, which assumes competition will improve efficiency and quality of care and within which social enterprises would operate, was driving the emergence of social enterprise. One was pro market, the other anti market.

Some of the views of policy implementers on the reasons behind the emergence of social enterprises were not mentioned by policy makers including the reduction in political accountability by removing the cost of health services from the government balance sheet (3 interviewees), and the need to introduce different types of provider to promote diversity (2 interviewees). The former was robustly denied by one policy maker, who pointed out that only 10% of NHS managed community health services became social enterprises. Rather, the approach to managing the logic of policy making and implementation, which is examined in more detail in the next section, would suggest that there is some truth to one policy maker's comment that social enterprises were a social experiment to resolve a problem. The perceived problem included poor productivity and what one policy maker described as the 'white elephant' ie community health services were believed by some to be expensive, poorly performing and policy makers did not know what to 'do' with them.

Despite the range of arguments put forward to encourage staff to form social enterprises in England, uptake varied across regions. A study in the West Midlands, one of the regions with low uptake, indicated that staff faced several barriers to setting up a social enterprise in this region including lack of staff support, lack of leadership, and lack of organisational or commissioning support. (Miller and Millar, 2011)

However, there was also a socio-political and historical context to social enterprise advocacy. Figure 6.4 illustrates the breadth of policy actors, working as a community of interest to argue for change from their different constituencies. These policy actors were working as institutional entrepreneurs, aiming to develop the market in health care services to allow for social value creation.

Figure 6.4 Power &amp; Health system strengthening in England



1875 1876 1877 1878 1879 1880 1881 1882 1883 1884 1885 1886 1887 1888 1889 1890 1891 1892 1893 1894 1895 1896 1897 1898 1899 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014

From the 1990s, policy actors included leaders from voluntary sector lobby groups including ACEVO and NCVO, argued for their constituencies to be offered government contracts to deliver health services. The newly formed Social Enterprise Coalition lobbied the Labour government ministers and policy makers directly, offering a new opportunity for new Labour to differentiate themselves from previous governments. One charity, Macmillan was specifically mentioned by one policy maker as illustrative of what they were trying to achieve. The larger Charities such as MacMillan were powerful advocates for change because of the size of their charities and the scope of health care services that they delivered and sometimes funded in partnership with NHS providers. They wanted more opportunities to grow their organisations. Towards the end of the Labour administration, Macmillan, for example, were able to negotiate with NHS commissioners across Staffordshire for a new way of commissioning cancer and end of life services. (MacMillan and NHS, 2016)



As outlined in this section some NHS managers and clinicians involved in policy dialogues with policy makers and politicians were also advocating for more independence from NHS management. Policy making and agenda setting was viewed as a demand driven process, policy makers responding to 'bottom up' ideas for change. Figure 6.2 (Section 6.3.2) also showed that there were resources available to invest in health system reform experiments, unlike in previous administrations, when financial challenges left little room for large scale investment in significant change programmes. Three policy makers also pointed out that political sponsorship from some politicians of all parties was important together with ego driven agenda setting by Health Ministers looking for an exciting opportunity to transform health which they could say was theirs. Think tanks, such as the New Economics Foundation (Lea and Mayo, 2002, Mayo and Moore, 2001) were also proposing that social enterprises offered a values based alternative to state managed public services.

The relative contribution of privately managed organisations is influenced by different actors. For example, interviews with policy makers in England demonstrated the extent of backroom politics in developing the social enterprise programme. None of those interviewed agreed to the publication of quotes from their interviews on this topic. The following lists the information provided into two groups based on comments on the market and advocates for the promotion of social enterprises:

#### Market:

- In England the for profit private sector lobbies at the top level of government, directly with the Prime Minister, whilst the not for profit organisations lobby at lower levels
- Decisions are made in the pub in Pimlico, which is where the Conservative party politicians and for profit lobbyists live

#### Social enterprises:

- In England, politicians look for a cause which will leave a lasting legacy. Ego driven politics influenced the emerging social enterprise agenda. Politicians championing social enterprise paid close attention to civil servants' progress in rolling out the idea

- In England, some politicians were driven by ideology and a long term belief in the values behind social enterprise. Within political parties there was tension over the idea of social enterprise and the market; sometimes the difference between for profit and not for profit companies was not recognised as important

Generally, committees were viewed as ineffective in England, although when challenged by the researcher, policy influencers recognised that they did not use the committees to put forward alternative policy proposals. Unlike in Tanzania, where policy influencers felt that, in general, the committee process was a useful way of influencing policy.

Over time, there was increasing public unease about what was perceived to be the 'privatisation of the health service' by some clinical groups (Socialist Health Association, 2013). Increasing choice of provider and the role of and quality of care provided by large 'for profit' corporations in the market came under scrutiny. The literature review in Chapter 2 emphasised that civil society ie freedom to associate and freedom of expression is a fundamental building block for the environment within which social enterprises operate. In both countries legislation embeds involvement of civil society in commissioning service decisions through regional Health and Wellbeing Boards and Health Watch Local in England, and consumer participation in regional structures in Tanzania. In both countries there are organisations established to perform this role at a national level but only Health Watch in England is mandated by legislation. (UK Government, 2012a). Sikkika<sup>20</sup> and Twaweza<sup>21</sup> in Tanzania perform an informal oversight role, each contributing in different ways to facilitating consumer engagement. Neither claims to represent health consumers at a national level. However, what this questions is the relative power of Health and

---

<sup>20</sup> Sikkika is a health advocacy NGO focused on health governance and financing, human resources for health, medicines and supplies. It is expanding its role in rural areas to complement urban and semi urban focus in Kibaha and Dar es Salaam. SIKIKA. 2016. *Sikkika* [Online]. Available: <http://sikkika.or.tz> [Accessed 29/1/16].

<sup>21</sup> Twaweza undertake public and policy engagement by partnering with media and global leadership initiatives TWaweza. 2016. *About Twaweza* [Online]. Available: <http://www.twaweza.org> [Accessed 29/1/16].

Wellbeing Boards and HealthWatch in England to influence the ideology of the time. Despite legislative structures and policy processes which invite the contribution of English citizens in policy formation, the institutional entrepreneurs influencing the development of social enterprise policies in England were not citizens working through these established engagement mechanisms but those with an interest in extending the market for their own communities of interest.

What was evident from all the interviews held with policy makers was that at no time were the development of strategies which built on the idea of social enterprise to reduce health inequality viewed as a policy priority. Eventually the idea of social enterprise resulted in a split between those which were predominantly employee owned ('mutuals') and those with a social mission. Chapter 7 will examine this in more detail and how a narrative for change was used by English policy actors which stemmed from the underpinning logic of the idea of social enterprises. The next section of this chapter will bring together this policy context to examine how social enterprises' organisational strategies use structural challenges in the composition of the health field to further their social purpose and meet health priorities.

## **6.5 Using structural overlap as a change strategy**

I demonstrated in Chapter 4 how social enterprise policy implementers interviewed for this study addressed national health policy priorities. This section considers how social enterprises, through their organisational strategies, may help to address some of the structural challenges which were identified as implementation priorities in each country's health policies. It suggests that policy actors may argue that these organisational strategies provide a further reason for introducing social enterprise into a health system. In this way, the third change process found in institutional logic can be illustrated, structural overlap. In England, it is the need for better integration across hospital and community boundaries of care, and between health and social care services. In Tanzania, better integration is required across vertical programmes, such as malaria, HIV/Aids and TB programmes (which are often donor funded) with the basic health care services funded by the state.

Five different types of organisational strategies were used by policy implementers to address these structural challenges:

1. integration of health, social care, prevention of ill health by pooling funding from different sources
2. bringing together multi-sectoral solutions to impact upon the causes of poverty
3. developing commercial partnerships
4. building capacity or infrastructure
5. redistributing profits from other income generating activities

Integration of health, social care, prevention of ill health by pooling funding from different sources enabled leaders to amend perceived flaws in the redistribution mechanism of the state to develop care models which integrate preventive and curative interventions for patients. In Tanzania one organisation had developed a strategy to build the capacity of the state managed health providers to improve the appropriateness of referrers to their service. In England, an organisation had developed partnerships with domiciliary care providers to develop skills for these low paid, transient staff providing care in people's homes. Both organisations strategies focused on a core group of clinical staff and staff trained in health improvement (prevention), within a network of care providers who were linked to the success of their organisational strategy. Freedom from bureaucratic control of the state allowed their organisations to develop strategies which gave them flexibility in the way in which they developed partnerships with others and built the capacity and skills of their workforce.

Those taking a multi-sectoral approach to reduce poverty by addressing the causes of poverty viewed health care as one of many potential funders. They pooled funding to create care models tailored to the holistic needs of individual users. In England, policy implementers leading these organisations emphasised how important other sources of funding were to promote employment or improve housing. In Tanzania, organisational strategies which address the causes of poverty such as access to financial services, improving financial literacy, education and empowerment of women were implemented. These organisations strategies aimed to overcome perceived barriers to state

redistribution of resources by pooling state and other funding (eg donor or grant funding) from different sources. Organisational strategies were set over the long term (more than 10 years) and care models redesigned in the short term in response to funding and need. Capacity and capability of staff and partnerships are built over the long term to support organisational strategies, often with partners outside of the immediate health context (eg schools).

One of the policy implementers interviewed from England described commercial partnerships they had developed with 'for profit' organisations to leverage management expertise, achieve efficiencies of scale or access infrastructure that they did not have. One of the main sources of tension she described was the conflicting value set between the actors. The 'for profit' company's values expressed through its focus on shareholder return, and its status in the market as a large multinational corporation conflicted with the culture of the social enterprise. In contrast, in Tanzania, one of those interviewed had used commercial partnerships with distributors, wholesalers and retailers as an organisational strategy to increase uptake of health products developing expertise within the organisation to integrate this strategy with their social mission. The different logic of these commercial partners were integrated into their business model by allowing them to build their status in the market (ie grow their business by selling health products).

Infrastructure/capacity building was found in one policy implementer in England and three policy implementers in Tanzania. In both countries the organisational strategy aimed to build the capacity of the health system by training health workers or, in the case of the English example, to create a new clinical role for the treatment of muskulo-skeletal problems. In the examples in Tanzania, both delivered specialist care and were training clinical staff in state managed hospitals to improve the quality of care provided. In this way they were overlapping the hospital/community and state/not for profit structural barriers found in the health system to effect change.

Redistributing profits from commercial health care services and other income generating activities to deliver health care services is the final example of organisations strategy used to overcome structural challenges. There were no examples amongst the policy implementers interviewed for this research of

redistribution of profits in England. However, although not evident in this research, they do exist in some parts of health care delivery, for example, end of life care. In Tanzania organisational strategies which redistribute profits from those able to pay to those who are the beneficiaries of the social mission of the organisation were found. An example from this research included strategies to provide primary health care services for middle class Tanzanians, the profits from which are used to fund maternal and child health programmes in rural or urban deprived populations. This NGO in Tanzania was able to use its position in the market as a provider of a vertical health care programme (maternal child health) to introduce a new service, primary care, which delivers general community based care (a 'horizontal' service) to a different population. The state rules for redistribution of resources are important context in this strategy. Business models which rely on co-payments for NHS funded care are illegal for most services in England, but allowed in Tanzania.

Using the change process, structural overlap, to interpret these results demonstrates how the design of a health system offers possibilities and closes off opportunities for organisational strategies and business models to be designed to meet health priorities. Social entrepreneurs blend roles, functions or organisational structures to implement change. They may specifically address challenges at the field level, or to develop their own internal organisational culture or capacity.

## **6.6 Summary and conclusions**

In England and Tanzania health system priorities and the resource base are significantly different. However, both countries' policy makers believe that privately managed health organisations have a role in achieving national health priorities. In both countries, one of the roles of the state is to design and manage a market in health care services. This market allows privately managed organisations to contract with the state to deliver some state funded services. Tanzania differs from England in that a distinction is made in legislation between private for profit and private not for profit organisations.

All three processes of change described in institutional logic meta-theory can be found in this research. These were event sequencing, the actions of

institutional entrepreneurs and structural overlap. The private sector was viewed as enhancing health system performance by interviewees from both countries. The results from this research show how the three change processes are interdependent, and used by social entrepreneurs in their organisations and when advocating for changes to state funded health care systems.

The historical socio-political context of health system reform is important. The results presented here demonstrated that control of the market for state funded health services has evolved over time. In England the percentage of services provided by private organisations is lower than in Tanzania, despite the English government specifically encouraging NHS staff to form social enterprises between 2006 and 2010 and increasingly offering management of health care services to the market. By locating the development of policies on private sector development in both countries in their historical context, event sequencing demonstrated how private sector organisations emerged in both countries despite different socio-political contexts of health system reform.

In England, institutional entrepreneurs worked together as a community of interest to influence the development of the market in health care services. These institutional entrepreneurs, demonstrating the second change process in institutional logic, were motivated differently, some from ideological beliefs, others by ego centred political self interest, or, as in the case of charities, to secure the survival of their organisations.

The organisational strategies adopted by social enterprise leaders interviewed for this research provided useful examples of how they aimed to overcome perceived structural problems in the health system to achieve their social mission. This section illustrated how the third change process, structural overlap was contingent on the socio-political context of health system reforms and the advocacy of institutional entrepreneurs. Whilst these organisational strategies are clearly linked to achieving their social mission, the system context enabled or limited their business or care models.

The results presented here demonstrate that all three types of change described in institution logic meta-theory can be found in health system reform. The logic of the market introduced over time in England demonstrated many of

the state logic categories. It may be inferred that this reflects how the state retains its authority over market rules, particularly in defining the legitimacy of the market in terms of quality of care, health outcomes and health impact rather than share prices, as described by Thornton et al (2012). In Chapter 8 I will return to this topic to discuss the breadth of change required in the health system context to support the introduction of social enterprise.

In the next Chapter, I examine in more depth how institutional entrepreneurs advocate for the introduction of social enterprise.



## **Chapter 7 Institutional entrepreneurs advocacy strategies to introduce social enterprise**

### **7.1 Introduction**

In Chapter 5 the analysis of the meaning of social enterprise demonstrated that these organisations have a distinct logic articulated through the purpose of their organisation, the social mission and a culture of social entrepreneurship. The analysis in Chapter 6 demonstrated how private providers, including social enterprises were introduced into both health systems. Event sequencing, institutional entrepreneurs and structural overlap change processes were all evidenced in this research. This chapter explores the dynamic between the health system and social entrepreneurs. Social entrepreneurs may act as institutional entrepreneurs, lobbying and negotiating for change in health system design to create a more favourable environment for the successful deployment of social enterprise strategies.

In England and Tanzania many individuals advocate for organisations with a 'not for personal profit' to have a role in delivery of state funded health services. Table 7.1 below summarises the six strategies for change adopted by interviewees, advocating for social enterprise.<sup>22</sup> Four policy influencers from Tanzania were included in the analysis for this table because they were either advocating for social enterprises to be recognised by policy makers or were actively advocating for a change in the health system to allow privately run organisations (including social enterprises) to be given greater opportunities to deliver health services.

---

<sup>22</sup> In Tanzania policy makers were excluded as neither social enterprise nor entrepreneurship was included in health policy.

Table 7.1 Change Strategies adopted by social entrepreneurs

Type of change strategy	England			Tanzania	
	Ply. Mak	Ply. Imp	Ply. Infl	Ply. Imp	Ply. Infl
How social entrepreneurs influence the social enterprise agenda	5	5	4	6	4
Implementation of ideas on social value	4	4	3	5	3
Organisations affiliated with different organisational fields	6	5	3	1	1
Translating wants of customer into advocacy for system change	3	5	2	3	4
Changing the relationship between employee and organisation / health system	3	3	4	1	1
Use of evidence	4	0	1	3	3

Of the policy implementers interviewed in England, 5 change strategies were adopted. One interviewee adopted all 5 change strategies, 3 adopted four of the strategies, and one adopted two of the strategies. In Tanzania, the most common strategies adopted by policy implementers were influencing the policy agenda and translating ideas of social value into meaning. Use of evidence and translating customer wants into advocacy for system change were also used by three policy implementers.

Of the policy influencers, the same strategies were used across both countries. The influencers in England used strategies which brought in ideas from other organisational fields particularly those focused on the way employees are engaged by the organisation and the organisational culture.

Each of these strategies is analysed separately below.

## **7.2 How social entrepreneurs influence the social enterprise agenda**

Those interviewed identified seven ways in which they influenced the social enterprise agenda. These were:

1. Engaging in formal committee structures
2. Change by example
3. Lobbyists advocating for an organisational form
4. Advocacy by politicians
5. Influencing the influencers
6. Stakeholder management
7. Sharing knowledge

Each of these will be described below.

### **7.2.1 Engaging in formal committee structures**

In England, five of the social enterprise leaders interviewed and all the policy influencers demonstrated involvement at health policy level, participating on committees both to advocate for social enterprise to be placed on the policy agenda and to set up and manage the implementation of social enterprises under right to request or pathfinder policies. One of the policy implementers interviewed withdrew from engagement at a national level in 2006 because he felt that policy making was too fluid and policy makers too 'fickle' demonstrating a lack of urgency on the big strategic issues facing nationally funded health services. Two of the policy implementers interviewed had been involved in engaging with policy makers through formal committee structures since the early 1990s. They viewed the emergence of social enterprise in health policy as a significant step in a strand of advocacy which could be traced back to the 1970s. Both emphasised that social enterprise is a new term that was only recognised from circa 2003, but that the idea of organisations which trade for a social purpose is not new.

In England and Tanzania policy makers structure engagement with policy influencers through committees. Membership is by invitation either because individuals are known to policy makers or because they represent a group of stakeholders (eg unions, representation bodies such as the NHS

Confederation). In Tanzania engagement with the private sector is structured through various technical working groups, all of which have stakeholder representation, and a Public Private Partnership cross government structure. A small team at the Ministry of Health and Social Welfare manage engagement and national health policy development concerning private sector partners.

All policy implementers were involved at either national or regional and community levels. This finding illustrated the multi-layered nature of engagement. Social entrepreneurs may aim to influence the environment to develop their businesses across different geographical configurations at the same time, working nationally and/or regionally.

How effective these national and local structures are at embracing new ideas and translating these into policies is a different research question. Contrasting views were expressed by policy influencers in England and Tanzania. In England three policy influencers questioned the effectiveness of these national committees in enabling policy change. In Tanzania all but one of the policy influencers felt engaged at a national level. Those that were positive about their ability to influence national policies were able to give examples of policy change as a result of their lobbying efforts which included changing tax treatment of private health care providers, obtaining recognition for social enterprise as a new type of not for profit organisation (outside the health system), changing the regulations on hazardous substances to allow home based treatment of mosquito nets, changing the branding of free state condoms to change the behaviour of the target population, and introducing social accountability monitoring.

The policy making process in both Tanzania and England encourages relationships at different levels of the health system through their committee structures but not all organisations feel that they are representative structures with processes which allow them to influence national policy processes. The perceived effectiveness of these committees differed between countries with policy implementers and influencers in Tanzania reporting that they were able to influence policy more than those in England.

### **7.2.2 Change by example**

All policy implementers interviewed emphasised the role of clinical teams within their organisation to develop new ways of working. The CEO was perceived to be responsible for being responsive to new ideas to allow innovation to occur within the social enterprise.

Specific examples from England included one policy implementer's reference to AGUBA, (Association of GPs in Urban Deprived Areas). Active in the 1990s, AGUBA tried various forms of organisation in primary care, demonstrating how to address social value as part of day to day clinical practice. In addition, Dr Sam Etherington, founder of the Bromley by Bow social enterprise in primary care was mentioned by three policy makers and one policy implementer as being influential in advocating for social enterprise. Bromley by Bow was cited by politicians in policy documents as an example of a successful social enterprise, demonstrating new care models which address the social determinants of health in vulnerable populations.

One policy implementer in Tanzania used his training as a clinician to influence policies in clinical care. He viewed this as an important leadership role that he performed in his position as a CEO, contributing to shaping health policy in non communicable diseases, linking patient groups, and drawing on the resources of international organisations such as WHO. Another policy implementer demonstrated, how, through their use of a national network of Community Ambassadors, they integrate enhanced community awareness of the opportunity for the social enterprise to provide specialist treatment with a supporting referral system.

### **7.2.3 Lobbyists advocating for an organisational form**

Academics in England were also influencing the agenda. For example, one policy maker described how Julian LeGrand at the LSE was advocating a professionally (clinically) led, employee cooperative as a form of social enterprise within a managed health market.

Mutuo (<http://www.mutuo.co.uk>), founded in 2001, was and remains influential. Its founder, Peter Hunt, actively lobbies policy makers to further the cause of mutuals and cooperatives. In 2010 they published a paper showcasing four

social enterprises delivering community health services, which, they claimed demonstrated the benefits of mutual forms of organisation. (Mills and Brophy, 2011) In so doing, they blur the distinction between ownership and the social purpose of the organisation, reflecting the period in time when the terms social enterprise and mutual were used interchangeably.

#### **7.2.4 Advocacy by Politicians**

In England, the emergence of social enterprise in policy was championed by some politicians from all parties. The All Party Social Enterprise Forum<sup>23</sup> although viewed as not influential by two policy makers, met to discuss social enterprise. In 2013 the All Parliamentary Group for Mutuals was established, illustrate the emerging separation of social enterprise and mutual forms of organisation. Fourteen politicians were mentioned by interviewees as being influential in the emergence of social enterprise, from all three main parties and across both Houses of Commons and Lords. These are listed in Annex C.

Policy makers interviewed who were responsible for implementing the right to request policies between 2008 and 2010 were inspired by the way in which social enterprises had translated their social mission into addressing inequalities. Analysis of Patricia Hewitts policy paper on social enterprise in primary and community care (2006) illustrates how politicians shaped the agenda. Choice of publication was noteworthy in itself. Breaking with the way in which policy papers are normally published, which is through the Department of Health, this paper was published by the Social Enterprise Coalition, with a forward written by Baroness Glynis Thornton, SEC Chair in support of the policy. Box 7.1 provides an analysis of the policy paper, drawing out the guiding principles of social enterprise, why and how they should operate in the health system in England. These theories are framed to allow health service employees and other stakeholders to identify with the theories proposed. Not only are social enterprises presented as something not new but also as exciting opportunities for professionals to implement new ideas for better care. State

---

<sup>23</sup> APPGs are informal cross-party groups, with no official status within Parliament. They are run by and for Members of the Commons and Lords.

managed organisations (NHS) were viewed as out of date, backward looking. The case studies give meaning to clinicians and managers, creating legitimacy.

Organisational culture and social mission is emphasised in this key paper. It gives permission for social enterprise implementers and policy makers in England to make change. The community emphasis that local people and/or staff and/or patients can be empowered through a culture of responsiveness will lead, it is suggested, to better services delivered by happier staff. These perspectives were also reflected in interviews with 4 right to request leaders and 3 policy makers who were in post during this time.

The market logic presented in the paper mentions competition but suggests that social enterprises will thrive. This optimistic view of the way the market will operate is presented with no analysis of alternatives or the challenges social enterprises might face in the future.

The role of the state is in theory reduced as social enterprises will be independent of state control, but it is also changed through application of market principles, which are state managed. State responsibility to ensure that social enterprises will not be disadvantaged in the market is not discussed.

*Box 7.1 Social Enterprise in Primary and Community Care.*

**Patricia Hewitt, 2006**

The theory proposes that social enterprises can make a significant contribution to health sector reform, particularly in primary and community care because of its 'capacity to engage and empower patients, staff and other stakeholders in new models of delivery'. Patients, staff and others will be engaged and empowered resulting in new and better care through innovation and flexibility, addressing the determinants of health, wealth and employment. She suggests that staff in the NHS have untapped potential which can be unleashed to deliver better services for patients. The 'old nationalised industry model of health care provision' needs to change. Hewitt argues that 'greater plurality of provision will ensure the best value for patients and users'. Hewitt reminds the reader that the big challenges faced by health care systems: increasing patient expectations, ageing populations and new health technologies and drugs, can be helped by the third sector and social enterprises whilst also 'safeguard the founding values of the NHS for another generation'.

This theory is framed within the context of a vision for the future health system where 'social enterprises are delivering transformational change and new solutions' within a market. 'We want to promote a level playing field so that third sector organisations including social enterprises, can compete fairly with other providers'. Emphasis is placed on the diversity of providers in community and primary care: the reader is reminded that GPs, dentists, pharmacists, opticians are independent, profit making businesses; that a range of for profit, social enterprises and NHS managed organisations provide out of hours care. Charitable trusts and third sector organisations run 75% of hospices. Household names such as MIND, Shelter and the NSPCC are specifically mentioned. Commissioners are viewed as a barrier to implementation. They need to change their mindset, and they lack understanding of the third sector and their potential. To address this commissioning will be strengthened and third sector organisations need to improve their ability to communicate their unique selling points and demonstrate delivery of the highest quality care. Hewitt wants 'third sector providers becoming mainstream partners in local health communities'.

Benefits of the third sector include its independence from government and private shareholders, its commitment to a wider social good, passion and commitment from staff and capacity for innovation and rapid change. In particular, emphasis is placed on the way in which they allow a stronger voice for users of services and staff.

Building on this idea of community. 'We need to give local communities a stronger voice in how local health and social services are developed.' Hewitt goes on to draw on the learning from the implementation of Foundation Trusts 'the benefits of local membership and accountability, strong governance and greater autonomy need not be restricted to acute and mental health services'.. Continuing with this energising theme, a Social Enterprise Unit, set up in the Department of Health will 'act as a catalyst for change, providing a 'hub' of ideas, energy and support for existing and emerging social enterprises'.



### 7.2.5 Influencing the Influencers

Policy makers in England actively engaged with unions and professional groups in an attempt to secure support for the implementation of right to request social enterprise policy. Professional groups, such as the nursing unions and associations and the British Medical Association (BMA) demonstrated varying degrees of interest. According to one interviewee the BMA were neutral, the Royal College of Nursing (RCN) were opposed to the idea, then changed their views to become supportive, Queens Nursing were supportive, Unison, Unite and GMB viewed right to request as privatisation, a threat to jobs and unionisation and thus were actively hostile to the idea.

Box 7.2 below analyses the content of one union's briefing on social enterprises, Unite.

*Box 7.2 Health B4 Profit Unite the Union. An example of stakeholder resistance*

The paper specifically challenges the government's right to request programme, which allows staff managed by NHS organisations to form their own social enterprise. The authors argue against the proposed market in NHS services, rather than the idea of social enterprises. They suggest that the market will lead to fragmentation of the NHS by creating multiple organisations which will damage the quality of patient care by making sharing of patient information difficult and therefore delivery of holistic care. They argue that long term public health needs will not be met by short term contracts. They question the ability of these new social enterprises to compete effectively for services with large and more experienced multi national firms. They also theorise that staff will be disadvantaged, arguing that better staff involvement can be achieved without creating social enterprises. Furthermore they rightly draw attention to a key concern of staff that access to the NHS Pension scheme will not be open to new employees of social enterprises. They frame their theories with references to the cost of the right to request scheme, citing the Social Enterprise Investment Fund as an example of poor use of public funds which could have been used for patient care. They appeal to staff reminding them that the decision to form a social enterprise can be challenged by staff themselves, referencing the result of a ballot in Luton where, as a result of their successful campaign, 97% opposed the transfer. Tensions between management and staff are mentioned, appealing to their representation role as a union, whose members are largely composed of administrative, rather than clinical or management staff. Finally, Unite envisions a reformed NHS, which is 'public owned and public accountable' which involves staff, allowing them to participate in decision making about services. The argument is that privatisation is not needed. 'A well resourced NHS, where investment is used wisely and staff are motivated'. Their refrain 'Together we can keep our NHS whole' is used to campaign to stop 'social enterprises'. (Health B4 Profit, Unite the Union. Unite Briefing on Social Enterprises, 2009)

Unison were also concerned about the undermining of unions, and increasingly a lack of accountability by the government for publicly run services (Marks and Hunter, 2007) The union commissioned academics at Durham University to examine the idea of social enterprise which reflected many of the concerns articulated in the Unite paper.(Marks and Hunter, 2007) However, as the implementation of the right to request programme progressed, some of the concerns rightly expressed by unions were addressed. For example, rules governing access to the NHS pensions were changed in 2014 after much lobbying by politicians, civil servants, unions and social enterprise leaders themselves to allow staff in independent organisations holding certain types of NHS contract to be eligible for NHS Pension Scheme. (Unison, 2010, NHS Business Services Authority, 2015) The use of ballots was discouraged by civil servants responsible for the right to request programme, following a number of unfavourable outcomes where staff voted against the proposed social enterprise, but there were exceptions. When I was CEO of an emerging social enterprise delivering dental services, a ballot received over 70% support from staff for the formation of a social enterprise in 2011. From my experience, Unite's use of local union representatives, who weren't trained in understanding the complexities of forming social enterprises resulted in inaccuracies and misinformation being provided to staff. Two policy makers interviewed described one meeting where social enterprise leaders were invited by civil servants to a meeting with union leaders to advocate for social enterprise, but the union leaders turned their backs on them in the meeting and refused to engage.

One strategy policy makers adopted to change the minds of the detractors was to invite social enterprise leaders to demonstrate how social enterprises improved the quality of health care and productivity. One policy influencer representing a professional group, emphasised how messages about social enterprise needed to be tailored to the audience's experience of clinical care, focusing on the way in which the social enterprise could help them to deliver better clinical care.

The Social Enterprise Coalition was very influential throughout the period of this study. They issued a social enterprise manifesto in 2010 to advocate for social

enterprise to be included in all parties election manifestos. (Social Enterprise Coalition, 2010)

Managing those influencing opinion within the NHS was only one aspect of broader stakeholder management. There was no similar process identified in Tanzania. This was almost certainly because health policy makers in Tanzania had not embarked upon a similar contentious policy like the Right to Request programme in England. However, insight into stakeholder management required to implement social enterprise in health care delivery systems in England is provided in the next section.

### **7.2.6 Stakeholder management**

Within the Department of Health in England there were also tensions between the Public Health policy makers and the Social Enterprise Unit. The former didn't recognise the value that social enterprises might make in addressing key public health priorities on health inequalities through their social mission. One policy maker viewed this as a missed opportunity. There were examples, however, of public health engaging at regional levels. Four social enterprise leaders emphasised how their local public health teams had been supportive of their strategies. One of these had also secured the public health function within their operations. A policy implementer contrasted the approaches taken by their regional Public Health functions with national policy makers:

Our public health commissioners are the one group ..[who]. are really supportive. They are in a difficult position because their Local Authority asked them to save money... Schools put forward money and asked public health to match fund, if they combine the curricula they get added benefits. They love all that. They are doing their best in a crazy environment. They believe in it. *Policy implementer, England*

I had a conversation with a national public health person. I was sharing some successes but they were not interested because it wasn't in the NHS. *Policy Implementer, England*

Table 7.2 describes my personal experience setting up Willow Bank Partnership in 2007, Community Dental Services in 2010 and Quay Health Solutions in 2015.

Comparison of my experiences setting up these three organisations illustrates how important time and context were when managing the relationships with these stakeholders. Comparing my experience at Willow Bank with that in Community Dental Services, by 2010, there was a small but rapidly growing number of individuals and companies with expertise in supporting NHS staff to form social enterprises. They were actively engaged by policy makers to draw learning into implementation plans at a national level, to shape policy priorities. By 2015 some of the big structural challenges identified by policy makers had been addressed, and there were a number of organisations providing specialist support. Nevertheless, the GPs in QHS still demonstrated different challenges which were associated with the culture of General Practice and their expectations, skills and experience, the new way of working across geographically defined units with member GP practices delivering services as independent organisations within the boundary of the social enterprise.

Table 7.2 Comparison of personal experiences setting up Social Enterprises

<b>Willow Bank Partnership CIC (General Practice)</b>	<b>Community Dental Services CIC</b>	<b>Quay Health Solutions CIC (GP Federation)</b>
<p>Role: Founding Director 2007 to 2015</p> <p>Willow Bank received grant funding from the Department of Health to establish a social enterprise under the Pathfinder scheme. Investment was used to buy in expertise and provide backfill to staff to design the new organisation and manage the transition. Staff would have preferred to stay as a managed unit within the NHS, but all directly managed GP practices were being put out to the market. The prospect of being managed by a for profit provider such as Virgin Health, acted as a strong incentive for staff to seek alternative ways of retaining their organisational purpose which was to address vulnerable people from a broad SDH perspective. A key issue at this time was that no one had expertise of supporting NHS teams to leave the NHS. Lawyers had no experience of the different implications of different legal forms and contract on access to NHS pension, the implication of taxation on company profits was unclear. Financial modelling</p>	<p>Role: Interim CEO and consultant 2010</p> <p>This very specialised service, had strong staff commitment and leadership from the senior management team to set up a social enterprise. The clinical team had a track record of successfully attracting additional investment from the DH for development of innovative clinical models. Social enterprise was seen as an opportunity to build on an existing value set, freeing themselves of what was perceived to be the constraining limitations of NHS bureaucracy. There were tensions between the NHS commissioners and the team, which were, in part, overcome by strong advocacy of the Chair and Managing Director of the Community Provider Unit which managed the service and the management of the interface with commissioners by myself. Staff believed that they could grow the service to vulnerable people eligible for NHS funded care (eg mental health, HIV/AIDS, vulnerable children) and build on their successful dental public health</p>	<p>Role: Interim CEO 2015</p> <p>QHS CIC had unanimous support from all GP practices in the geographical area with a strong vision of how it would facilitate improvements to care through the social enterprise. Many of the challenges experienced by other social enterprises earlier, such as access to NHS Pensions had been resolved and there was ready expertise available from legal firms and other professional services organisations such as accountants on the rules governing social enterprises, the structural and cultural shift required to establish an effective Board and organisations and the implications of different types of contract (eg VAT, corporation tax). In common with other social enterprises, a viable financial model underpinning the business model required a number of assumptions to be made about the development of the market and how QHS could secure a market niche. Support from commissioners was critical. This support took the form of</p>

<p><b>Willow Bank Partnership CIC (General Practice)</b></p> <p>required an assessment of the way in which the health market might develop. Financial viability of the organisation relied upon the explicit and tacit support of commissioners to support rapid business growth. Within this team there was no experience of business planning, Board governance or senior management. Expertise had to be grown in house or brought in. Board structure was a balance between staff ownership and a strong ideology about addressing the SDH, to improve life chances of Stoke-on-Trent residents. Strong support was provided by the SEU at the DH, learning was fed into the later and larger right to request initiative, allowing the right to request policy programme be shaped so that larger teams could set up SE effectively, including ongoing negotiation with Treasury around some of the big issues eg access to pensions for new employees and tax treatment. At Willow Bank, the unions were unprepared. The BMA didn't engage. Unison were unclear about how to approach change when staff were leading the change, demonstrating very little understanding</p>	<p><b>Community Dental Services CIC</b></p> <p>programmes. Subsequent market research at the business planning stage demonstrated a gap in the market with older people in residential care and nursing homes receiving limited dental care. Commissioners gave mixed messages to the team, at one point requiring the team to reduce the size of the service by 40% and make significant financial savings. At one point, consultation had been started with staff to reduce the staff establishment significantly. This uncertain environment, together with strong leadership from the clinical team, who were able to articulate a vision for the future, was instrumental in achieving the 70% staff support obtained in the ballot with staff. The level of support provided by the DH Social Enterprise Unit was more structured with a clearer understanding of the challenges to be overcome. Expertise on how to move teams out of the NHS into social enterprises was readily available. Unions were more experienced. Some, like Unison and Unit published fact sheets to guide staff decision making (Unison, 2010) The BDA did not oppose the change, satisfying</p>	<p><b>Quay Health Solutions CIC (GP Federation)</b></p> <p>scrutiny of the business plan (in common with Community Dental Services and Willow Bank commissioners) and review by commissioner's committees. In common with Willow Bank, GP practices lacked experience at Board level, and had limited experience of working at senior management level. Development support to address the skills and capacity gap was built into the change management plan to enable directors elected by GP practices to 'step up' to the new context. QHS was a new type of social enterprise operating both as a social enterprise and membership organisation (mutual). GPs themselves clearly understood the difference but they lacked experience working within such a corporate structure. The cultural, capacity and competency challenges are significant for different stakeholders including GP practice teams, external advisers, health care partners (eg NHS Trusts) and local commissioners of health care services.</p>
--	--	--

<p><b>Willow Bank Partnership CIC (General Practice)</b></p> <p>of what SE were.</p>	<p><b>Community Dental Services CIC</b></p> <p>themselves that staff had been consulted. However, UNITE were difficult, disseminating inaccurate information to staff which needed to be challenged during the staff consultation sessions.</p>	<p><b>Quay Health Solutions CIC (GP Federation)</b></p>
--	---	---

### **7.2.7 Sharing knowledge. International influence**

The previous sections of this chapter demonstrate how continuous learning was built into the pathfinder and right to request policy processes at all levels of the health system. This sharing of knowledge was found between policy implementers and policy makers, between consultants/specialist advisers and teams wishing to set up social enterprises, and between new social enterprise teams and their stakeholders including union representatives, health service partners and commissioners. Lobby groups such as Mutuo and academics tried to influence learning. Also of interest in this research is the international influence exerted by donors and international NGOs in Tanzania.

Although in England, learning was not restricted to the UK, one policy implementer mentioned how Mondragon (a Spanish cooperative: <http://www.mondragon-corporation.com/eng/>), and India's social enterprises had influenced his thinking. In Tanzania, the influence of international actors was much more evident. There were five main areas of influence: funding, providing support to committees, grants for health service delivery, ideas on social entrepreneurship and the design of business models. For example, Danida, in their policy documents, describe their aid philosophy in supporting the development of the private sector:

By growing the role of the private sector:

Denmark will therefore give targeted support to the cooperation between public and private partners with the intention of stimulating and strengthening support to the private sector's active involvement in promoting access, availability and quality in the health services.

By strengthening capability and capacity of the PPP at regional levels:

Besides supporting public-private partnerships in the urban areas, Denmark will support the establishment of public-private partnership forums at the regional level (25 regions in total). It will strengthen the cooperation between the public and private sectors in seeking to ensure increased access and choice for the users of health and social services. (Ministry of Foreign Affairs of Denmark, 2014)

These international influencers were evident in Tanzania through an interview with one policy influencer:



When I was working, actually in Denmark we had our own definition of SE, it is cross cutting so we were defining it as a way to intervene different social issues, tracing social issues using entrepreneurial principles so that at the end of the day you have a way of solving problems and relying on making sure there is a social impact of our intervention or solution. *Policy influencer, Tanzania*

Three country offices of international NGOs, interviewed for this research demonstrated diffusion of ideas on social entrepreneurship and business models into their country operations. One was actively in transition to a social enterprise. They were developing their organisational strategies and options for new business models which were more responsive to the evolution of a market and were less reliant on grant funding.

Of these change strategies, one way in which the idea of social value used by social entrepreneurs to argue for change in the health system is analysed in the next section. It is a consistent theme used by social entrepreneurs in both countries and at all levels in the health system.

### **7.3 Implementation of ideas on social value**

Social value narratives were found in both countries to effect change. This section describes how social value and social impact were not embedded in health system change processes in England. In Tanzania social impact was more readily evidenced and formed an important part of organisational strategies to demonstrate effectiveness.

Of those interviewed in England, four policy makers (who were responsible for implementing the right to request initiative) and four policy implementers used ideas of social value to advocate for change. They interpreted social value in one or more of the following ways:

- As a way of addressing the complex needs of vulnerable people ie by bringing into the service model other organisational fields eg housing, education, employment, often by creating partnerships with other organisations (eg schools, housing associations)
- redesigning the service model so that patients/clients change their health behaviours to reduce their risk of ill health and/or manage existing health

conditions (often by giving the patient and their family more control over the management of their health)

- Influencing the financial institutional and organisational fields to enable social value to be recognised as a legitimate currency for external investors and to create opportunities for social enterprises to attract investment
- Influencing government legislation to recognise social value in public sector procurement.

In Tanzania one policy influencer described how they had been able to influence policy makers to include social accountability in the health strategic plan. Five policy implementers in Tanzania demonstrated how they measured social value and used it to demonstrate the effectiveness of their services. They argued that demonstrating social value enabled them to grow their business. Measuring social value was highly structured:

It is something that we would like to do. For example, when we deliver family planning services we measure impact: we look at the outcome and the level of protection given to women so we can tell clearly what impact we have made. We can calculate out of the service we provided, how many maternal deaths we have avoided, how many pregnancies we have avoided, how many unsafe abortions we have stopped, how many child deaths we have stopped and how much money we have saved the health system. Our impact evaluation is peer reviewed. *Policy implementer, Tanzania*

This next example demonstrates how measuring social value was built into the narrative of a service redesign project. Social value emerged as the project progressed:

In our project on maternal/newborn capacity building, the way we are doing things is by learning by doing. There is definitely a social value which we couldn't have anticipated including coaching and mentoring, the whole aspect of being there, being with that person and losing a child; coaching and mentoring them that they haven't done a bad job, it's the circumstances around you. Our [clinical lead] doesn't say it's a problem with individual health care workers. She talks about the problems with the system, which has so many holes. Don't blame individuals. We have changed how interventions for maternal newborn services are done. People say wow you have achieved a lot. But it wasn't intended, to change how the game is played, we've learnt and we've changed. [The clinical lead] is honest that she didn't plan it from the beginning, she's changed her game plan as she's gone along. *Policy implementer Tanzania*

One aspect of social value was the spread of ideas to other organisations. For example, in the same organisation as above, the spread of their ambassador programme model to another part of the health sector was viewed as a success, even though they did not receive any monetary reward.

We are among the NGOs who use mobile technology. I know an NGO addressing cervical cancer, who are going to use our ambassadors to help pay for the transport of women to a treatment centre. Just by piloting it & seeing how it goes, it has trickled out to other parts of the health system. People are seeing how it can be used in different ways in health care. It's not strategic that we set out to do it. We find we do it and stumble into things, which people recognise, for example, we can really harness it. *Policy implementer, Tanzania*

Social value narratives were used by the Department of Health in England to influence health service procurement by emphasising the 'value add' of social enterprises over the long term. (Social Enterprise Unit, 2010) However independent research conducted by Millar and Hall, (2013) indicated that the idea of social return on investment was undervalued and under used due to practical and ideological barriers. In England, interviewees for this study (described in section 5.8) drew attention to the tension between the length of contracts offered and the complexity and approach to health system change required to achieve social impact sometimes reflected a dissonance with regional commissioners.

This concern over the competency of regional commissioners to take a more strategic (ie long term) approach to system transformation was also raised by a policy maker.

On changing the commissioning system. I would start it re: social innovation and meeting the demands of the contract. [You need] collaborative working arrangements where both sides would work out what you would get. [We need a] more dynamic approach to commissioning. The evidence suggests that is the way it should go. The Government and the public sector are good at focusing on purchasing the service, then drops right off. It's the wrong way round. You need to be spending time understanding the market, what you're trying to buy, what's out there, what are the best options - invest lots of time there. Purchasing process is straightforward. We invent a lot of it - an entire ecosystem which believes procurement process is about how you go about buying stuff. Its hogwash. You should take your time to understand your market, buy in quick way, and then spend time making sure you get what you want from the contract. We need more dialogue based management of a contract. *Policy maker, England*

The respondent interviewed articulates clearly a difference between using commissioning in a market that is a transaction to maintain the status quo versus using it as a tool for systemic change.

Despite initiatives in England through, for example, the Public Services (Social Value) Act (2012) and regulation to build social value into procurement for public contracts described in Chapter 5, policy implementers struggled with some commissioners to recognise the social impact of their business models and evidencing their social impact. In Tanzania, although more readily evidenced at an organisational level, social value was not explicitly incorporated into national or local PPP structures to support health system change.

#### **7.4 Learning from organisations outside the health system**

In England five policy makers drew attention to the tension between the Department of Health and the Treasury over matters such as tax, pensions and investment to support health system change. Five policy makers also gave examples of where ideas were drawn from outside the health system. For example, in the implementation of the right to request initiative, the three policy makers interviewed, mentioned the influential lobbying of John Lewis and the Social Enterprise Coalition. The former advocated for employee controlled business models. The latter drew on community or grass roots solutions which allowed greater community control of health. In the latter context, NAVCA, ACEVO and voluntary groups such as Big Life Group were all mentioned as advocating for policy change in the 1990s. Their reported objective was to enable a greater share of state (NHS) funded health services to be delivered by voluntary and community groups. One policy implementer who was influential in the 1990s argued that their strategy was not to replace the state managed services, but to offer an alternative for those population groups, often vulnerable people, who could receive a better service (and by implication better outcomes). These providers, who specialised in delivering services to this group argued that they could use their position in the market as experts to deliver care which merged or integrated service models from outside the health system.

Three policy influencers drew on learning from outside the health system to develop their strategies. Other individuals mentioned (from outside the health

sector) included Pauline Green (Cooperative movement), Ed Mayo (Mayo and Moore, 2001), Jonathon Bland (Social Enterprise Coalition) and his successor Peter Holbrook (Social Enterprise UK <http://www.socialenterprise.org.uk>). Peter Hunt (Mutuo <http://www.mutuo.co.uk>) and Cliff Mills (Mills and Brophy, 2011), Steve Bubb (ACEVO <https://www.acevo.org.uk/about-us>). Social Enterprise Ambassadors introduced by Gordon Brown in 2007 included Tim Smith (Eden Project), Anita Roddick (Body Shop) and John Bird (Big Issue). International movements such as Ashoka (<https://www.ashoka.org>) were also influential through their ambassador programme.

One policy maker of the right to request initiative, also noted which lobby groups were not involved in influencing policy at the time. The interviewee specifically mentioned Coops UK, the Blaxi Partnership and Consumers Association as examples of organisations that, on reflection, perhaps should have been engaged.

Similar evidence of learning from outside the health system was not evident in Tanzania. In England, there were three types of influence from actors outside the health system. These were: democratic participation in organisational form or culture, partnerships with organisations outside the health field, and building relationships within a locality to address social determinants of health. Each of these will be analysed below.

#### **7.4.1 Democratic participation in organisational form or culture**

One policy maker who had been involved in this area of policy since the 1980s mentioned how social enterprise policy emerged from traditional labour ideas stemming from the cooperative movement, referring back to various 'failed' attempts at building worker cooperatives (outside of the health field) during Tony Benn's period of power in the 1970s. This historical perspective was viewed as important by all interviewees in England. For example, outsourcing of the leisure industry from local authorities, eg the social enterprise Greenwich Leisure (<http://www.gll.org/b2b>) was referred to by policy makers, policy implementers and policy influencers as a successful example of democratic participation by employees. The different types of cooperatives in England (consumer, supplier, employee or combinations of these), models of empowerment and self help of workers' cooperatives were referred to by all

policy makers. Internationally, reference was made to forms of social enterprise which incorporated the idea of democratic participation into their organisational form or culture. These included Mondragon in Spain, Japanese forms of social enterprise in health and social care, Reitheiser in Germany, Italian consumer/staff social cooperatives, and Community Business in Scotland. Fair Trade was mentioned as an example of social change between suppliers and consumers.

A separate strand of argument stemmed from the advocacy of employee controlled organisations. The significant influence of John Lewis PLC in the run up to the right to request initiative has been described above. One policy implementer emphasised how important employee control was to their idea of social enterprise.

The ownership model is critical. It affects the commitment of our employees engagement in the agenda. For example, there is strong evidence of the difference it makes when compared with other NHS organisations. We do a survey with all our co-owners... year on year. 94% of co-owners said they are enthusiastic about their job compared to 68% in the NHS staff survey this year. These are dramatic differences. How do you work with colleagues: 99% said they have a good working relationship, 79% in NHS. How does your work relate to patient care? Even if staff are not directly involved, co-owners say 100%, NHS 82%. These are powerful things that tell us that employee ownership works. We have an engagement index of 83% as compared to NHS Trusts 32%

*Policy implementer, England*

However, this belief was not ubiquitous. Two social enterprise leaders which externalised their services into social enterprises as part of the right to request initiative argued against employee ownership. The two charities in the sample did not mention employee control at all.

Nevertheless, three policy makers viewed it as an important vehicle for change, one for pragmatic reasons, as it was needed to ensure staff were supportive of the externalisation of their services into independent organisations (social enterprises). Two drew on new research, already mentioned (Lampel et al, 2012), to argue for greater employee control as it improved productivity and the quality of health care provided. The perceived shift in policy emphasis is described below by one social enterprise CEO, frustrated with the change:

This government is more about mutuals or mutuality and they don't necessarily share our values. You don't hear politicians talk about social enterprise any more. It was important then. ... but I'm not sure some of my colleagues who left the NHS running social enterprises are necessarily running social enterprises. They've moved on re: values - following a more commercial or corporate ethic than a social one. They have followed the policy which is about employees having ownership rather than values. There is a set of values about employees having ownership. but [reference to an organisation] have employee ownership but they don't care a monkeys about the communities they live in. We are a community benefit society, not a staff benefit society. *Policy implementer, England*

In Tanzania, a social enterprise leader demonstrated the organisational change required to move from a donor funded model to a social enterprise. However, none of the interviewees for this study viewed employee ownership as an important feature of their social enterprise.

#### **7.4.2 Partnerships with organisations outside of the health field**

Five of the policy implementers specifically mentioned partnerships with organisations outside of the health field as important strategies for their organisations to deliver social value. The reasons behind this varied. In the following example, integrating services across systems enabled more holistic interventions tailored to the needs of the child and their families.

'Systemic change requires us to work with partners. There are some really good organisations we can learn from. [Re: social enterprise taking over management of a school] We were really lucky recruiting a head teacher who was born and brought up in the area whose second language is English. We partnered with a local school. The head teacher helped set the school up. He is on our governing body. Because we have the children's centre, nursery, school, we are developing a 0-11 tracking model so we can track child development all the way through. The important thing is to have the integration. We can look at the whole cohort and inform intervention.' *Policy Implementer, England*

A very different commercial partnership was described by one policy implementer in Tanzania.

Our way of distributing condoms was very expensive from 1992 until 2002/3 because we were responsible for importing from outside the country, repackaging them in the country, distribute it with our own trucks to the agents in the regions, then we take from the agents to the wholesalers, then to the retailers ..... With time we started backing off by linking the number of condoms sold in a year by agent and the profit margin. but we have to trace where these wholesalers commonly go - where you buy your sugar, salt, condoms will be available there after 3

months, we won't be delivering to your outlet any more. Our trucks will not take condoms to the regions any more. *Policy implementer, Tanzania*

In this example, this policy implementer described how they built partnerships with retailers to reach their customers to change health behaviour and changed the relationship over time.

### **7.4.3 Building relationships within a locality to address the social determinants of health**

Three CEOs emphasised the importance of building relationships within a locality to promote social cohesion (and in this way contributing to addressing health inequality). Two of the three organisations in England were referenced by policy makers as influencing their thinking about the contribution social enterprises can make to addressing health priorities at a national level. One was used to advocate for change when challenging stakeholders such as the unions Unite.

One social enterprise aimed to promote employment and quality of care provided by building new partnerships across health and social care with voluntary, private and local authority care providers:

At the localised end we are able to articulate how we use the resources that come to us to deliver the contract, employ local people, normal thing... as we move on, so we're currently engaged in a piece of work where we are thinking in a more system based way - being willing to invest time & energy in thinking differently - try to create an employment type that picks up volunteering, apprenticeship, job coaching, [targeting the] potentially disadvantaged in order to meet need across statutory, private and independent providers for value based recruitment so you can be assured of your workforce... eg stop unsupervised people working in people's homes. How can we work collectively to ensure for the service user there is consistent high quality care?..... Act collectively, by developing something. At the moment it's a collaboration between the Local Authority, private sector and voluntary sector. No NHS organisations, but will be, that is about system change while also addressing need in industry. *Policy implementer, England*

One CEO aimed to build social cohesion within the community by building partnerships with small private sector businesses in the community. Another CEO aimed to improve the material circumstances of his employees and users by actively engaging in regional fora to promote the development of the community and reduce health inequality by creating more affordable housing for service users and staff.



[We are] delivering high quality care to vulnerable people [which] has a high social impact but it's not valued in that way... Our remit is to be more than that... It is about enabling people to do more for themselves, ...We are the 4<sup>th</sup> or 5<sup>th</sup> biggest company in [geographical area] and should be using that to leverage more change. For example, we're looking at whether we become guarantors for housing, so if a young nurse is not going to get on the housing ladder, in the 1st 2 or 3 years we can put a deposit down. Helps attract staff. We have a massive recruitment problem. We would like to do that for customers. We inherited 14 houses where we held tenancies for housing for people with learning disabilities. [We proposed that we] will support people to hold their own tenancies which should be in their names. Feels small and piecemeal. But that is my job to turn the system on its head. ....I'd like us to be buying rubbish houses, using service users to do them up, putting tenants in who need them. High social impact is having an impact on determinants of health. *Policy implementer, England*

A consistent theme running through each of these three types of influence from outside the health system is how social enterprise leaders used partnerships to create social value. Some were formal contractual relationships. Others built on regional partnership structures of trust and collaboration to achieve change. At a national level advocacy of household names gave credibility and publicity to achieving social value through markets and contextualised health system leaders work.

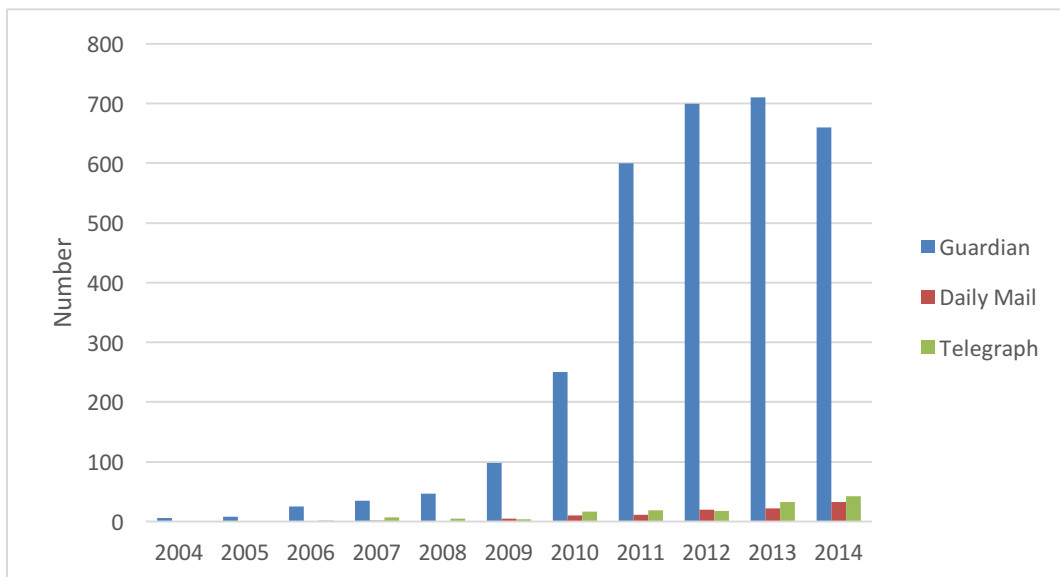
## **7.5 Translating wants of customers into advocacy for system change**

The mobilisation of different actors, acting collectively but often with different agendas for change has been described in the preceding sections of this chapter. One area for change which has not been considered, so far, is the mobilisation of customers (service users or patients). Examples in England and Tanzania differ in their focus. In England publicity surrounding social enterprises in health focused on the rights of citizens as taxpayers to be consulted on proposed introduction of health care organisations independent of direct management by the NHS. In Tanzania, examples related to the advocacy of organisations on behalf of patients to change the health system. Each of these will be considered below.

In England, three policy makers and four policy implementers suggested that they used this strategy to advocate for change. Yet, analysis for this research

found that evidence of this kind of grass roots mobilisation, advocated in the early 2000s by the Social Enterprise Coalition, is limited. In the context of social enterprise, it was the policy makers and the policy implementers who advocated for change on behalf of the customers. Analysis of the use of the term social enterprise, by different newspapers over time, demonstrates that one newspaper, The Guardian, politically on the left and sympathetic to Labour had significantly more coverage than others. Figure 7.1 illustrates this unequal media coverage which meant that Guardian readers, predominantly from the wealthier socio economic groups (81% of the Guardian readers are from socio economic groups ABC1) received more exposure than others. Conservative, politically right leaning papers, the Daily Mail and Daily Telegraph had noticeably less coverage, although also counting a similar proportion of readers from socioeconomic groups ABC1 (67% and 83% respectively). Whilst the Daily Telegraph's combined print and online readership is only slightly lower than the Guardian's (2,059,000 compared to 2,270,000), that of the Daily Mail's is more than twice (2.28 times) that of the Guardian (5,189,000 compared to 2,270,000). (Newsworks, 2016c, Newsworks, 2016a, Newsworks, 2016b)

Figure 7.1 Frequency of the use the term 'Social Enterprise' by newspaper by year



This unevenness in media coverage was not mentioned by any of those interviewed. Yet, one policy maker was frustrated at the lack of accountability of government, suggesting that English citizens, as funders of the NHS, should have more of a say over important policy changes such as the introduction of a

market in health care and the types of organisation allowed to participate in that market (ie for personal for profit organisations might have restricted market access). One lobby group argued that citizens should have a legal right to influence procurement decisions and went further, in advocating that organisations with a social purpose should be prioritised. For example, if service users have grounds to make too many complaints, then the contract for service delivery should be withdrawn.

This broader perspective on the democratic right of British taxpayers to influence the type of organisations commissioned to deliver NHS services was a theme that ran through this research in England, raised by all the policy influencers and three policy makers. Moving beyond the debate on 'privatisation' of the NHS, a survey of 1006 adults conducted in 2013 on behalf of the lobby group 'We Own It' asked the question 'Should organisations that have a "social purpose" (objectives other than profit-making) such as the public sector and the not-for-profit sector, including cooperatives, charities and social enterprises, be prioritised above private companies in the tendering process for public services?' 56.6% answered yes, 22.7% answered no. Of those voting yes, there was an even spread across the regions and age groups. More labour and liberal democrat voters agreed with the statement than conservative or 'other' voters. 79.3% of respondents thought that citizens should be consulted and have their views considered before any service is privatised or outsourced.

One of the arguments for establishing social enterprises is their customer focus. (Hewitt, 2006). In the interviews conducted for this research, one policy implementer suggested that social enterprises offered an opportunity to move away from standardised care models, that they could tailor care to the needs of the individual user. However, there has been no systematic analysis which compares the care models designed by social enterprise organisations with those of state managed or for profit enterprises nor their effectiveness.

Publicity since 2014 of the withdrawal of corporations, such as Serco following an estimated £18m loss on health service contracts would suggest that corporations do need to make a profit at levels which are acceptable to their shareholders. (Illman, 2014) The same argument can be made for social

enterprises who need to make a surplus to reinvest in furthering their social mission.

The democratic role of customers (patients/users) in system change is therefore limited in England. Despite efforts of lobby groups such as 'We Own It' and public comment about the role of for profit and not for profit organisations, citizens had little influence over the type of organisation receiving state funding for health care delivery.

A similar debate was not found in Tanzania. However, three policy implementers and four policy influencers interviewed for this research gave several examples of where they had advocated for change to the health system. These included the following:

- Advocating for public funding for clinical services to treat emerging health conditions, including HIV/AIDS and long term conditions such as diabetes
- Developing new services in relation to customer demand in rural areas
- Providing donor funding to support business development of innovative care practices in the emerging health care market
- Advocating for changes to the health system to allow greater consumer choice in health care services.

This research identified no lobbying by consumer or public representative bodies for a greater influence on the type of organisations delivering state funded health care in Tanzania.

## **7.6 Use of evidence**

In England a change strategy adopted by policy makers which was not found amongst the policy implementers was the use of evidence. Four policy makers in England referred to this mechanism. Up to 2010 the main form of evidence used by all policy implementers and policy makers was the use of qualitative case studies. Building these narratives contributed to a growing body of evidence to demonstrate the effectiveness of social enterprises. Quantitative evidence relating to the performance of individual organisations, including clinical care, staff satisfaction, and productivity also began to emerge.

On closer inspection, however, the nature of this evidence was used to argue for various forms of employee control or engagement rather than organisations with a social mission. This approach to the gathering of evidence reflects the ambiguity in the meaning of social enterprise in England, where employee control of social enterprise forms figured prominently in the right to request initiative and subsequent policies around mutuals. As one policy maker said, staff engagement was critical to the success of the right to request policy. Building on anecdotal and case study narratives various research was undertaken which focused on employee control as a form of cultural shift to improve the quality of care delivered (Chris Ham, 2014) and improve productivity (Lampel et al, 2012) but these formed a body of evidence well after the right to request policy in health had been implemented.

Of note is a move in 2014 by 22 social enterprise leaders of health organisations, who formed their own membership organisation in an attempt to control the type of research undertaken. A driver for this group was a more balanced research agenda based on evidencing the impact of social enterprises in the health system.

In Tanzania, evidencing social impact is an important aspect of social enterprises. It was used to demonstrate the effectiveness of the service provided and as a case to argue for additional funding from either donor or state sources. Donors also used and funded research to gather evidence. One policy influencer described how they had invested in research to understand the market opportunities in health for private sector organisations. Another policy influencer in Tanzania illustrated how a competitive funding model, based on performance, had been very effective in enhancing the quality of care provided by members. Evidence gathering on the social impact of interventions was viewed as critical to demonstrate the effectiveness of their organisation and advocate for change.

## **7.7 Impact of social entrepreneurs advocacy in England**

An analysis of how institutional entrepreneurs advocate for the emerging ideas of social enterprise suggests that rather than change being a carefully managed process, there are continual contradictions between organisations actors

influencing, designing and implementing state policy and managing change within organisations over time. These contradictions were demonstrated in this research in the for profit/not for profit tensions which exist between actors in England and Tanzania, ideas of the relative importance of social value as both an objective and as a meaning for change. Beliefs about the best way to achieve policy goals of productivity and quality of care demonstrate tensions between policy makers and social enterprise leaders.

The policy makers interviewed all emphasised the fluidity of the policy making process. One policy maker in England referred to policy development as a social ecology, subject to Darwinian influences where the survival and demise of ideas and policy influences continually evolves.

In relation to policy development: I take the view that there is no such thing as “the system”. It is a false imaginings that what we've got is perfectly designed, balanced. The idea that there is a grand unified theory of everything was doing the rounds; starting to move away from that - comfortable with randomness and chaos. Need to be ok with that. Yes, it's hard to create new systems what I would argue is that we're not creating new systems, but opportunities for organisations to evolve within the current setup. We don't have a set of structured blocks that you move ... around; it's an ecosystem, don't just plonk things into an ecosystem an evolutionary process. Started small, experimental. Ministers can get frustrated as they want more people to notice the success. At the same time very sensible and long lasting policy reform is often evolutionary. It's not necessarily where you impose a change all at once.. ... Policy ecosystem is about dabbing bits of ink into the mix.  
*Policy maker, England*

However, all the policy implementers criticised the disjointed nature of policy development in relation to social enterprise in England.

‘The real problem was that we didn't have it joined up at the Centre. ....At one stage [we were sending] SOS messages via the SHA to the DH.... had to keep track because people didn't value each other's bit of policy or didn't understand. It could have been smoother and more joined up and people needed to be clear what this was the solution to. It was never clear. For us it was a solution to keeping services together but I'm not clear what the policy agenda was.....It would be hard to say, looking retrospectively, that there was a coherent policy rolled out from concept to prototype to implementation to adoption to spread. ... [I'm] not sure how the Department of Health functions. Is it like the Wizard of Oz... sweep back the curtain and there's nobody in there.’ *Policy implementer, England*

Arguably, this research indicates that three main preconditions were required in the health system to support the emergence of social enterprises in England. One was the presence of a market, second was the long history of 'not for profit' organisations such as charities which was embedded in the culture of service delivery in England and the third was a culture of experimentation amongst state policy actors who had resources (funding and capacity) to act. All three of these preconditions were controversial. The approach taken to all was the subject of much debate and tension between actors. However, it was the process of debate, the relative power of different communities of interest and the relative receptiveness to change embedded into the policy makers' decision making that influenced the emergence of organisations which called themselves social enterprises.

Internal contradictions were present in the health field, but also external events (such as the financial crises) influenced perceptions of the need for change in England. The relative importance of these internal contradictions and external events will continue to be debated. For example, some interviewees suggest various financial crises either self imposed (eg political commitment to address long waiting lists in beginning of Labour government) or externally imposed (eg financial crisis of 2008) caused the emergence of social enterprises in health policy. However, the analysis presented here suggests that no single critical external event can be identified.

What is evident from the analysis presented in this thesis is that the emergence of social enterprise in England can be viewed as a time limited phenomenon. From 2010, political attention refocused on employee controlled enterprises, or mutuals, and largely replaced social enterprise in policy discourse. However, the analysis of the meaning of the terms presented in Chapter 5 demonstrates that mutuals are not the same as social enterprises. It is the social mission, the way in which the organisational surplus is used within a trading environment which distinguishes social enterprises from mutuals. Furthermore, an organisation may be both a mutual and a social enterprise ie a staff controlled enterprise may also have a social mission and the surplus used to further that social mission.

In relation to social enterprise, the diagram over the page summarises how change might be conceptualised in England.

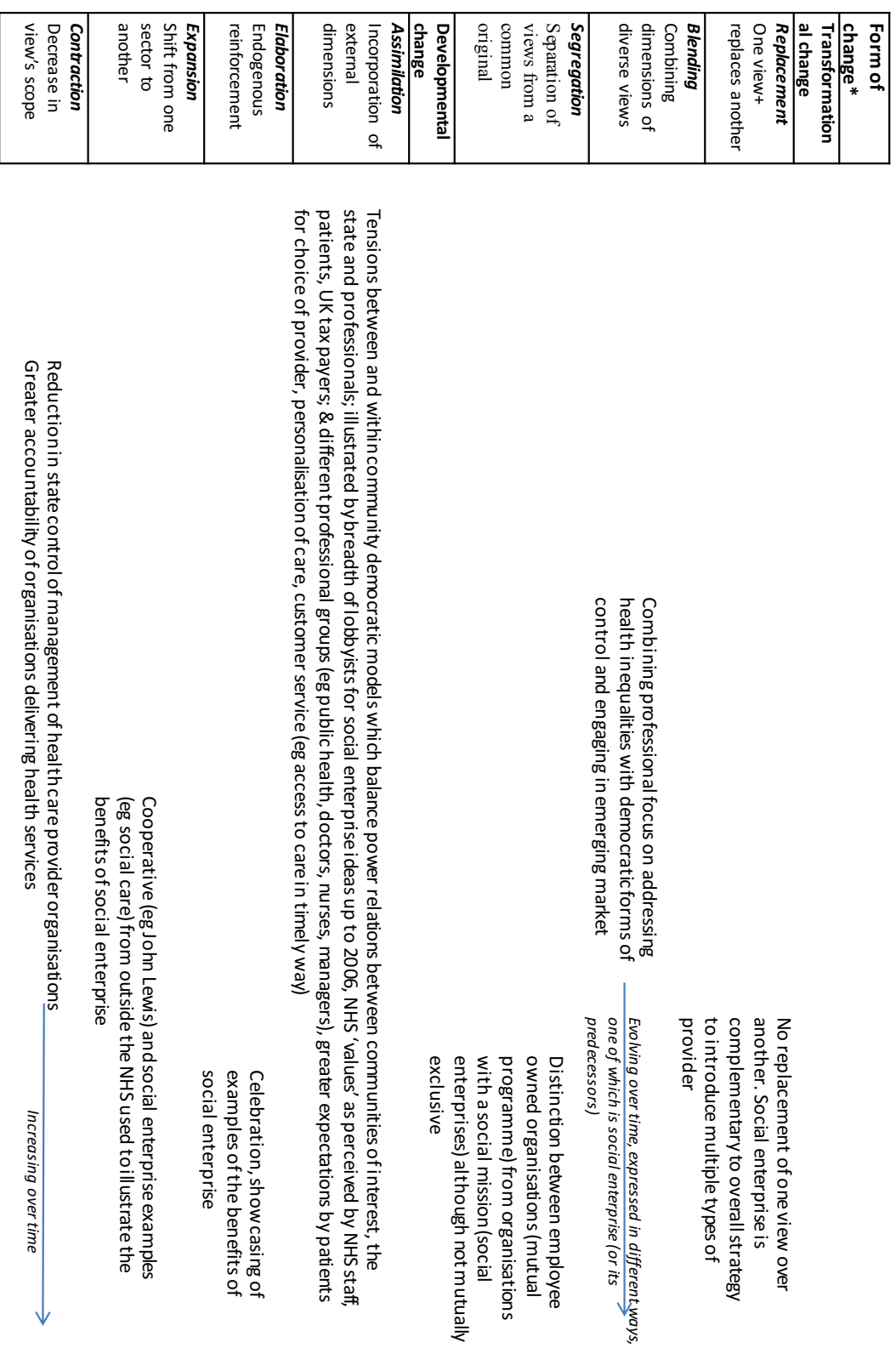
Institutional logic meta-theory makes a distinction between transformational change and developmental change. Transformational change involves replacement of one logic with another. It is the type of change that some of those interviewed for this research, illustrated by the quote below, wanted to achieve, believing that the combination of social enterprises' core characteristics offered opportunities to make more of an impact than state managed services alone.

'Some social enterprises are driving and delivering service transformation, but not the majority. Whether they're delivering transformation does not seem to relate to issues of ownership or governance, rather leadership and values – particularly whether there's a strong focus on users' needs. Frankly, it's not worth spinning out services or bringing in new contractors unless this is going to enable major transformation which improves services and outcomes for patients.' *Policy maker, England*

However, the analysis from this research suggests that only partial transformational change occurred at the health system level. This was achieved by the introduction of the community logic through the Transforming Community Services initiative, when some state managed organisations were externalised into social enterprises. This community logic of social enterprise competed with the logic of for personal profit private corporations, mutuals, and the state logic. At best there was a blending of different logics within the health field which started in the 1980s and evolved over time. Tensions between these different institutional orders and also with the professional logic created new identities and practices that contested the authority of the state, clinicians and corporations. The hybrid model (social enterprise / staff controlled mutuals) adopted by some social enterprises in the right to request initiative, subsequently evolved into a segregation of meaning, with the employee owned/managed model (mutuals) emerging as the dominant logic in policy post 2010.



Figure 7.2 Types of Change used by policy actors to support emergence of social enterprises in England



\* Framework for forms of change developed by Thornton et al, 2012

+ Views are Community, Professional, Corporation, State, Market

1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014

However, change was also developmental. Examples of assimilation of ideas about social enterprise from lobbyists arguing for change were presented in this chapter and Chapter 6. Expansion of the logic of health care delivery to incorporate ideas from social care and John Lewis PLC were used developmentally to support NHS staff to consider different ways of growing their organisations when implementing the Transforming Community Services. Chapter 6 also illustrated how politicians and other lobbyists celebrated perceived successes of social enterprise in improving health care for patients. This elaboration was a powerful developmental tool to promote the new logic of social enterprise.

The contraction of the state complemented the expansion of the community logic in some parts of the health system in England but not others. The Transforming Community Services policy only applied to some community and primary care services providers, not hospitals. This policy never resulted in a replacement of one logic with another. The underpinning logic of social enterprise expressed through the three core characteristics described in Chapter 5 never gained sufficient power to act as a transformative logic in the health system as a whole.

## **7.8 Conclusions**

The previous sections have focused on the role of social entrepreneurs in effecting change. At least six strategies for change could be identified which were common across both countries. Individuals came together to influence change in communities of interest at different points in time. Not all strategies were equally effective. For example, in England, translating the wants of customers and their preferences on the organisation receiving state funding demonstrate ongoing lobbying for involvement at this more strategic level. Similarly, in England, social value as a strategy for change has some way to go before it is recognised as a meaningful priority in commissioning processes for services, unlike in Tanzania where both measurement of social impact and recognition was more readily referenced by those interviewed. In England employee value and engagement was supported by a body of evidence which

evidenced improvements in productivity and quality of service, reflecting an imbalance in the focus of research.

In Tanzania, the diffusion of ideas associated with social enterprise was seen amongst international NGOs, the parent organisation influencing thinking in country offices. Local NGO leaders interviewed for this research, were also behaving like social entrepreneurs: responding to market opportunities to grow their organisations to further their social mission.

In England, Chapters 6 and 7 illustrated how change was advocated by different individuals acting together as institutional entrepreneurs but with different and sometimes conflicting perspectives on what needed to change. However, a core theme running through the interviews in England was that these teams were seeking greater independence from the perceived bureaucratic constraints of the state managed NHS, within a value set which recognised the role of a 'not for personal profit' ethos in companies participating in a market. In Tanzania, the not for profit organisations already have a greater share of state funded health services (analysed in chapter 6) and this desire to leave the nationally managed state health system was not evidenced.

Using institutional logic, both transformational and developmental change were evident in England at different periods over time and multiple strategies were used by actors to achieve change. However, whilst it is possible to describe the underpinning logic of social enterprise in both countries, the evidence from this research does not support the idea that introduction of social enterprise resulted in a transformation of the state and market logic of state funded health care services in England.

The next chapter will discuss the implications of this analysis across several themes.

## **Chapter 8 Discussion and conclusions**

### **8.1 Introduction**

I draw on the three themes described in Chapter 2 to structure this discussion of the research results. I have ordered this discussion so that it is consistent with the structure of the literature review in Chapter 2 and the presentation of the results. My approach builds on my ontological premise that the conceptualisation of social enterprise as a social construction, means that it needs to be interpreted within the context of time, place, and from the perspectives of different actors, all of which may be valid.

Drawing from the methodological approach, therefore, I start this discussion in section 8.2, at the field level of inquiry, where each health system forms a distinct case study. I argue that the results from this research, can aid conceptualisation of health systems, the role of governments and markets in relation to social enterprise in health systems. This section therefore provides important context for considering how this understanding can be applied to aid policy actors wishing to introduce social enterprise into a health system. In section 8.3, I discuss the contribution of this research to the ongoing debate about the meaning of social enterprise and how socio-political processes of change influence this meaning over time. Recognising that social entrepreneurs are aiming to achieve social change, I discuss the implications for this in Section 8.4. It contains a discussion on the interface between the social entrepreneurs' goal for social change with the management of social enterprises delivering health care services.

Section 8.5 revisits the research objectives to discuss how far this study has met each objective, concluding with recommendations. I finish this thesis with my conclusions in section 8.6 which contains observations about the implications of this study for bringing together academic and practitioner perspectives on social enterprise in health systems.

## **8.2 Conceptualising health systems**

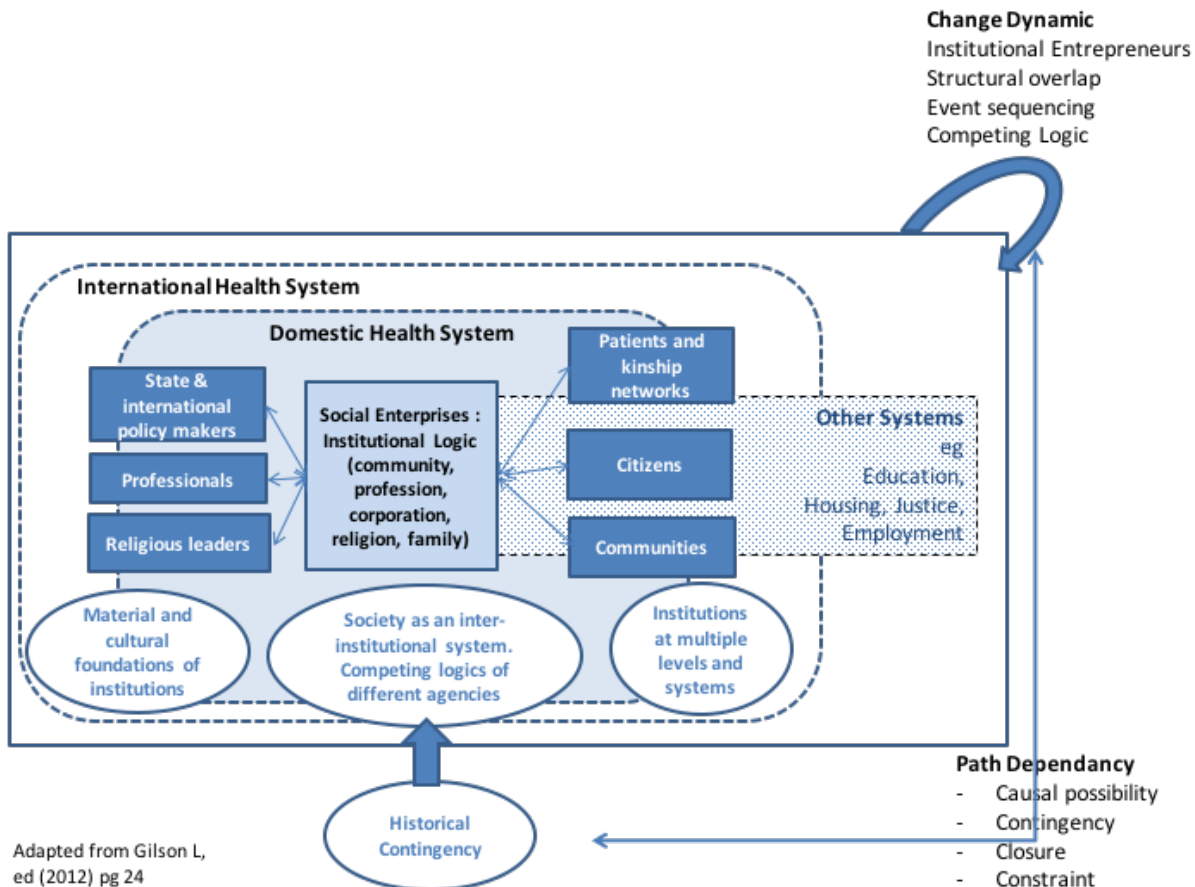
In this discussion, I start section 8.2.1 by revising the health system framework presented in Chapter 2.6, to reflect the competing logics which may be present in a health system. I then propose a diagnostic tool in section 8.2.2 which can be used by policy actors to plan for the introduction of social enterprises into health systems. Policy actors can use it to assess the breadth of change required in health and other related systems if social enterprises are introduced. Section 8.2.3 summarises the contribution of this discussion on health systems to the development of theory.

### **8.2.1 Embedding institutional logic into health systems.**

The results from this research suggest that elements of the health systems framework developed in chapter 2.6 were useful when analysing these results. The framework reflected the change dynamic and the structural conceptualisation of the health system. It also captured the institutional entrepreneurship of different actors working at multiple levels within a historical context. This conceptualisation can be further enhanced by explicitly referencing the competing logic of different institutional orders. If the institutional logic conceptualisation of a 'field' is used to refer to a domestic health system, then the framework can be enhanced further by reflecting explicitly the other systems outside of the health system which may contribute to social entrepreneurs strategy making to achieve social missions. This latter extension is particularly relevant for those leading social enterprises to deliver services to vulnerable people with complex health and social care needs.

The diagram below builds on Gilson's (2012) concept including the results of this research by incorporating the institutional orders found from this research.

Figure 8.1 Different levels of health systems, institutional logic and change



In support of Gilson's (2012) model, the competing logics of different agencies exist at any point in time even when resources and health goals are significantly different. It may also be demonstrated from this research that although the resource base is very different in Tanzania and England, there are common underpinning institutional logics across both health systems. In Chapters 5 and 6, the results from this research showed that more than one institutional order may be present at any level in a health system at the same time, within organisations, nationally and internationally. Each will have different levels of 'power' over others. For example, section 5.6 illustrated how the profession logic is evident in social enterprises' business plans and care models, reflected in the quality of care provided, and built into the mission of some social enterprises.

Comparing the meaning of social enterprise in Tanzania and England involved striking a balance between potential cultural differences between the two countries versus the identification of a common logic. Cultural relativities placed

a different emphasis on particular logic characteristics, particularly in the parallel and sometimes combined social enterprise/ mutual/cooperative models in England, described in section 6.4 and the importance of faith in shaping the scope of care provided and the social mission of some organisations in Tanzania (section 5.6.1). Institutional logic needs to be seen, as Gilson (2013) advised as a guide to structure thinking. This hybridisation of logic needs to be recognised by policy actors and researchers when interpreting change within health systems and understanding differences between them. However, over use of the broad brush categories of institutional orders may lead to simplistic analyses.

Figure 8.1 also illustrates the different policy actors which influence this logic within a domestic health system. These may be state or international policy makers, professionals, religious leaders, patients and their kinship networks, citizens and communities of interest. The influence of actors on the definition of social enterprise and on processes of change were different when the two countries were compared. In particular, the international community (international NGOs, WHO, World Bank, donor countries) had much more power in Tanzania than in England. In Tanzania, this research evidenced in sections 6.3 and 7.2.7 how these actors influenced both health policy and, through making changes in social enterprise business models, at health care delivery level as well. The influence of religious leaders on the purpose of organisations and systems of authority was also more apparent in Tanzania than in England.

The national health system interacts with other systems, such as education or employment, through these policy actors. As demonstrated in Chapter 7, social entrepreneurs, through their organisations, social enterprises, bring together these competing logics to influence change in the logic of the market design (sections 5.8, 6.3.3) of the health system. This research demonstrated how these social entrepreneurs, acting as institutional entrepreneurs worked at multiple levels (eg international, domestic, organisational, and individual) to advocate for change.

However, this research also indicates that although it can be argued that social enterprise is a new cultural / cognitive logic in health systems, in section 7.7, its

relative contribution to transformational or developmental change in improving the health of populations was unclear. Its logic can be made to fit with different political ideologies. Whilst it was clear from the English case study in section 6.4, how social enterprises were used by politicians as instruments to guide change, the implementation of social enterprise varied. Advocates of social enterprise created 'cultural resonance' which has been described by other researchers as an important component of mobilisation with only some individuals and teams in the NHS. (Lounsbury et al., 2003)

Furthermore, multi systemic responses may be required to effect transformation in care outcomes for some client groups but not for others. The three types of social enterprise described in section 5.7 illustrates how the range of organisational strategies used by social enterprises may go beyond the scope of health funders leading to opportunities to develop cross governmental solutions. It also leaves out transformative agents such as new health technologies which may transform care for a population.

Reflecting the amendments to the institutional orders suggested in this research, there are other definitions of the meaning of the term transformation in health care including increasing efficiency, improving access to health care services, increasing health impact, and not just market share as implied in institutional logic. The logic of the 'market' was described as a 'pure market' in economic terms in the original framework. (Thornton et al., 2012) Section 6.3 demonstrated how the logic of state managed health care delivery markets when analysed in relation to social enterprise needed to be amended to allow for different market currencies and reward which supported achievement of social objectives as well as health delivery performance. This research, in sections 4.4 and 5.8, also showed how uncertainty/complexity influences resistance to change. Lawrence (2008) describes how control and domination influences the range of options open to actors. In this research domination by the state of market rules restricted the range of business models open to English and Tanzanian social entrepreneurs to further social objectives.

Whilst the meaning of transformative and developmental change may be subject to ongoing debate within a domestic health system, Figure 8.1 recognises the importance of historical policy decisions in domestic health



systems. In Chapter 6, both case studies demonstrated historical contingency in the different institutional logics present in the health system. The change process, event sequencing, described in 6.3.4 illustrated how implementation of the concept of social enterprise builds from historical policy decisions. This creates a context unique to a domestic health system. It was illustrated in Chapter 6 in the contrasting market shares of state managed, for profit and not for profit organisations in the two countries. In Tanzania, it could be argued that the separation of 'not for profit' from 'for profit' private organisations in legislation and the ban on participation of for profit organisations in health care delivery, which was only recently removed, influenced the market share of 'not for profit' organisations. In England 'not for profit' organisations, independent of the state have always been present in the health care delivery system, but following the formation of the NHS in 1947, with a much reduced role. This research shows that the role of state funded private sector health care delivery organisations in both countries evolves over time, each new legislation or policy initiative building on or reacting to previous legislation.

This research demonstrates how by using the institutional logic framework, more than one institutional order may be present in a health system at any point in time and that they may compete for primacy with each other. This research therefore complements others (Park and Wilding, 2013, Kerlin, 2013, Kerlin, 2010) in demonstrating that this cultural and material context is influenced by and influences government policy orientation. By developing Gilsons (2012) model further to recognise the different combinations of institutional logic at different levels of the health system and within the context of the historical influence from policy actors, this research offers an alternative way of conceptualising health systems and theorising about health system change.

### **8.2.2 Applying health system framework to health policy development**

A structured approach to evaluating the evidence for the effectiveness of social enterprise was beyond the scope of this research. However, if social entrepreneurs are correct in distinguishing their social business models from others, as described by Yunus et al (2010) and in this research, it may be inferred that encouraging the development and accountability of social

enterprises in a health system for delivering social change may be important. Results from this research show that certain institutional conditions in the capacity of the health system need to be met before an idea like social enterprise can be implemented (Helderman, 2005). I have developed a diagnostic tool to assess how favourable the health system is to the development of social enterprise organisations. The implication from this research is that the 'success' of social entrepreneurs and social enterprises is at least partly contingent upon the environment within which they operate.

The proposed tool is an indicative illustration of what the different contextual factors and their interdependencies could be to enable policy stakeholders to assess at a point in time how well the logic of social enterprise is embedded into policy. This tool is broader than others which are currently available. The Schwab (Schwab, 2008) for example, have proposed a narrower framework for government action as a policy guide to scale up social entrepreneurship. They identify six elements: engage market stakeholders, develop government capacity for action, build market infrastructure and capacity, prepare enterprises for growth, grow and direct private capital and review and refine policy.

However, based on the results from this research the framework is too narrow, (at least for health systems), focused on financial and market resources, rather than the broader context for government action.

It may be inferred from this research that there are three domains which need to be considered. These are social impact, government systems and health system capacity. Table 8.1 below describes how this diagnostic tool links with institutional logic meta-theory, previous research and the results presented in this thesis.

Table 8.1 Linking institutional logic, research results and diagnostic tool

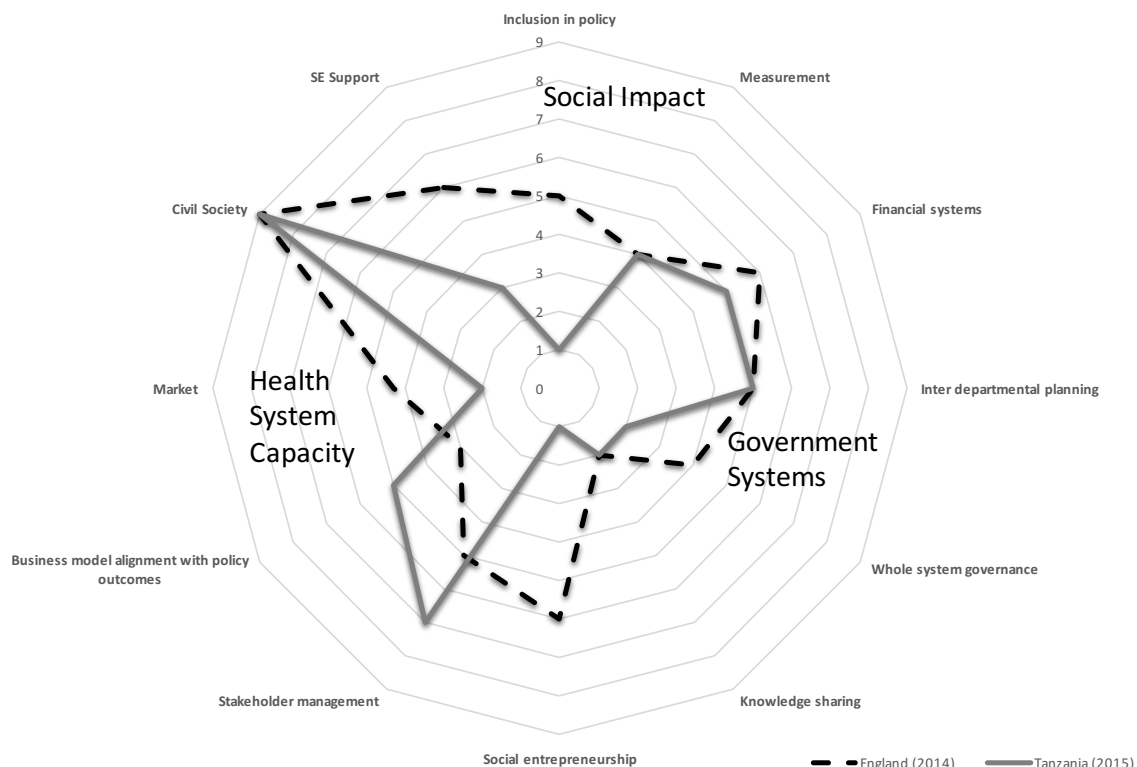
Domain	Institutional Logic	Review of previous research	Reference to the results in this research (section or chapter in this thesis)
Social impact	<p>Community of interest expressed through social purpose</p> <p>Hybrid organisations reflect community logic combined with categories from other institutional orders</p>	<p>2.4: the concept of social enterprise and their characteristics</p> <p>2.5.2: social innovation strategies</p>	<p>5.2: social value as a characteristic of social enterprise</p> <p>5.5: community institutional order distinguishing social enterprise from other types of organization;</p> <p>5.6 expression of other institutional orders with community institutional order</p> <p>7.3 measuring or arguing for social value</p>
Government systems	<p>State and market logic</p> <p>Change processes:</p> <ul style="list-style-type: none"> <li>: Event sequencing</li> <li>: Institutional entrepreneurs</li> </ul>	<p>2.3: role of government</p> <p>2.4.4 Political influence on meaning of social enterprise</p> <p>2.5.1: historical contingency of social change</p> <p>2.5.3 Design of markets in state managed health system</p>	<p>3.2: Reasons for introduction of private providers in relation to health system reform</p> <p>4.3: scope of health funding &amp; health system reform strategies</p> <p>4.4.1: securing investment</p> <p>5.3: Political use of term social enterprise</p> <p>5.4 Policy makers need to build social enterprise logic into policy</p> <p>6.2: policy makers perceptions of value of privately managed organisations and the market logic implemented.</p> <p>6.3.2: historical contingency of policy change</p>
Health system capacity	<p>Change processes</p> <ul style="list-style-type: none"> <li>: event sequencing</li> <li>: institutional entrepreneurs</li> <li>: structural overlap</li> </ul>	<p>2.3.3: Hierarchy of health system capacity linked to capacity building strategies and socio political context</p> <p>2.5: change processes linked to types of change</p> <p>2.5.4: social entrepreneurs as advocates for</p>	<p>4.4.2 social entrepreneurship culture</p> <p>5.7: organizational strategies to achieve social value responsive to context</p> <p>5.8: how social value embedded as a currency in health markets</p> <p>6.3.3: design of market logic related to social enterprise</p> <p>6.4: learning from England recognizing value in investing in development of skills and capacity</p>

Domain	Institutional Logic	Review of previous research	Reference to the results in this research (section or chapter in this thesis)
		institutional change	in social entrepreneurship 7.2, 7.4, 7.6: Enhancing capacity by building knowledge and experience 7.5 civil society – mobilizing consumers

Social impact forms one of the three domains of this diagnostic tool because it reflects the interface between all three core characteristics of social enterprises and the effectiveness of social entrepreneurship in achieving social innovation. Management by the state of health system design in both England and Tanzania means that the second domain, government systems, is critical in creating the institutional environment within which health care organisations trade. This domain builds on the evidence of this research which links the effectiveness of social enterprises' contribution to health equity policy priorities through the articulation of organisational strategies which address the social determinants of health. This domain recognises the importance of the socio-political context which allows social entrepreneurs acting as institutional entrepreneurs to influence and be influenced by the environment created by governments. The third domain, health system capacity, reflects the multi faceted dynamic between social entrepreneurs and health system capacity building.

Figure 8.2 below illustrates how the idea might be developed for use by policy actors when designing policies to introduce social enterprise into health systems.

Figure 8.2 Proposed diagnostic tool for policy stakeholders



I have demonstrated how the tool might be applied comparatively by comparing the research results for England and Tanzania, using an indicative 0-9 scale which assumes that 0 is low and 9 is high. Other scales, such as 1-3 or 1-100 could be used and can be the purpose of future research. Further details can be found in Annex D about each of the three domains together with scores for England and Tanzania.

Development is needed on the dimensions themselves and the type of scale and questions that might form a validated tool for comparison purposes. If this was done, it could be used in assessing, strengthening or monitoring strategies which shape the health system environment. Further, the diagnostic tool could be used with policy actors to achieve a facilitated view about what needs to change in health system design and what capacity needs to be built into a health system before change can be made.

It could also be used in a more qualitative way, to enable policy stakeholders to discuss and review how the environment supports or challenges social enterprises. Used in this way, it might inform what future policy changes need to be made across systems and to structure consideration of the potential impact of these changes upon the dynamic between different policy actors in the health system.

### **8.2.3 Implications for the development of theory**

This research contributes to the growing body of literature on the potential of social enterprise to support health system reforms. There is almost no research which compares how adoption and policy implementation of social enterprise varies transnationally. Social enterprise is growing in international focus, yet its meaning and implementation in a health systems context is little researched. As national donors such as DFID and DANIDA and influencers such as the British Council embrace the idea of social enterprise in their strategies for supporting development of low to middle income countries, more research on when and how these strategies are relevant will become increasingly important.

The development of the diagnostic tool demonstrates how this research has contributed to the knowledge base. By scoping the characteristics of social enterprise within the context of a health system it provides a way for institutional entrepreneurs to conceptualise the breadth of change required in the health systems and intra government fields to allow social enterprises to be introduced and developed. The diagnostic tool is an idea that one organisation has expressed an interest in to help them to understand the systemic impact of their social investments.

Chapter 2 contained an overview of other research where institutional logic has been used in analysis of health systems change. It demonstrated that the amount of research is small, and has focused on higher income countries. I could find no published literature on institutional logics in middle to lower income countries. This research contributes to previous research on the changing logic in health systems in higher income countries as well as providing one example of how it could be applied in a middle to lower income country.

The proposed amendments to the health systems framework originally developed by Gilson (2012) use institutional logic to incorporate a cognitive dimension to our understanding of health systems. This development complements existing structural, systems and actor agency approaches which are already well established in the health systems literature. The three change processes in institutional logic offer a new way to analyse change within health systems. Further, they bring in an organisational perspective which is an underdeveloped area of health systems research. Albeit only a beginning, using institutional logic offers a new way of building knowledge and conceptualising the interface between organisational and system change, and the cognitive perspectives of policy actors advocating for health system change.

### **8.3 The conceptualisation of social enterprise**

This thesis illustrates how social enterprise has its own logic which is expressed through the institutional logic order, community. The comparative case study approach used in this research enabled a common meaning to the phenomenon of social enterprise to be identified across two contrasting health systems. Organisations with this community logic have a social purpose which is expressed through a culture of social entrepreneurship within a market. Important aspects of other institutional orders such as profession, corporation and in the case of Tanzania, religion may also be present. The combination of different aspects of these other institutional orders ('hybridisation') brings together structural and cultural combinations within the social enterprise organisation. In Chapter 5 of this research the results show that this mixing of logic categories from different institutional orders, around one central logic allows social entrepreneurs through their organisations to experiment with different structural and cultural opportunities to achieve social change.

However, this research also shows that interpreting this broad logic is complex. Considering different institutional logic categories and how they apply to the meaning of social enterprise can further the theories underpinning the meaning of social enterprise and the way in which control and power over these meanings are used by different policy actors. This research also demonstrates how social entrepreneurs can differentiate their organisations from others by

integrating the social purpose of their social enterprise with organisational strategy and business models. In this way, social entrepreneurs build capability to innovate within their organisations and in the health system.

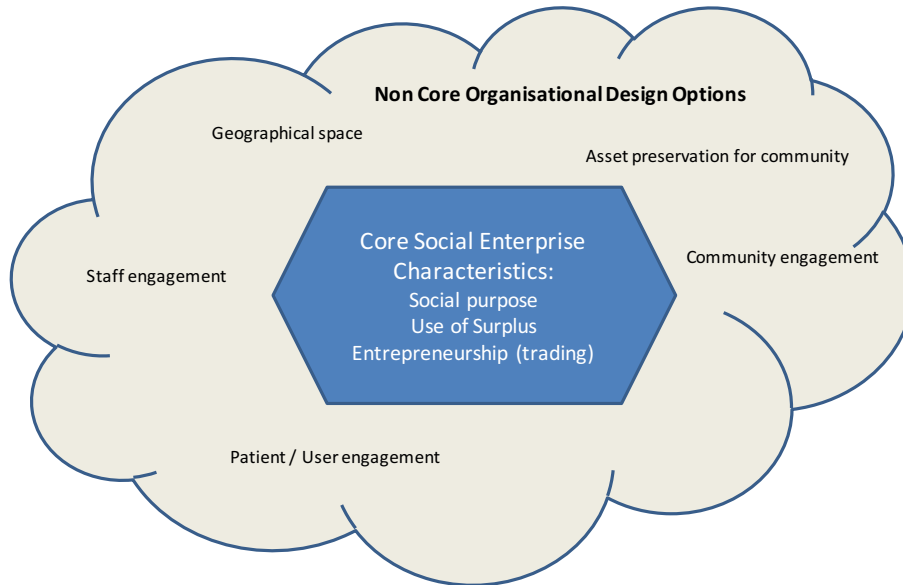
The following sections will discuss each of these three aspects of social enterprise. The first section (8.3.1) explores how, by using institutional logic theory to describe core and non core characteristics of social enterprise, this research contributes to the development of institutional logic theory and theories about the meaning of social enterprise. If, as is argued in this research, social enterprise has its own underpinning logic, then the way in which policy actors can influence the change of meaning of a policy term over time in a health system is important learning from this research. Using the example of the introduction of social enterprise into the NHS, this politicisation of the meaning of the term has implications for actor agency, which is discussed in section 8.3.2. I argue in section 8.3.3 that this social construction of the meaning of social enterprise has broader implications for health systems reforms.

### **8.3.1 The logic of social enterprise in England and Tanzania**

From the case examples examined it has been possible to distinguish between core and non core characteristics of social enterprise. This finding contrasts with other researchers reviewed in the literature review of the concept of social enterprise (Chapter 2.4). These included using social and economic criteria, organisational culture of social entrepreneurship, international definitions associated with philanthropy, leadership and context, and political definitions linked to political ideology and power. Figure 8.3 illustrates how the three core characteristics identified in this research might be conceptualised. I argued in section 5.2 that non core organisational design options may also be present, but in themselves may not reflect the logic of social enterprise without the presence of the three core characteristics.



Figure 8.3 Core and Non Core Organisational Design Options



The three core characteristics (social purpose, social entrepreneurship and use of the surplus to achieve the social mission) are common across England and Tanzania.

When compared with the institutional logic categories of the order community in section 5.5, some alignment could be identified. Five categories in the institutional logic framework developed by Thornton et al., (2012) can be further refined to reflect the community logic of a health system as expressed through social enterprises. These were the root metaphor, sources of legitimacy, sources of authority, basis of strategy and informal control mechanisms and are listed below.

1. The root metaphor of a social enterprise is a common boundary or community of interest. For example, this community of interest could be a staff or a client group, a geographical area, or a social enterprise as a type of organisation with a distinct identity. This fluidity of community of interest has implications for how social entrepreneurs view the scope of a health system. There is a dynamic between organisations' social entrepreneurs and the policy makers in negotiating the scope of the health policy field. This negotiation is important because, as described in section 5.7 it influences how social entrepreneurs design their business models and strategies.

2. A social enterprise's legitimacy, its freedom to act in the interests of its community and its accountability to that community rests on its ability to demonstrate its social value to that community of interest. This social value is reflected in the social purpose of the organization, which is also influenced by the context within which the social enterprise trades. For example, section 4.2 demonstrated how all social entrepreneurs interviewed for this research in Tanzania, were able to describe how they were contributing to policy makers' priorities to improve access to health care and capacity building.
3. This commitment to community values and ideology is a social enterprise's source of authority. In England, democratic accountability to a community of interest was evident in relation to some lobbyists argument in section 7.5 that tax payers have a 'right' to be consulted on changes made to the health system to allow the entry of 'for profit' organisations into health care delivery systems in the NHS. Inclusion of democratic rights at a social enterprise (organisational) level was less clear cut, reflected in the debate (sections 6.4 and 7.7) amongst social enterprise leaders and policy makers on the relative importance of democratic forms of engagement through their employees and/or client group.
4. Engagement with employees and/or client groups was used as a strategy by all leaders interviewed for this study in both countries to support service redesign or organisational governance. In this way communities of interest were 'allowed' by social entrepreneurs to influence or lead service design ('empowerment') to improve the quality of services delivered to achieve the social mission. The basis of social entrepreneurs' strategy was not to increase the status and honour of members and practices of the community of interest as suggested by Thornton et al. (2012). Rather it was to work together as a community of interest to have a social impact. As is illustrated in Chapters 4 and 5, this social impact may go beyond the funding scope of a health system, depending on the social enterprises' organisational strategies to achieve their social purpose.

5. Many informal control mechanisms were evident in this research. This fifth category in the institutional logic framework was made visible by social entrepreneurs through their actions, expressed through partnerships, formed to further the social purpose of the organisation. The relative complexity of partnerships in relation to the three groups of social enterprises identified in this research (section 5.7) was not understood by all commissioners of services in England in relation to the length of time contracts were required to deliver innovative service models.

Figure 8.3 also illustrates how other material or cultural features can be built into the design of the organisation as required. For example, in Tanzania and England, the following three aspects of community were identified in social enterprises:

1. Building in collective forms of engagement at an organisational level was evidenced in England through attempts to include patients/users and/or staff in decision making processes at an organisational level. This was illustrated in Sections 6.4 on allowing NHS teams to form social enterprises and Sections 5.2 and 5.3 which reflect both the changing political interpretations of the term over time and the tension between meanings which reflect democratic control versus social purpose. These tensions were not found in those organisations in Tanzania interviewed. In Tanzania, other culturally influenced meanings were evident for example in Section 5.6.1 faith based social enterprises interviewed for this research demonstrated the idea of community through religious affiliation.
2. More so in England than in Tanzania, a suggestion that, by building in principles of social value, into their organisational purpose, that an alternative economic model which is based upon achieving a social mission binds social enterprises together into a community of interest. In England, as illustrated in section 5.3, collective representation of social enterprises was viewed as weak in relation to the power of the 'for profit' corporations. However, in Tanzania, section 5.2 demonstrated that whilst the 'not for profit' type of organisation has

been a recognised classification distinct from 'for profit' there were no collective mechanisms in place to advocate for their place in the health system as a distinct organisational type compared with 'for profit' types. In Tanzania, section 7.2.7 illustrated how international NGOs and donors bring their own ideas on how health service markets can be managed to achieve their social mission, with the translation of ideas found internationally into the domestic health market.

3. Geography was another perspective on ideas of community. Geographically based state managed planning structures to set health care delivery priorities, commission health care service providers and review the effectiveness of health service provision in achieving local priorities was done at national and regional levels in both countries. These geographically based planning and delivery systems are bound by the national policy and legislative framework for health services in a domestic health system. Social enterprises delivering health care services engaged with other organisations on a geographic basis to design care tailored to the needs of their population and to achieve their social mission.

There were also important values based non core characteristics used which were drawn from ideas of business. For example, in section 5.2.2, the issue of whether or not social enterprises should carry an asset lock, which preserves the assets for the social benefit of those communities identified in an organisation's social mission regardless of changes in company ownership, illustrated how ideas associated with business (in this case mergers and acquisitions) were translated into a social enterprise logic.

These different characteristics influence the structural and cultural identity of the organisation, for example, through its legal structure and organisational cultures. No published academic studies were found which used institutional logic to interpret the meaning of social enterprise. However, drawing on published literature which emphasise the 'hybrid organising' (Battilana and Lee, 2014) aspects of social enterprise and reviewed in Chapter 2, interpreting the institutional logic categories associated with the institutional order community in

this way suggests that the institutional logic framework developed by Thornton et al. (2012) can be developed further. The results from this research, presented in chapter 5, demonstrate that at least for social enterprises in a health system, the structure and culture of social enterprises are in fact blended with many aspects of different institutional orders.

In England, employee ownership of some social enterprises in the form of shareholding interests without the presence of a social mission places them in an ambiguous position depending on whether or not the employees are the objects of the organisation's social mission. For example, an organisation structured where the benefits of the employee shareholders are also members of the target group benefitting from the social mission may also be classified as a social enterprise. An organisational culture which promotes quality of care and links to the institutional order profession through either embedding the staff in the governance of the organisation in its ownership structures or through culture further blurs the distinction.

This research therefore can be interpreted as a first step in supporting Thornton et al. (2012) argument that the community institutional order is a distinct economic order which they have called 'cooperative capitalism'. (Thornton, 2013) England and Tanzania have significantly different health priorities yet it can be argued in general terms, that there is a common logic to social enterprise organisations in both systems (community, state, profession and corporation), all of which compete with each other for power through the actions of different actors.

### **8.3.2 Changing the meaning of social enterprise over time**

Throughout this research, locating the correct historical period in time was important. Drawing on the three change processes of institutional logic meta-theory in Chapter 6, two processes, event sequencing and the advocacy of institutional entrepreneurs for social enterprise ideas were both important in influencing the changing meaning of social enterprise over time.

When NHS staff were invited to form their own social enterprises independent of state management, my analysis in section 6.4 showed how policy actors used their institutional power to influence policy priorities. English politicians in

government saw social enterprise as a way of furthering their political ambitions. Some policy makers and politicians were inspired by social enterprise advocates who presented opportunities to address health inequalities. Staff engagement, which was used initially as one argument for releasing NHS staff from direct NHS management, (a perceived constraining factor (Addicott, 2011)) would allow them to be innovative and to deliver better patient care. Over time staff engagement became central to the meaning of social enterprise in policy discourse. Ambiguity of the meaning of social enterprise in England allowed one aspect, social value, to, over time, be down played in favour of mutual or employee controlled organisational forms.

Ideas of social enterprise found in Tanzania showed that the term social enterprise was not present historically but is emerging as a new term amongst 'not for profit' organisations and some policy influencers. In section 5.2, this research shows how, in the Tanzanian context, although the idea of social enterprise has not entered health policy making yet, some leaders of not for profit organisations interviewed for this research have either always viewed themselves as social entrepreneurs, but not called themselves by this term, or are actively transitioning their organisations to become social enterprises. Advocates in Tanzania who argue for recognition of social enterprise as a distinct type of 'not for profit' organisation make their case on the basis of culture not structure ie social enterprise leaders demonstrate a social entrepreneurial outlook which is different from the culture in other 'not for profit' organisations which rely on grant funding.

This interplay between power and agency shapes the meaning of policy as well as the policy environment and the decisions and priorities that follow. This research showed in section 7.7 that whilst social transformation might have been an objective for some actors advocating for social enterprise in England, the institutional environment limited its implementation. Whilst policy makers might argue, as two did in this research, that the policy making process is an ecology of ideas which are tried and discarded or further implemented in a Darwinian way, this research indicates that in relation to social enterprise this receptive culture at a national level to new ideas arguably needs to be implemented within a strategic framework and underpinning principles which

are favourable to addressing health inequalities. Without recognising the importance of social value and therefore social enterprises as a distinct type of organisation with its own logic, policy makers may miss opportunities to effect change.

The extent to which democratic forms of engagement were reflected in social enterprise structure and culture varied. These new communities of organisations were perceived to be threatening by key stakeholders such as Unite who actively resisted change. This finding complements that done in other sectors which demonstrated that new organisational forms with different values sometimes threatened stakeholders (Marquis and Lounsbury, 2007) . This resistance to social enterprise was driven by ideological and political concerns about the meaning of the NHS and implications of the market driven policies for quality of care.

This research demonstrated the tension between stakeholders who enable access to resources (governments and donors) and the beneficiaries, who may lack a voice. The debate in England, described in chapter 7.5, concerning the 'privatisation' of the health service is a good example from this research of this systemic issue where some citizens feel that a debate has yet to be had about the underpinning values of organisations invited to deliver care using tax payers' money. The results from this research demonstrate the importance of other academics' observations that societal cultural interpretations of the scope and role of a health system in a national context cannot be ignored. (Saltman & Bergman, 2005). This democratic argument has broader implications. Ebrahim et al. (2014), for example, draw on their analysis of governance in social enterprises to draw attention to this systemic dynamic between organisational governance and system governance arguing that how social enterprises may reshape the institutional order and demonstrate their legitimacy as a new form of organisation will be important for the future. The results from this research build on others (Doherty et al., 2014, Battilana and Lee, 2014) who argue that this hybridisation ie organising activities, structures, processes and meanings of social enterprise organisations result in novel institutions. But this research goes further indicating that in a health system this 'hybrid organising' (Battilana and Lee, 2014) is sensitive to the historical and cultural context of policy making

at a national level and in Tanzania internationally. In Tanzania the presence of international NGOs and donors influenced not only policy making but also organisational strategy.

### **8.3.3 Implications of social enterprise logic for health systems design**

This research has advanced the idea of community logic, proposed by Thornton et al (2012) in relation to social enterprise. Using the idea of institutional orders, I have expanded and refined the new community logic categories, suggesting various enhancements. I also proposed refinements to the market and state institutional orders in the context of implementing social enterprise in a state managed health system context. The idea of institutional orders was a useful framework to interpret the data, particularly when differentiating the logic behind social enterprises and mutuals. It also provided a useful frame of reference for interpreting the logic, rather than the use of the term itself when comparing across cultures and health systems. Without the logic categories described in institutional orders, it would have been easy (and a mistake) to assume that because social enterprise as a term is not used in Tanzania that social enterprise as an idea does not exist. Unexpectedly, therefore, use of the idea of institutional orders did do what Thornton et al (2012) have said was one of their aims which was to allow cross cultural comparison.

The analysis of the policy to support NHS staff to form their own social enterprises contributes to the existing debate on how the political interpretation of the term can be used to further policy and political agendas. The analysis contributes to policy and management practitioner's knowledge base on how such a policy can be implemented.

It can be concluded from this research that the historical and cultural policy context will influence the way in which these core and non core characteristics of social enterprise are combined. Both countries had common principles underpinning their health systems but in neither country do policy makers explicitly make the link between social value, policy priorities and organisational purpose in the way in which they plan reform of the health system. However, if looked at from the perspective of the policy implementers interviewed for this study, their ambitions for system reform varied depending on their client group



and their social mission. Policy influencers interviewed for this study perceived the need for change in relation to their constituency views, which was sometimes narrower than those delivering care in social enterprises.

In Tanzania, those who used the term social enterprise thought it was important to differentiate social enterprises as a form of 'not for profit' organisation, distinct from 'for profit'. Certainly some of the reasons respondents gave included access to investment capital, tax and other benefits enjoyed by the 'not for profit' organisations. They also argued that entrepreneurial focus on sustainable income strategies, and reduction in historic forms of funding such as donor funding, merited recognising social enterprise as a distinct category in itself. Arguments that the cultural shift within organisations and the health system both of which need to take a more social-entrepreneurial outlook were also persuasive.

The institutional logic change processes were therefore able to be applied to the changing meanings of the term social enterprise. Institutional entrepreneurship, event sequencing and to a lesser extent structural overlap, could be demonstrated in this research. A limitation, however, was that institutional logic does not assist in understanding the causes of change.

This research demonstrates that social enterprise is a social construction influenced by historical and policy choices. From the perspective of health policy therefore, if addressing health inequalities is a policy priority, social enterprise may present a useful tool for health system reform, but health systems strengthening may be required. From this research the type of strengthening required at state and market levels is common across both England and Tanzania. Social entrepreneurs were not just leaders of social enterprises. Many also aimed to challenge the rules found in the health system, to change the health system so that social value could be more readily evidenced and achieved.

#### **8.4 Using social enterprises to achieve social change**

This research demonstrated that some social entrepreneurs' aim to make a social impact by influencing the environment within which they trade. In so

doing they extend the meaning of social entrepreneur to that of institutional entrepreneur. The views of social enterprise leaders interviewed for this research in both countries demonstrate support for the idea that communities of interest are both the genesis and mediators of organisations development and growth. For example, international donor agencies and NGOs in Tanzania, and some charities in England influence health system change. They lobby for institutional change, adapting to opportunities to further their social mission and grow their organisations.

Cultural, social and legal systems do influence actors organisational strategies and those in power can often 'determine' outcomes that are more coherent. When comparing Tanzania and England, it was possible to see and described in Chapter 4 that the national health system priorities and funding systems in both countries influence the organisational strategies and the types of business models adopted by social entrepreneurs. I demonstrated how the socio-political and historical context is important for social enterprise strategy making. For example, in Chapter 6, the history of the development of the market in England and the more recent PPP structures in Tanzania enabled a growing number of non state managed organisations to contribute to national health priorities by delivering health care services. When policies which affected social enterprises in England did not appear coherent to social enterprise leaders, managerial agency by social entrepreneurs made sense of the environment.

Throughout this research there was an underpinning theme in the data collected through interviews and analysis of policy documents that social enterprises enable innovative strategies to achieve social impact (eg Anderson, 2014, European Union). Building on this idea of using social impact as a way of grouping types of social enterprises, I presented the idea of social value using the WHO's social determinants of health framework. (World Health Organisation, 2008a) This approach to the analysis of the data builds on recent published research which argues that social enterprises can align their social mission with the the social determinants of health. (Roy et al., 2013, Mason et al., 2015). By bringing together the social determinants of health with the client group and organisational strategy, the analysis presented in Chapter 5 demonstrated that there were three groupings of social enterprises, which were

common to both countries. In both countries there is an opportunity to acknowledge in policy making the contribution that social enterprises can make to address the broader determinants of health.

This research advances academic and practitioner theories on ‘social innovation’ where social entrepreneurs, through realising their organisation’s social purpose, aim to influence the rules of government systems. I have structured this section of the discussion around social enterprises planning processes for social change. From this organisational perspective, I discuss in section 8.4.1 how capability and capacity may be combined in new ways in social enterprises’ strategies to deliver their social mission. I then discuss, in section 8.4.2, the implications of this research for creating different types of service innovation to achieve social change. In section 4.4, I demonstrated how social entrepreneurs strategise to acquire resources for investment and, in sections 5.7 and 5.8, how they use a surplus to reinvest to further their social purpose. What has not been explored in this research are the tensions that might arise within social enterprise organisations between social and economic value creation. I explore this subject in section 8.4.3, in the main, to identify it as a future area for research. I then discuss in section, 8.4.4 how academics and practitioners may take a new approach to conceptualising planning for social impact within social enterprises to help them to address this potential tension. In section 8.4.5 I discuss how this aspect of the research has contributed to theory.

#### **8.4.1 Developing capability and capacity in new ways**

Results from this research demonstrate that social enterprises combine the capabilities found in people in new ways to create capacity for change. For example, in Tanzania, in Section 7.3, the use of community champions and mobile phones improved access to specialist health care. Interviewees in England in the Holistic social enterprises group, section 5.7.1, used partnerships and relationship building with others as one way of achieving social innovation, in this way combining and developing the capabilities of their teams, customers (patients/users) and partners. Two organisations leaders, one in England (section 7.4.3) and one in Tanzania (section 7.3) explicitly developed the capabilities of patients, members of the community or

professionals in other agencies to deliver their organisational strategies. This systemic outlook of social entrepreneurs to developing health system capacity supports ideas of social innovation, proposed by other researchers. (Ziegler, 2010) Consideration of social innovation as expressed by a culture of staff and/or user engagement both within the social enterprise and in its systemic contribution to social impact broadens the literature on theory of social innovation to include the possibility that culture within organisations as well as the development of partnerships with others and has potential for future investigation.

#### **8.4.2 Creating different types of service innovation**

Bringing together ideas of capability and capacity to create social innovation, classifying types of innovation are useful (Bessant and Tidd, 2011). For example, social entrepreneurs interviewed for this study demonstrate different types of social innovation including:

- new products or services which were not there before (eg in Tanzania programmes which empower women were delivered as part of the health care services illustrated by Group B social enterprises in 5.7.2)
- new processes to deliver services (eg linking community champions and specialist services to increase access to health care services in Tanzania),
- shifting market positions – altering the perspective/benefits of existing products or services to target new users without the service changing (eg extending existing primary care services to vulnerable people found in England and Tanzania) or
- evolving paradigms, for example in this research a socially inclusive charging structure was found in social enterprises in England and Tanzania, which allowed new care models to be designed. These were enabled by pooling funding from different funders in England, creating partnerships with other organisations to increase capacity in England and Tanzania, or using different charging systems in Tanzania to redistribute resources from the rich to the poor.

The importance of scale in applying service innovation (Anderson, 2014; Young, 2006) was evident in this research from a health system perspective. In Tanzania policy implementers interviewed were able to demonstrate application of these service innovations at national or regional levels. In England, none of the policy implementers were able to demonstrate national application of innovations, some equating the idea of community with geographically bound, regional ideas. Some policy makers in England expressed frustration at the slow pace of change in 'scaling up' social innovations which contrasted with policy makers in Tanzania who readily referenced the 'scaling up' of social innovations at a national level. It was unclear in this research why such a difference in scale was found in each country. This aspect of social enterprise is important for policy actors to understand. Further insight may lie from more in depth analysis of the interface and dynamic between health system policy and social enterprises organisational strategies.

#### **8.4.3 Managing the tension between social and economic value**

In a health system with a state managed market and where health equity is a policy priority, it can be inferred from the results of this research that policy makers may need to design market mechanisms which favour social over economic value creation in some segments of the health market. In this research, in section 5.8, examples of this approach emerged in the English case study when a policy implementer described how commissioners worked with them to allow time for a new service model to be tested and designed. This focus on health and social outcomes rather than service inputs was also raised by two policy makers interviewed as the preferred commissioning model, believed to result in positive social change. Yet, as described in this research, Monitor are explicitly organisational type agnostic in their management of the health market in England, and the Social Value Act (UK Government, 2012b), which applied to all state funded procurement has had limited impact on the operation of the market. (Lord Young, 2015)

Of importance in the literature is the proposal that this balance between social value and economic value creation, the so called 'shared value creation', (Porter and Kramer, 2011) offers a new way of doing business. This idea has been critiqued by Pirson (2012) whose longitudinal research of three social

enterprises showed that none managed to balance social and economic value creation over time ie either social value or economic value creation became dominant.

The results from this research indicate that, in health systems, the receptiveness of the state to the three core characteristics of social enterprise is important context. As shown in the English case study, the ability of social entrepreneurs to make a case for social enterprise may be a useful political tool for politicians but without complementary and favourable institutional changes within the health system implementation of objectives related to achieving social transformation may be weakened. This was illustrated in this research in section 6.4, when exploring how the policy to allow staff to leave NHS management to form social enterprises was managed, including the way the idea was sold to staff as exciting, innovative and in some way better than being managed within the NHS. (Hewitt, 2006) As explored by Chew and Lyon (2012) a conducive policy environment is important to allow social enterprises to grow. They argue that if commissioners are too risk averse or overly prescriptive in their commissioning processes and output requirements they may create isomorphism in the system, thus limiting innovation. However, as suggested by Pirson (2012), if an organisation is too business like in a competitive environment, social value might be eroded.

Research in commercial companies has shown that to sustain value creation, successful companies demonstrate three capabilities: identifying new business opportunities and experimenting and exploiting them; a balanced use of resources; and achieving coherence between leadership, culture and employee commitment. (Achtenhagen et al., 2013) This emphasis on sustainability was important learning from this research ie I concluded in section 5.2.1, that adoption of business principles alone are not sufficient in themselves to define a social enterprise. The in depth interviews undertaken with policy implementers demonstrate how, in a market of health care services, social entrepreneurs developing strategy need to manage the tension between achieving social impact and commercial activities, supporting observations made by others. (Moizer and Tracey, 2010, Teasdale, 2010) Furthermore, there is some evidence that high social performance can also have an effect on commercial

performance through a halo effect. (Liu et al., 2014) It may be inferred that the performance of social enterprise needs to reflect this tension (Bagnoli and Megali (2011) and is important to social enterprise and policy makers in health systems. The next section discusses how social entrepreneurs might plan to balance this tension.

#### **8.4.4 Application of social enterprise logic to organisational planning**

The results from this research show that there is merit in linking the logic underpinning social enterprise with the planning for social impact at an organisational level. If, as is argued in this research that social enterprises' social purpose, distinguish them from other organisations, then there may be structures, cultures and processes which are internal to social enterprises which need to be considered. This is recognised as an under researched area in institutional logic (Thornton et al, 2012) and a detailed examination of this is beyond the scope of this research. However, organisational strategies do set the framework for the medium term. (DaSilva and Trkman, 2014) As demonstrated in this research, social enterprises develop organisational strategies to achieve their social mission by combining, protecting and rearranging their tangible and intangible assets (dynamic capabilities) to anticipate, shape and take opportunities over time.

Yunus, (2010) suggests that this approach to organisational strategy represents a distinct culture. He argues that social businesses have social business models, which distinguish themselves from other forms of enterprise because they require new value propositions based on social impact, different ways of achieving that value (value constellations) and measuring profit on the basis of social as well as financial impact.

From this research, it can be seen that fluidity of organisational structures and logics allow flexible business models, which are able to respond to and be influenced by the health system environment. An internal organisational dynamic is reflected in the development of business models in the short term, ie 'a specific combination of resources which through transactions generate value for both customers and the organization'. (DaSilva et al, 2013, pg 4). This

research demonstrated that health system design constrained or enabled different types of business models. This interplay between people, culture and context is illustrated in the diagram below which summarises how a social enterprise might build social value into its business planning cycle.

Figure 8.4 the Social Enterprise planning cycle: Building on social value

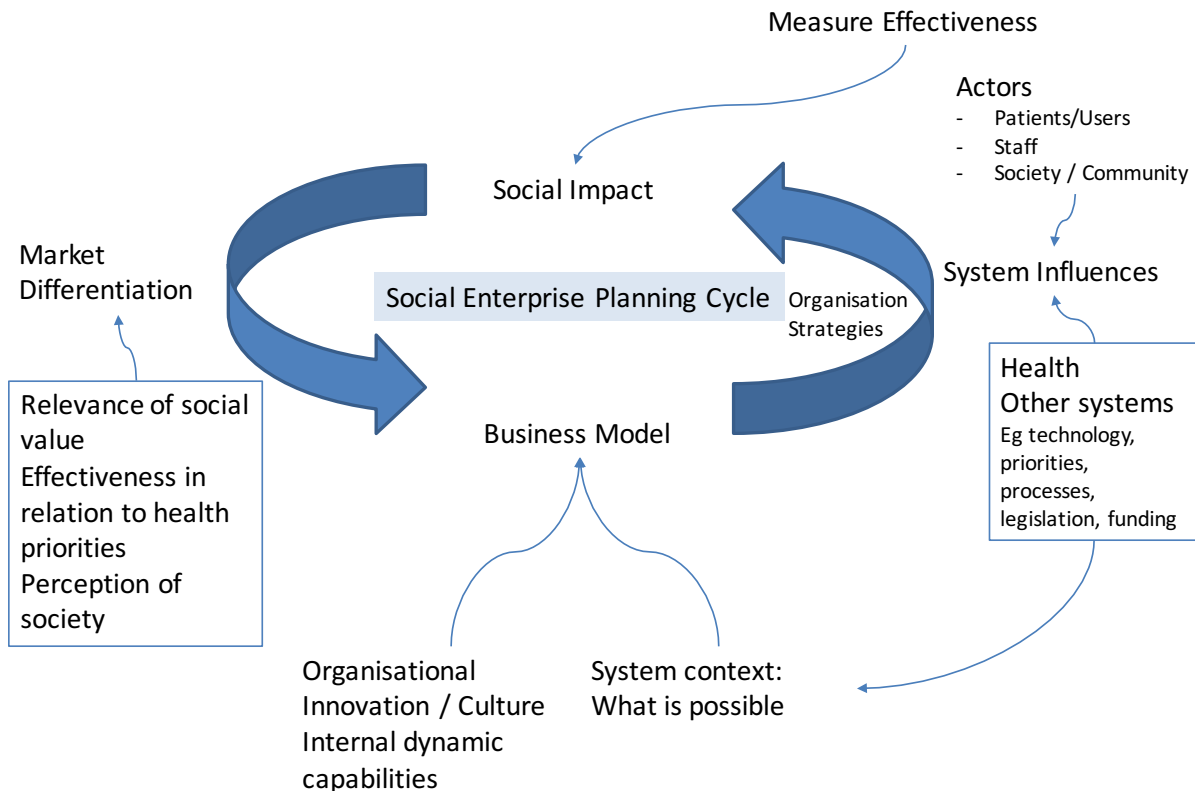


Figure 8.4 illustrates how social entrepreneurs might implement different short term business models to achieve organisational strategies in a planning cycle iteratively over time. External systemic and internal cultural and material factors influence the development of business models. In Tanzania, for example, I showed in section 6.5 how by reflecting the health priorities of policy makers, and the rules / governance of the health system, social entrepreneurs designed different types of business model to those found in England. In this social enterprise planning cycle, business models are a consequence of strategy making but also influence organisational strategies. The latter are guided by the social purpose of the organisation and the effectiveness of the strategy and business models in making a social impact over the short and medium terms. This idea is similar to DaSilva et al's (2013) distinction between strategy,



dynamic capabilities and business models. This model of the planning cycle, places strategy, dynamic capabilities of the organisation and business models within the three underpinning principles of social enterprise, but also reflects the synergy and differentiation between the social mission, social impact, strategy and business model.

Of importance for this research is the finding that health context is important for social entrepreneurs in England and Tanzania. In Chapter 4, I demonstrated how social entrepreneurs in both countries use national health policy priorities to guide their organisational strategies. The national and local context within which social enterprises delivering health care services operate, provides the awareness of problems and legitimacy for entrepreneurial action which are then integrated into organisational strategies and business models. Figure 8.4 captures this by recognising that 'system influences' may go beyond health to include other systems such as housing, employment etc, depending on the way in which social entrepreneurs choose to realise their social purpose.

This research also demonstrates that some social entrepreneurs aimed to change not just their own organisations but also the system within which they work by influencing other policy and organisations' actors. Raghda El Ebrashi (2013) also makes this distinction. It is important because it acknowledges that some social entrepreneurs also become institutional entrepreneurs. This research demonstrates that business model design and social value creation are tightly coupled conceptually but are also influenced by context. In both countries in this study social entrepreneurs who linked social motives and innovativeness to recognised health system challenges eg health equity, capacity, access to services gave visibility and credibility to their actions. Some social entrepreneurs also chose to use their position of influence to advocate for change in the institutional context. Social entrepreneurs from the Holistic type (Group A) of social enterprise in England and the Health care type (Group B) of social enterprise in Tanzania identified in this research were good examples of this institutional advocacy.

Drawing on research from the management literature this tight coupling of mission, method and operationalisation in the design of business models has been found to be an important feature of successful organisations. (Wilson and

Post, 2013) This research complements those of others which finds that in the social entrepreneurial process entrepreneurial commitment and sensitivity to the problem is important, as is the ability for leaders to be able to articulate effectively the social motives and innovativeness of the opportunity through a vision for the future. (Perrini et al. , 2010) Opportunities have more likelihood of moving from opportunity formulation to opportunity exploitation and scalability if leaders are able to identify and create networks within a context where awareness of the problem and level of competition recognises the need for entrepreneurial action. (Perrini et al., 2010)

This research demonstrates that it is not sufficient to measure social value only at the organisational level, but that it also needs to be integrated at the health system level. Actors in the health system need to be able to meaningfully incorporate the idea of social value into decision making, for example, commissioning for delivery of services or demonstrating the social value arising from an organisational strategy or business model. All the policy implementers interviewed for this research were able to make this link between business model, service provision, organisational strategy and social mission.

This research complements other research which brings together the concept of social entrepreneurship with organisational strategy. (Nicholls and Cho, 2006, Mair and Marti, 2006, Di Domenico et al., 2010, Hulgard, 2010) The organisational strategies described in the three groups of social enterprise developed in this study, demonstrate different ideas of how inter-organisational relationships might operate in a state managed health market. Building on Lyon (2013) who identified different types of relationship based on trust and risk (formal/informal, vertical/horizontal), these new ways of combining people, context, the deal and opportunity (Austin et al., 2006) in terms of relationships using cultural and institutional resources (Dacin et al., 2010) can be brought together in the design of organisational strategies and the health care services provided.

#### **8.4.5 Implications of social innovation for development of theory**

Explicit integration of organisational strategy with achieving a social mission can be demonstrated in this research, but there is little research evidence to argue

for the benefits for social business models. Particularly in health system reform, policy actors beliefs in the value of social enterprise in market based health systems need to be tempered with an understanding of the relationship between the opportunities for realising social value and the effect of the systems context on the ability of social entrepreneurs to design new business models. I argue from this research that social enterprises' value is in supporting the achievement of health equity priorities. If these are not policy actors priorities then the value offered by social enterprise is unclear.

Throughout this research, and reflected in the literature in section 2.4.2 there is an implicit belief that a culture of social entrepreneurship exists which allows new business models to be implemented. Advocates of social enterprise, taking on the role of institutional entrepreneurs would strengthen their arguments for change if more evidence could be gathered on what a culture of social entrepreneurship is and how this translates into organisational performance. This links to the values based arguments put forward by policy actors in England about tax payers' rights to influence not only the design of health service markets but also the type of organisation permitted to bid for state funded health service contracts. More clarity is needed about how social enterprises' value is reflected in health systems; where cooperation and partnership allows the development of new care models to meet needs or address particular problems is required. If this can be achieved, then the role and type of competition in a state managed health market might become clearer.

The absence of social enterprise and its underpinning principles in Tanzania was an interesting and unexpected benefit to this study. With the further development of the market in health services Tanzanian policy makers may consider whether they wish to integrate, more explicitly, social value into their design of market mechanisms and build on existing distinctions between 'not for profit' and 'for profit' organisations to try to address the social determinants of health. Drawing on the learning from England, this was viewed as a missed opportunity as advocates for social enterprise failed to 'win over' national public health policy makers.

To my knowledge, application of the social determinants of health framework to the planning processes within organisations with a social mission has not been done before in either management or health systems research. This research shows that this integration is intrinsic to social enterprise as it influences both organisational strategy and business models. The integration is tied closely to the capacity and capability of social entrepreneurs and is contingent on the environment within which they operate. Arguably, this integration within the organisation sets social enterprises apart from other types of organisation such as 'for profit' or state managed organisations. The role of organisations such as social enterprises in contributing to public health priorities on health equity is only beginning to be explored by researchers. This research contributes to this body of knowledge by demonstrating how different business models and organisational strategies integrate the social determinants of health into both their social missions and their strategies.

## **8.5 Research objectives and recommendations**

The three research themes in this research were:

1. the health system and the socio-political-economic context of social enterprise policy development and implementation.
2. the meaning and purpose of social enterprise
3. social change processes in relation to the design and implementation of social enterprise policies in health systems.

This study took an innovative approach to the conceptualisation of health systems using institutional logic. Applying the concept of institutional orders and the change processes found in institutional logic enabled me to take a new approach to researching and operationalising a phenomenon, social enterprise. Further, through my use of institutional logic meta theory, I have been able to advance understanding and conceptualisation of social enterprise in two diverse health systems. There was no fixed definition of the term, however organisations exhibiting a set of core characteristics could be identified across both health systems. Bringing together the health systems and management disciplines provided new insights into how social entrepreneurs' strategies for system change could be researched. This study demonstrated how social

entrepreneurs acted as institutional entrepreneurs within the health system, advocating for changes in the health system to realise their ambitions for social change.

The results of this research will be useful for policy actors in a number of ways. Those with an interest in advocating for the introduction of social enterprise into a health system will be able to assess the readiness of the health system by using the diagnostic tool developed in this research. The proposed core characteristics of social enterprise will help institutional entrepreneurs to focus their arguments and challenge politically driven ideological interpretations of the term in health policies. Focus on demonstrating social impact and how this translates into a more effective health system through organisations strategies for change can also guide the scope of further academic research. Building the evidence base on the way in which social enterprises can improve the health of populations can inform policy development and commissioning strategies.

At the start of this project I had four research objectives. This section assesses how far each of these have been met, concluding with the recommendations from this research.

*Objective 1: enhance understanding of the concept of social enterprise in its ability to effect change within health systems.*

Despite the fluidity in different actors' interpretation of the term social enterprise. I argue that it can be defined. The definition of social enterprise is based upon a combination of an organisations' social objectives, its entrepreneurial outlook in a market and clarity about the way in which its profits are used to further the social mission. This objective was underpinned by three research questions. Each of these has been addressed by this research.

This research demonstrates that social entrepreneurs' implement organisational strategies and business models which aim to achieve social change. In so doing they support achievement of health equity goals. I argue in this research that this is what distinguishes them from other types of organisation delivering health care services. Leaving aside the lack of recognition of the term itself by Tanzanian policy makers, research question 1i is met through this study.

This research shows how the term is politically contested in England, and not recognised at a policy level in Tanzania. However, this research has demonstrated that it does have its own logic and that the concepts used by institutional logic meta-theory can contribute to interpretation of meaning (Research question 1ii). The new institutional order community proposed by Thornton et al (2012) contained many of the features of social enterprise, but not all. I proposed refinements to several institutional logic categories.

Policy makers and commissioners can do more to recognise the complexities around the meaning of social value and how this is represented in health policies designed to address health system reform. Research question 1iii has been met to some extent. This research demonstrates that the relationship between the term, its application by social entrepreneurs and how it may effect change in health systems is complex. This complexity needs to recognise the relationships that need to be built and maintained across sectors over time to achieve social innovation.

*Objective 2: understand how different approaches are shaped and have been adapted to national contexts in order to support policy actors to design and implement social enterprise policies to effect change within health systems.*

This research demonstrated how important health system context is to the implementation of social enterprise policies. In both England and Tanzania, the link was not made by national public health policy leads between achieving health equity goals and the opportunity social enterprises offer in a market based health economy to contribute to realising those goals. Yet, in both countries, social entrepreneurs, through their organisational strategies and business models, responded to and influenced the health system context. Furthermore, through their trading activities some of them demonstrated social innovation.

Despite national contexts presenting challenges which were unique to each country, some social entrepreneurs interviewed for this research believed that they also had a role as institutional entrepreneurs ie influencing the health system context to further their social purpose. Ideas of social innovation

therefore went beyond the organisation to include the health system environment.

This research helps to develop insight into the actions of some policy actors: research questions 2i and 2ii . However, further research to understand when, why and how they act is needed in England and Tanzania in relation to social enterprise. The results presented in this research contribute to the development of knowledge in this area and will provide a foundation for future researchers interested in developing understanding on the cognitive spread of ideas in health systems.

The research demonstrated the relationship between social enterprise organisational strategies and the health field. Research question 2iii was therefore met. A new conceptualisation of business planning demonstrated this relationship between social impact, organisational capabilities and strategies with health system context.

*Objective 3: compare the key contextual influences eg socio-political and economic factors on the design and implementation of social enterprise strategies to effect change within different health systems.*

This research demonstrated how the two disciplines of management and health systems can be viewed as complementary. The approaches of each, described in this research can be brought together to articulate a new conceptualisation of health systems (research question 3i) and was presented in the proposed health systems framework.

Research questions 3ii and 3iii were also met. The scope, structure and culture of a health field does influence the design and implementation of social enterprise policies. Despite England and Tanzania having significantly different resource contexts, a common core set of characteristics in the definition of social enterprise could be identified. However, the socio-political context resulted in different approaches to social enterprise policy making at a national level. In England the policy to allow NHS staff to leave direct management by the NHS was not found in Tanzania. This policy context in England generated considerable debate about the idea of social enterprise and it became a politically contested term. In Tanzania, whilst the distinction between 'not for

profit' and 'for profit' organisations has been embedded in national policy since the 1960s, the idea of social enterprise was found in policy implementers and influencers but not in policy makers. There was therefore, an important socio-political and historical context to the way in which the concept of social enterprise was expressed in each health system.

Related to this, conceptualising the health system in relation to the breadth of a social entrepreneur's social purpose demonstrated a close relationship between social enterprises' social purpose and the social determinants of health. This relationship allowed a new grouping of three different types of social enterprise to be described: Holistic, Health care and Lifestyle. Each grouping, which contained examples of social enterprises from each country, illustrated what social change each type of social enterprise aimed to achieve.

The breadth of health system change was presented in the diagnostic tool. Within each of the three domains, various dimensions were identified which influenced the design and implementation of social enterprise strategies.

*Objective 4: develop recommendations for policy makers, and other actors, for improving the design and implementation of social enterprise strategies to effect change within health systems.*

A generic set of recommendations can be made for all policy actors with an interest in furthering health policies which support social enterprise development in market based health systems. These are:

1. The underpinning logic of social enterprise needs to be clearly defined and its purpose and performance in support of health policy priorities understood by policy actors
2. Resources to support structural and cultural change at all levels in the health system need to be available to achieve a shift in the logic of a health system
3. Freedom to associate, including meaningful democratic mechanisms to allow freedom of expression on health policy need to be present
4. The processes of change will be influenced by previous policy decisions and societal expectations on the role and scope of a national health



system and need to be considered by policy actors advocating for change.

5. The capacity of the health system and the capabilities of actors will enable or limit implementation of key aspects of the market in relation to social enterprises.

Further recommendations (research question 4i) are made for the different policy actors interviewed for this research and presented in Annex E.

In reference to research question 4ii, policy makers, social entrepreneurs and policy influencers are hampered by the lack of evidence on the effectiveness of social enterprise, firstly because there has been a lack of clarity about the term's meaning, but also because the dynamic between health care organisations with a social purpose and health systems has, historically not been a focus of research. This research suggests that institutional logic does offer a new mode of enquiry for health systems research, but it is not the only approach. Its limitations suggest that it complements but does not replace other established research approaches (research question 4iii).

## **8.6 Conclusions**

This has been a complex research project. I have drawn on my experience as a social enterprise practitioner in England throughout this project, but also been open to new ideas and interpretations of observations. The inter-disciplinary approach has also been a challenge to resolve. Whilst as a senior manager I am used to working across disciplines, this was different in academia. My hope is that bringing together the practitioner and academic perspectives across disciplines becomes a more accepted approach to research in the future.

The diagnostic tool is offered as a starting point. Further development of the tool at project, organisational and system levels will help understanding of both the breadth and complexity of change required to implement social enterprise in different national contexts. Exploring this cross-cultural dimension of health system research presents an exciting opportunity for the future. It offers opportunities to introduce greater evidence to inform health system change but

also to answer other research questions associated with evaluating health system reforms in different contexts.

Interestingly, an unexpected finding from this study is how a common core logic could be identified to the meaning of social enterprise across both countries.

The resource context influenced the way in which social entrepreneurs designed their organisational strategies and business models to address health priorities, but not the underpinning core characteristics of social enterprise.

The well documented broader health system reform policies which involve implementation of a market in health services do not usually consider how the logic of these reforms are expressed in different cultural contexts. This under researched area can build on the strengths of institutional logic meta-theory to integrate structural and cultural analysis of change over time. In this sense institutional logic could offer a common language for practitioners and policy makers to frame the cognitive aspects of health system reforms in the future.

## List of References

1946. National Health Service Act.
2003. Health and Social Care (Community Health and Standards) Act.
2004. The Companies (Audit, Investigations and Community Enterprise) Act (c 27).
- ACHTENHAGEN, L., MELIN, L. & NALDI, L. 2013. Dynamics of Business Models – Strategizing, Critical Capabilities and Activities for Sustained Value Creation. *Long Range Planning*, 46, 427-442.
- ADAM, T. & SAVIGNY, D. D. 2012. Systems thinking for strengthening health systems in LMICs: need for a paradigm shift. *Health Policy and Planning*, 27.
- ADDICOTT, R. 2011. Social enterprise in health care. Promoting organisational autonomy and staff engagement. London: The Kings Fund.
- ALTER, K. 2005. Social Enterprise Definition. Available: <http://www.4lenses.org/setypology>.
- ALTER, K. J. 2010. The European Court and Civil Society: Litigation, Mobilization and Governance. *Perspectives on Politics*, 8, 698-699.
- ANDERSON, O., MERRIFIELD, S., PATEL, A., TAYLOR, E., TUFFIN, A. & YOUNG, J. 2011. Establishing social enterprises under the Right to Request Programme. National Audit Office.
- ANDERSON, S. G. 2014. *New strategies for social innovation. Market-based approaches for assisting the poor*, Columbia University Press.
- ARCHEMBAULT, E. 2009. The Third Sector in Europe: Does it Exhibit a Converging Movement. *The Third Sector and Sustainable Social Change: New Frontiers of Research*. Barcelona, Spain: EMES Conference Selected Paper Series.
- ARORA, S., CHARLESWORTH, A., KELLY, E. & STOYE, G. 2013. Public payment and private provision. Research report Nuffield Trust and Institute for Fiscal Studies.
- ATKINSON, S., MEDEIROSA, R. L. R., HENRIQUE, P., OLIVEIRAA, L. & ALMEIDAA, R. D. D. 2000. Going down to the local: incorporating social organisation and political culture into assessments of decentralised health care. *Social Science & Medicine*, 51.
- ATUN, R. 2012. Health systems, systems thinking and innovation. *Health Policy and Planning*, 27, iv4-iv8.
- AUSTIN, J., STEVENSON, H. & WEI-SKILLERN, J. 2006. Social and commercial entrepreneurship: Same, different, or both? . *Entrepreneurship Theory and Practice*, 30, 1-22.
- BACQ, S. & JANSSEN, F. 2011. The multiple faces of social entrepreneurship: A review of definitional issues based on geographical and thematic criteria. *Entrepreneurship & Regional Development*, 23, 373-403.
- BAGNOLI, L. & MEGALI, C. 2011. Measuring performance in Social Enterprises. *Nonprofit and Voluntary Sector Quarterly*, 40, 149-165.
- BATTILANA, J. 2006. Agency and Institutions: The Enabling Role of Individuals' Social Position. *Organization*, 13.

- BATTILANA, J. & LEE, M. 2014. Advancing Research on Hybrid Organizing – Insights from the Study of Social Enterprises. *The Academy of Management Annals*, 8, 397-441.
- BENNETT, A. & ELMAN, C. 2006. Complex Causal Relations and Case Study Methods: The Example of Path Dependence. *Political Analysis*, 14, 250-267.
- BESSANT, J. & TIDD, J. 2011. *Innovation and Entrepreneurship*, John Wiley & Sons.
- BEVAN, G. & ROBINSON, R. 2005. The Interplay between Economic and Political Logics: Path Dependency in Health Care in England. *Journal of Health Politics, Policy and Law*, 30.
- BOSCHEE, J. 2006. Social Entrepreneurship: The Promise and the Perils. In: NICHOLLS, A. (ed.) *Social Entrepreneurship. New Models of Sustainable Social Change*. Oxford: Oxford University Press.
- BOSSERT, T. J. 2012. Health Systems. Commentary. *Health Policy and Planning*, 27, 8-10.
- BOURDIEU, P. 1977. *Outline of Theory of Practice*, Cambridge, MA, Cambridge University Press.
- BRETTINGHAM, M. 2005. Local control over foundation trusts is “rhetoric”. *British Medical Journal*, 330, 1408.
- BRITISH COUNCIL. 2016. Available: <https://www.britishcouncil.org/society/social-enterprise>.
- BUREAU OF POLICY AND STRATEGY MINISTRY OF PUBLIC HEALTH 2009. Health Policy in Thailand.
- BUSE, K., MAYS, N. & WALT, G. 2012. *Making Health Policy* Open University Press.
- CABINET OFFICE 2009. A Guide to Social Return on Investment.
- CABINET OFFICE. 2014. *Right to Request Right to Provide* [Online]. Available: <http://mutuals.cabinetoffice.gov.uk/health/Rights> [Accessed 2nd April 2016].
- CARSON, D. 2000. Raising Standards for Patients. New Partnerships in Out of Hours Care. An Independent Review of GP Out of Hours Services in England. In: DEPARTMENT OF HEALTH (ed.). London.
- CHARMAZ, K, 2014. Grounded Theory in Global Perspective: Reviews by International Researchers. *Qualitative Inquiry*, 20(9) PG 1074-1084
- CHELL, E., NICOLOPOULOU, K. & KARATAŞ-ÖZKAN, M. 2010. Social entrepreneurship and enterprise: International and innovation perspectives. *Entrepreneurship and Regional Development*, 22, 485-493.
- CHEW, C. & LYON, F. 2012. Innovation and social enterprise activity in third sector organisations. *Third Sector Research Centre*.
- CHRICHTON, J. 2012. Changing fortunes: analysis of fluctuating policy space for family planning in Kenya. 2012 In: GILSON, L. (ed.) *Health Policy and Systems Research A Methodology Reader*: WHO.
- CHRISTIAN SOCIAL SERVICES COMMISSION. undated. *Mission* [Online]. Available: <http://www.cssc.or.tz/mission> [Accessed 8/1/16].
- COHEN, L. DUBERLEY, J. & MUSSON, G. 2009. Work - Life Balance?: An Autoethnographic Exploration of Everyday Home - Work Dynamics *Journal of Management Inquiry*; Thousand Oaks 18.3 Sep: 229.

- COWI 2007. Local Government Reform Program - Embedding Decentralisation by Devolution Across Government. Assessment Report for the Ministry of Health and Social Welfare.
- CRICHTON, J. 2008. Changing fortunes: analysis of fluctuating policy space for family planning in Kenya. *Health Policy and Planning*, 23, 339-350.
- CUNLIFFE, A. L. 2011. Crafting Qualitative Research: Morgan and Smircich 30 Years On. *Organisational Research Methods*, September.
- DACIN, M. T., GOODSTEIN, J. & SCOTT, W. R. 2002. Institutional Theory and Institutional Change: Introduction to the Special Research Forum. *Academy of Management Journal*, 45, 45-57.
- DACIN, P. A., DACIN, T. M. & MATEAR, M. 2010. Social Entrepreneurship: Why We Don't Need a New Theory and How We Move Forward From Here. *Academy of Management Perspectives*, 24, 37-57.
- DASILVA, C. M. & TRKMAN, P. 2014. Business Model: What It Is and What It Is Not. *Long Range Planning*, 47, 379-389.
- DE SAVIGNY, D. & ADAM, T. 2009. Systems Thinking for Health Systems Strengthening. In: SAVIGNY, D. D. & ADAM, T. (eds.). Alliance for Health Policy and Systems Research World Health Organisation.
- DEFOURNY, J. & NYSSSENS, M. 2006. Defining social enterprise. In: NYSSSENS, M. (ed.) *Social Enterprise. At the crossroads of market, public policies and civil society*. Abingdon: Routledge.
- DEFOURNY, J. & NYSSSENS, M. 2008. Social Enterprise in Europe: Recent Trends and Developments.
- DEPARTMENT FOR BUSINESS INNOVATIONS & SKILLS. 2011. *Guide to mutual ownership models* [Online]. Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/31678/11-1401-guide-mutual-ownership-models.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/31678/11-1401-guide-mutual-ownership-models.pdf) [Accessed 8/1/16].
- DEPARTMENT OF HEALTH 2000. The NHS Plan. A Plan for Investment. A Plan for Reform. In: DEPARTMENT OF HEALTH (ed.). London: HMSO.
- DEPARTMENT OF HEALTH 2005. A Short Guide to NHS Foundation Trusts. In: DEPARTMENT OF HEALTH (ed.).
- DEPARTMENT OF HEALTH 2006. Our Health Our Care Our Say: Making it happen. In: DEPARTMENT OF HEALTH (ed.). London: HMSO.
- DEPARTMENT OF HEALTH 2008. High Quality Care For All. NHS Next Stage Review. Final Report. London.
- DEPARTMENT OF HEALTH 2010. Equity and Excellence. Liberating the NHS. London: HMSO.
- DEPARTMENT OF TRADE AND INDUSTRY 2002. Social enterprise..... A strategy for success.
- DI DOMENICO, M., HAUGH, H. & TRACEY, P. 2010. Social Bricolage: Theorizing Social Value Creation in Social Enterprises. *Entrepreneurship Theory and Practice*, 34, 681-703.
- DIMAGGIO, P. J. 1988. Interest and agency in institutional theory. In: ZUCKER, L. G. (ed.) *Institutional patterns and organizations: Culture and environment*. Cambridge, MA: Ballinger.
- DIMAGGIO, P. J. & POWELL, W. W. 1983. The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organisational Fields. *American Sociological Review*, 48, 147-160.

- DIRECTORATE OF COMMISSIONING AND SYSTEM MANAGEMENT 2008. Social Enterprise – making a difference. A guide to Right to Request. *In: COALITION, S. E. U. S. E. (ed.)*.
- DOHERTY, B., HAUGH, H. & LYON, F. 2014. Social enterprises as Hybrid Organisations: A Review and Research Agenda. *International Journal of Management Reviews*, 16, 417-436.
- DORADO, S. 2005. Institutional Entrepreneurship, Partaking, and Convening. *Organization Studies*, 26.
- DRAYTON, B. 2011. *You Gotta Be a Changemaker* [Online]. John Converse Townsend. Available: [www.ashoka.org/story/bill-drayton-you-gotta-be-changemaker](http://www.ashoka.org/story/bill-drayton-you-gotta-be-changemaker).
- EASTERBY – SMITH, M., THORPE, R. & JACKSON, P. R. 2008. *Management Research*.
- EASTERBY - SMITH, M., THORPE, R. & JACKSON, P. R. 2015. Management and Business Research
- EBRAHIM, A., BATTILANA, J. & MAIR, J. 2014. The governance of social enterprises: Mission drift and accountability challenges in hybrid organizations. *Research in Organisational Behaviour*, 34, 81-100.
- EISENHARDT, K. M. & GRAEBNER, M. E. 2007. Theory Building from Cases: Opportunities and Challenges. *Academy of Management Journal*, 50, 25-32.
- ELKINGTON, J. 1994. Towards the Sustainable Corporation: Win-Win-Win Business Strategies for Sustainable Development. *California Management Review*, 36, 90-100.
- ELLINS, J. & HAM, C. 2009. NHS Mutual Engaging staff and aligning incentives to achieve higher levels of performance London: The Nuffield Trust.
- ENTHOVEN, A. C. 2004. Market Forces and Efficient Health Care Systems. *Health Affairs*, 23, 25-27.
- EUROPEAN UNION. *Definition of social enterprise* [Online]. Available: [http://ec.europa.eu/growth/sectors/social-economy/enterprises/index\\_en.htm](http://ec.europa.eu/growth/sectors/social-economy/enterprises/index_en.htm) [Accessed 18/1/2016].
- EVANS, R. G. 2005. Fellow Travelers on a Contested Path: Power, Purpose, and the Evolution of European Health Care Systems. *Journal of Health Politics, Policy and Law*, 30.
- FERLIE, E., FITZGERALD, L., WOOD, M. & HAWKINS, C. 2005. The (Non) Spread of Innovations: The Mediating Role of Professionals. *Academy of Management Journal*, 48, 117-32.
- FISCHER, F. 2003. *Reframing public policy: discursive politics and deliberative practices*. , Oxford, Oxford University Press.
- FLICK, U (2009) *An Introduction to Qualitative Research*, 4<sup>th</sup> edn. London: Sage
- FLYVBJERG, B. 2006. Five Misunderstandings About Case-Study Research. *Qualitative Enquiry*, 12.
- FRITH, L. 2014. Social enterprises, health-care provision and ethical capital. *Social Enterprise Journal*, 10, 105-120.
- GARTON, S. & COPLAND, S. 'I like this interview; I get cakes and cats!': the effect of prior relationships on interview talk *Qualitative Research* vol. 10(5) 533–551
- GATINEAU, M., HANCOCK, C., HOLMAN, N., OUTHWAITE, H., OLDRIDGE, L., CHRISTIE, A. & ELLS, L. 2014. Adult Obesity and Type 2 Diabetes. *In: PUBLIC HEALTH ENGLAND (ed.)*. London.

- GHANA MINISTRY OF HEALTH 2007. National Health Policy. Creating Wealth through Health. Accra.
- GILSON, L. (ed.) 2012. *Health Policy and Systems Research. A Methodology Reader*. WHO.
- GILSON, L. & RAPHAELY, N. 2008. The terrain of health policy analysis in low and middle income countries: a review of published literature 1994–2007. *Health Policy and Planning*, 23, 294-307.
- GILSON, L., SCHNEIDER, H. & ORGILL, M. 2014. Practice and power: a review and interpretive synthesis focused on the exercise of discretionary power in policy implementation by front-line providers and managers. *Health Policy and Planning*, 29, iii51-iii69.
- GLASER, B. G. & STRAUSS, A. L. 1967. The discovery of grounded theory: Strategies for Qualitative Research. New York: Aldine.
- GOVERNMENT OF UGANDA 2010. The second national health policy. Promoting People's Health to Enhance Socio-economic Development.
- GREENWOOD, R. & SUDDABY, R. 2006. Institutional Entrepreneurship in Mature Fields: The Big Five Accounting Firms. *Academy of Management Journal*, 49, 27-48.
- GRENIER, P. 2006. Social Entrepreneurship: Agency in a Globalizing World. In: NICHOLLS, A. (ed.) *Social Entrepreneurship. New Models of Sustainable Social Change*. Oxford: Oxford University Press.
- GRIECO, C., MICHELINI, L. & IASEVOLI, G. 2015. Measuring Value Creation in Social Enterprises: A Cluster Analysis of Social Impact Assessment Models. *Nonprofit and Voluntary Sector Quarterly*, 44, 1173-1193.
- GUMMESSON, E. 2000. Qualitative methods in management research. Sage.
- HALL, K., MILLER, R. & MILLAR, R. 2012. Jumped or pushed: What motivates NHS staff to set up a social enterprise? *Social Enterprise Journal*, 8, 49-62.
- HAM, C. 2013. Regulating the NHS market in England The government must make its intentions clear as it rewrites the regulations on competition. *British Medical Journal*, 346:f1608.
- HAM, C. 2014. Improving NHS Care by Engaging Staff and Devolving Decision-Making Report of the Review of Staff Engagement and Empowerment in the NHS.
- HARDING, R. & HARDING, D. 2008. Social Entrepreneurship in the UK Delta Economics.
- HARDY, C. & MAGUIRE, S. 2008. Institutional Entrepreneurship. In: GREENWOOD, R., OLIVER, C., SUDDABY, R. & SAHLIN-ANDERSEN, K. (eds.) *The Sage Handbook of Organizational Institutionalism*. Sage.
- HARRISON, S. & MCDONALD, R. 2008. The Politics of Health Care In Britain. Sage.
- HAYNES, K. 2012 Reflexivity in Qualitative Research. In: SYMON, G. & CASSELL, C. (eds.) *Qualitative Organisational Research: core methods and current challenges*. Sage, pg 72-89
- HEALTH AND SOCIAL CARE INFORMATION CENTRE 2014. NHS Immunisation Statistics England 2013-2014
- HEINRICH, V. F. & MALENA, C. 2008. How to assess the state of Civil Society around the world? A description and Preliminary Review of the CIVICUS Civil Society Index's Conceptual Framework and Research Methodology. In: FIORAMONTI, V. F. H. A. L. (ed.) *Civicus Global Survey of the State*

- of Civil Society, Volume II: Comparative Perspectives*. Bloomfield, CT: Kumarian Press.
- HELDERMAN, J.-K., SCHUT, F. T., GRINTEN, T. E. D. V. D. & VEN, W. P. M. M. V. D. 2005. Market-Oriented Health Care Reforms and Policy Learning in the Netherlands. *Journal of Health Politics, Policy and Law*, 30.
- HENDRIKSA, A.-M., HABRAKEN, J., JANSENA, M. W. J., GUBBELSE, J. S., VRIESB, N. K. D., OERSC, H. V., MICHIEG, S., ATKINSH, L. & KREMERSE, S. P. J. 2014. 'Are we there yet?' – Operationalizing the concept of Integrated Public Health Policies. *Health Policy*, 114, 174-182.
- HEWITT, P. 2006. Social Enterprise in Primary and Community Care *In: SOCIAL ENTERPRISE COALITION* (ed.).
- HOFFMAN, S. J., RØTTINGEN, J.-A., BENNETT, S., LAVIS, J. N., EDGE, J. S. & FRENK, J. 2012. A Review of Conceptual Barriers and Opportunities facing Health Systems Research to inform a Strategy from the World Health Organization. *In: ALLIANCE FOR HEALTH POLICY AND SYSTEMS RESEARCH* (ed.). WHO.
- HSIEH, H. F. & SHANNON, S. E. (2005) Three approaches to qualitative content analysis, *Qualitative Health Research*, 15 (9): 1277-88
- HULGARD, L. 2010. Discourses of Social Entrepreneurship - Variations of the Same Theme? , WP 10/01.
- ILLMAN, J. 2014. SERCO to withdraw from UK clinical services market. *Health Service Journal*.
- INTERNATIONAL CENTRE FOR RESEARCH AND INFORMATION ON THE PUBLIC, S. A. C. E. 2007. The Social Economy in the Economic Union. *In: COMMITTEE, E. E. A. S.* (ed.).
- INTERNATIONAL DIABETES FEDERATION AFRICA. 2014. *Tanzania Country Report* [Online]. Available: <http://www.idf.org/membership/afr/tanzania> [Accessed 15/1/2016].
- JIAO, H. 2011. A conceptual model for social entrepreneurship directed toward social impact on society. *Social Enterprise Journal*, 7, 130-149.
- KENYA MINISTRY OF MEDICAL SERVICES, M. O. P. H. A. S. undated. Kenya Health Policy 2012 – 2030.
- KERLIN, J. 2013. Defining Social Enterprise Across Different Contexts: A conceptual framework based on institutional factors. *Non profit and voluntary sector quarterly*, 42.
- KERLIN, J. A. 2010. A Comparative Analysis of the Global Emergence of Social Enterprise. *Voluntas*, 21, 162-179.
- KILIMANJARO CHRISTIAN MEDICAL CENTRE 2015. Five Year Rolling Strategic Plan 2015 - 2020. Kilimanjaro, Tanzania.
- KISTRUCK, G. M. & BEAMISH, P. W. 2010. The Interplay of Form, Structure, and Embeddedness in Social Intrapreneurship. *Entrepreneurship: Theory and practice*, 34, 735-761.
- KNIGHT, M. 2014. Saving Lives Improving Mothers' Care. Executive Summary. *In: KNIGHT, M., KENYON, S., BOCKLEHURST, P., NEILSON, J., SHAKESPEARE, J. & KURINCZUK, J. J.* (eds.) *Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012*. National Perinatal Epidemiology Unit.



- LAFOND, A. K., BROWN, L. & MACINTYRE, K. 2002. Mapping Capacity in the Health Sector: A Conceptual Framework. *International Journal of Health Planning and Management*, 17, 3-22.
- LAING AND BUISSON 2011. Laing's Healthcare 20. In: LAING AND BUISSON (ed.).
- LAMPEL J, B. A., JHA P. 2012. The Employee Ownership Advantage. Benefits and Consequences. *Cass Business School, Department for Business Innovation and Skills* [Online]. Available: [www.bis.gov.uk](http://www.bis.gov.uk).
- LAWRENCE, T. B. 2008. Power, Institutions and Organisations. In: GREENWOOD, R., OLIVER, C., SUDDABY, R. & SAHLIN-ANDERSSON, K. (eds.) *The SAGE Handbook of Organizational Institutionalism*. SAGE Publications.
- LAWLER, S. (2002) Narrative in Social Research. In: T. May (ed). *Qualitative Research in Action*. London: Sage, pg 242-58
- LEA, R. & MAYO, E. 2002. The Mutual Health Service. How to decentralise the NHS Institute of Directors and New Economics Foundation.
- LEIGHTON, D. & WOOD, C. 2010. Measuring Social Value: the gap between policy and practice. DEMOS.
- LEVANDER, U. 2010. Social Enterprise: Implications of Emerging Institutionalized Constructions. *Journal of Social Entrepreneurship*, 1:2, 213-230.
- LEWIS, R., HUNT, P. & CARSON, D. 2006. Social Enterprise and Community-based Care. Is there a future for mutually owned organisations in community and primary care? In: KINGS FUND (ed.) *Working Paper*. London.
- LITERACY TRUST. 2011. *Adult literacy* [Online]. Available: [http://www.literacytrust.org.uk/adult\\_literacy/illiterate\\_adults\\_in\\_england](http://www.literacytrust.org.uk/adult_literacy/illiterate_adults_in_england) [Accessed 2nd April 2016].
- LIU, G., TAKEDA, S. & KO, W.-W. 2014. Strategic Orientation and Social Enterprise Performance. *Non profit and voluntary sector quarterly*, 43.
- LORD YOUNG 2015. Social Value Act Review. In: CABINET OFFICE (ed.).
- LOUNSBURY, M. 2007. A TALE OF TWO CITIES: COMPETING LOGICS AND PRACTICE VARIATION IN THE PROFESSIONALIZING OF MUTUAL FUNDS. *Academy of Management Journal*, 50, 289-307.
- LOUNSBURY, M., VENTRESCA, M. & HIRSCH, P. M. 2003. Social movements, field frames and industry emergence: a cultural-political perspective on US recycling. *Socioeconomic Review*, 1, 71-104.
- LYON, F. 2013. Social innovation, co-operation and competition: inter-organisational relations for social enterprises in the delivery of public services. In: THIRD SECTOR RESEARCH CENTRE (ed.) *Working Paper 114*.
- MACMILLAN & NHS. 2016. *Transforming Cancer and End of Life Care Programme* [Online]. Available: <http://www.staffordshirecancerandcol.com> [Accessed 30/1/16].
- MAIR, J. & MARTI, I. 2006. Social entrepreneurship research: A source of explanation, prediction, and delight. *Journal of World Business*, 41, 36-44.
- MARKS, L. & HUNTER, D. J. 2007. Social Enterprises and the NHS. Changing patterns of Ownership and Accountability. London: Unison.

- MARQUIS, C. & LOUNSBURY, M. 2007. VIVE LA RESISTANCE: COMPETING LOGICS AND THE CONSOLIDATION OF U.S. COMMUNITY BANKING. *Academy of Management Journal*, 50, 799-820.
- MASON, C., BARRAKET, J., FRIEL, S., ROURKE, K. O. & STENTA, C.-P. 2015. Social innovation for the promotion of health equity. *Health Promotion International*, 30.
- MAUDE, F. & LAMB, N. 2014. Mutuals in Health: Pathfinder Programme. In: CABINET OFFICE AND DEPARTMENT OF HEALTH (ed.).
- MAYO, E. & MOORE, H. 2001. *The Mutual State. How local communities can run public services*, New Economics Foundation.
- MCADAM, D. & SCOTT, W. R. 2005. Organisations and Movements. . In: DAVIS, G. F., MCADAM, D., SCOTT, W. R. & ZALD., M. N. (eds.) *Social Movements and Organization Theory*. Cambridge University Press.
- MCINTYRE, D. & KLUGMAN, B. 2003. The Human Face of Decentralisation and Integration of Health Services: Experience from South Africa. *Reproductive Health Matters*, 11, 108-119.
- MEYSKENS, M., ROBB-POST, C., STAMP, J. A., CARSRUD, A. L. & REYNOLDS, P. D. 2010. Social Ventures from a Resource-Based Perspective: An Exploratory Study Assessing Global Ashoka Fellows. *Entrepreneurship Theory and Practice*, 661-680.
- MILBURN, A., BENNETT, D., EDWARDS, N., MCLELLAN, A., NAYLOR, R., TAYLOR, T., BELL, S., FENWICK, L., PEDDER, A. & THORNE, T. 2014. 'An irreversible shift in power was long overdue': 10 years of FTs. *Health Service Journal*.
- MILLAR, R. 2012. Social enterprise in health organisation and management: hybridity or homogeneity? *Journal of Health Organization and Management*, 26, 143-8.
- MILLAR, R. & HALL, K. 2013. Social Return on Investment (SROI) and Performance Measurement. *Public Management Review*, 15, 923-941.
- MILLER, R. & MILLAR, R. 2011. Social enterprise spin-outs from the English health service: a Right to Request but was anyone listening? In: THIRD SECTOR RESEARCH CENTRE (ed.).
- MILLER, T. L., GRIMES, M. G., MCMULLEN, J. S. & VOGUS, T. I. 2012. Venturing for others with heart and head: how compassion encourages social entrepreneurship. *Academy of Management Review*, 37, 616-640.
- MILLS, A. 2012. Health policy and systems research: defining the terrain; identifying the methods. *Health Policy and Planning*, 27.
- MILLS, C. & BROPHY, C. 2011. Community Health Services: Made Mutual. In: MUTUO (ed.). Boreham Wood.
- MINDELL, J. S., REYNOLDS, L., COHEN, D. L. & MCKEE, M. 2012. All in this together: the corporate capture of public health. The UK government is increasingly handing over its role of health policy maker to private corporations. *British Medical Journal*, 345:e8082.
- MINISTRY OF FOREIGN AFFAIRS OF DENMARK 2014. Denmark – Tanzania: Country Policy Paper 2014 – 2018. Ministry of Foreign Affairs of Denmark.
- MINISTRY OF HEALTH AND SOCIAL WELFARE undated. Health Sector Strategic Plan 111 June 2009 - June 2015. United Republic of Tanzania.

- MINTROM, M. & NORMAN, P. 2009. Policy entrepreneurship and policy change. *Policy Studies Journal*, 37, 649-667.
- MINTZBERG, H. 2012. Managing the myths of health care. *World Hospitals and Health Services*, 48.
- MINTZBERG, H. & AZEVEDO, G. 2012. Fostering "Why not?" social initiatives – beyond business and governments. *Development in Practice*, 22.
- MOIZER, J. & TRACEY, P. 2010. Strategy Making in Social Enterprise: The Role of Resource Allocation and Its Effects on Organizational Sustainability. *Systems Research and Behavioral Science*, 27, 252-266.
- MONITOR 2013. The Fair Playing Field Review. A fair playing field for the benefit of NHS patients. 4 Matthew Parker Street, London SW1H 9NP: Monitor.
- MONITOR 2014. Reforming the payment system for NHS services: supporting the five year forward view.
- MONITOR. 2015. *Role of Monitor* [Online]. Available: <https://www.gov.uk/government/organisations/monitor/about> [Accessed 29/1/16].
- MOONEY, H. 2006. Social enterprise. Good intentions could be disguising a big, bad threat. *Health Serv J*, 116, 14-5.
- MORI, N. & FULGENCE, K. 2009. SOCIAL ENTREPRENEURSHIP IN TANZANIA: ASSESSMENT OF ENABLING ENVIRONMENT. *In: EMES (ed.) 2nd EMES International Conference on Social Enterprise*. Trento (Italy).
- MOSQUERA, M., ZAPATA, Y., LEE, K., ARANGO, C. & VARELA, A. 2001. Strengthening user participation through health sector reform in Columbia: a study of institutional change and social representation. *health Policy and Planning*, 16, 52-60.
- MULGAN, G., TUCKER, S., ALI, R. & SANDERS, B. 2007. Social Innovation: What It Is, Why It Matters and How It Can Be Accelerated. Working Paper. . *In: SCHOOL, S. B. (ed.)*. Oxford University, Oxford.
- NATIONAL INSTITUTE OF CLINICAL EXCELLENCE. 2016. *What we do* [Online]. Available: <https://www.nice.org.uk/about/what-we-do> [Accessed 30/1/16].
- NEW ECONOMICS FOUNDATION 2011. Small Slices of a Bigger Pie- Attribution in SROI. 2011, New Philanthropy Capital: Social Return on Investment- Position Paper. .
- NEWSWORKS. 2016a. *The Daily Mail* [Online]. Available: <http://www.newsworks.org.uk/Daily-Mail> [Accessed 16/1/16].
- NEWSWORKS. 2016b. *Daily Telegraph* [Online]. Available: <http://www.newsworks.org.uk/The-Daily-Telegraph> [Accessed 16/1/16].
- NEWSWORKS. 2016c. *The Guardian* [Online]. Available: <http://www.newsworks.org.uk/The-Guardian> [Accessed 31/1/16]
- NHS BUSINESS SERVICES AUTHORITY. 2015. *Independant Provider Guide to NHS Pensions* [Online]. Available: [http://www.nhsbsa.nhs.uk/Documents/Pensions/IP\\_Guide-20150407-\(V5\).pdf](http://www.nhsbsa.nhs.uk/Documents/Pensions/IP_Guide-20150407-(V5).pdf) [Accessed 16/1/16].
- NHS ENGLAND. 2012. *The Mandate. A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015*. 2012 [Online]. Available: [www.dh.gsi.gov.uk/mandate](http://www.dh.gsi.gov.uk/mandate) [Accessed 30/1/16].

- NHS ENGLAND. 2014a. *Five Year Forward View* [Online]. NHS England. Available: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> [Accessed 07/02/2016].
- NHS ENGLAND. 2014b. *NHS England's Actions for End of Life Care* [Online]. Available: <https://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf>.
- NHS ENGLAND 2015. *NHS England Annual Report and Accounts 2014-2015*. London.
- NHS ENGLAND. 2016a. *NHS Constitution* [Online]. Available: <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/> [Accessed 2nd April 2016].
- NHS ENGLAND. 2016b. *Our Vision* [Online]. Available: <https://www.england.nhs.uk/about/our-vision-and-purpose/>
- NICHOLLS, A. 2010. The Legitimacy of Social Entrepreneurship: Reflexive Isomorphism in a Pre-Paradigmatic Field. *Entrepreneurship Theory and Practice*, 611-633.
- NICHOLLS, A. & CHO, A. H. 2006. Social Entrepreneurship: The Structuration of a Field. In: NICHOLLS, A. (ed.) *Social Entrepreneurship. New Models of Sustainable Social Change*. Oxford: Oxford University Press.
- OFFICE FOR NATIONAL STATISTICS. 2013. *Births in England and Wales* [Online]. Available: <http://www.ons.gov.uk/ons/rel/vsob1/birth-summary-tables--england-and-wales/2013/info-births-2013.html> [Accessed 15/1/2016].
- OFFICE FOR NATIONAL STATISTICS 2014. *Life Expectancy at Birth and at Age 65 by Local Areas in England and Wales, 2011–13*. Statistical Bulletin.
- OFFICE FOR NATIONAL STATISTICS. 2015. *Deaths Registered in England and Wales, 2014* [Online]. Available: <http://www.ons.gov.uk/ons/rel/vsob1/birth-summary-tables--england-and-wales/2013/info-births-2013.html> [Accessed 15/1/2016].
- OFFICE OF THE REGULATOR OF COMMUNITY INTEREST COMPANIES 2013. Information pack.
- OFFICE OF THE REGULATOR OF COMMUNITY INTEREST COMPANIES 2014. Chapter 6 Asset Lock Information and Guidance notes Department for business innovations & skills,.
- OLAFSDOTTIR, S., BAKHTIARI, E. & BARMAN, E. 2014. Public or private? The role of the state and civil society in health and health inequalities across nations\*. *Social Science & Medicine*, *Social Science & Medicine*, 174-181.
- OLIVER, A. & MOSSIALOS, E. 2005. European Health Systems Reforms: Looking Backward to See Forward. *Journal of Health Politics, Policy and Law*, 30.
- PARK, C. & WILDING, M. 2013. Social enterprise policy design: Constructing social enterprise in the UK and Korea. *International Journal of Social Welfare* 2013, 22, 236-247.
- PEREDO, A. & MCLEAN, M. 2006. Social entrepreneurship: A critical review of the concept. *Journal of World Business*, 41, 56-65.
- PERRINI, F., VURRO, C. & COSTANZO, L. A. 2010. A process-based view of social entrepreneurship: From opportunity identification to scaling-up

- social change in the case of San Patrignano. *Entrepreneurship & Regional Development*, 22, 515-534.
- PETTIGREW, A. M., WOODMAN, R. W. & CAMERON, K. S. 2001. Studying Organizational Change and Development: Challenges for Future Research. *Academy of Management Journal*, 44, 697-713.
- PIRSON, M. 2012. Social entrepreneurs as the paragons of shared value creation? A critical perspective. *Social Enterprise Journal*, 8.
- POLLITT, C., HARRISON, S., DOWSWELL, G., JERAK-ZUIDERENT, S. & BAL, R. 2010. Performance Regimes in Health Care: Institutions, Critical Junctures and the Logic of Escalation in England and the Netherlands. *Evaluation*, 16.
- POPULATION SERVICES INTERNATIONAL. 2016. *About PSI* [Online]. Available: <http://www.psi.or.tz> [Accessed 30/1/16].
- PORTER, M. & KRAMER, M. 2011. The Big Idea: Creating shared value. *Harvard Business Review*, January/February, 1-17.
- POTTER, C. & BROUGH, R. 2004. Systemic capacity building: a hierarchy of needs. *Health Policy and Planning*, 19, 336-345.
- PRINMAT. undated. *Mission* [Online]. Available: <http://www.prinmat.org/about> [Accessed 18/1/16].
- RAGHDA EL EBRASHI 2013. Social entrepreneurship theory and sustainable social impact. *Social Responsibility Journal*, 9, 188-209.
- RAPHAELA, D. & BRYANT, T. 2015. Power, intersectionality and the life-course: Identifying the political and economic structures of welfare states that support or threaten health. *Social Theory & Health* 13, 245-266.
- REAY, T. & HININGS, C. R. B. 2005. The Recomposition of an Organizational Field: Health Care in Alberta. *Organization Studies*, 26, 351-384.
- REAY, T. & HININGS, C. R. B. 2009. Managing the Rivalry of Competing Institutional Logics. *Organization Studies*, 30, 629-652.
- REYNOLDS, L. 2011. For-profit companies will strip NHS assets under proposed reforms. *British Medical Journal*, 342:d3760.
- RICO, A. & COSTA-FONT, J. 2005. Power Rather Than Path Dependency? The Dynamics of Institutional Change under Health Care Federalism. *Journal of Health Politics, Policy and Law*, 30.
- RIDLEY-DUFF, R. 2007. Communitarian perspectives on social enterprise. *Corporate Governance-an International Review*, 15, 382-392.
- RIDLEY-DUFF, R. & BULL, M. 2011. *Understanding Social Enterprise. Theory and Practice*, London, Sage Publications Ltd.
- ROBERTS, M., HSIAO, W., BERMAN, P. & REICH, M. 2008. *Getting Health Reform Right: A Guide to Improving Performance and Equity*, Oxford, Oxford University Press.
- ROCHAIX, L. & WILSFORD, D. 2005. State Autonomy, Policy Paralysis: Paradoxes of Institutions and Culture in the French Health Care System. *Journal of Health Politics, Policy and Law*, 30.
- ROY, M. J., DONALDSON, C., BAKERA, R. & KAYB, A. 2013. Social enterprise: New pathways to health and well-being? *Journal of Public Health Policy*, 34, 55-68.
- SACCHETTI, S. & CAMPBELL, C. 2014. Creating Space for Communities: Social Enterprise and the Bright Side of Social Capital. *Journal of Entrepreneurial and Organisational Diversity*, 3, 32-48.

- SALAMON, L. M., SOKOLOWSKI, S. W. & LIST, R. 2003. Global Civil Society. An Overview. Johns Hopkins University.
- SALTMAN, R. B. & BERGMAN, S.-E. 2005. Renovating the Commons: Swedish Health Care Reforms in Perspective. *Journal of Health Politics, Policy and Law*, 30.
- SCHMITZ, H. P., RAGGO, P. & VIJFEIJKEN, T. B.-V. 2012. Accountability of Transnational NGOs: Aspirations vs Practice. *Nonprofit and Voluntary Sector Quarterly*, 41, 1175 - 1194.
- SCHWAB, K. 2008. Global corporate citizenship - Working with governments and civil society. *Foreign Affairs*, 87, 107-118.
- SCOTT-SAMUELA, A. & SMITH, K. E. 2015. Fantasy paradigms of health inequalities: Utopian thinking? *Social Theory & Health*, 13, 418–436.
- SCOTT, W. R. 2008. Lords of the Dance: Professionals as Institutional Agents. *Organization Studies*, 29.
- SCOTT, W. R. 2013. *Institutions and Organisations: Ideas, Interests and Identities*, Sage.
- SCOTT, W. R., RUEF, M., MENDEL, P. J. & CARONNA, C. A. 2000. *Institutional Change and Healthcare Organizations: From Professional Dominance to Managed Care*, University of Chicago Press.
- SEWELL, W. H. 1996. Historical events as transformations of structures: Inventing revolution at the Bastille. *Theory and Society*, 25, 841-881.
- SHIFFMAN, J. STANTON, C. & SALAZAR, A. P. 2012. The emergence of political priority for safe motherhood in Honduras. In: GILSON, L. *Health Policy and Systems Research. A Methodology Reader*. WHO.
- SIDDIQI, S., MASUDA, T. I., NISHTARB, S., PETERSC, D. H., BELGACEM SABRIA, BILE, K. M. & JAMA, M. A. 2009. Framework for assessing governance of the health system in developing countries: Gateway to good governance. *Health Policy*, 90, 13-25.
- SIKIKI. 2016. *Sikika* [Online]. Available: <http://sikika.or.tz> [Accessed 29/1/16].
- SMITH, B. R. & STEVENS, C. E. 2010. Different types of social entrepreneurship: The role of geography and embeddedness on the measurement and scaling of social value. *Entrepreneurship & Regional Development*, 22, 575-598.
- SMITH, K. E. 2015. Understanding responses to the political context of health inequalities in research and policy: Can post-structural theories of power help? *Social Theory & Health* 13, 355-376.
- SOCIAL ENTERPRISE COALITION 2010. No more business as usual. A Social Enterprise Manifesto. London.
- SOCIAL ENTERPRISE MARK. Available: <http://www.socialenterprisemark.org.uk/what-is-the-social-enterprise-mark/> [Accessed 18/1/2016].
- SOCIAL ENTERPRISE UK. 2012a. Social Enterprise UK. Available: <http://www.socialenterprise.org.uk/about/about-social-enterprise#what%20are%20ses>.
- SOCIAL ENTERPRISE UK 2012b. Public Services (Social Value) Act 2012. A brief guide.
- SOCIAL ENTERPRISE UNIT 2010. Measuring social value – How five social enterprises did it. Department of Health,.

- SOCIAL INVESTMENT BUSINESS. 2016. *Social Enterprise Investment Fund* [Online]. Available: <http://www.sibgroup.org.uk/past-funds/seif/> [Accessed 2nd April 2016].
- SOCIAL RETURN ON INVESTMENT NETWORK. undated. Available: [www.thesroinetwork.org](http://www.thesroinetwork.org) [Accessed 18/1/16].
- SOCIALIST HEALTH ASSOCIATION. 2013. *So what of social enterprises and the NHS?* [Online]. Available: <http://www.sochealth.co.uk/2013/05/14/social-enterprises-in-the-nhs-y...> [Accessed 27/01/2014]
- SOMERVILLE, P. & MCELWEE, G. 2011. Situating community enterprise: A theoretical exploration. *Entrepreneurship and Regional Development*, 23, 317-330.
- STAKE, R. E. 2007. Qualitative case studies. In: DENZIN, N. K. (ed.) & LINCOLN, Y. S. (ed.) *Strategies of Qualitative Enquiry*. SAGE publications
- STEVENS, R., MORAY, N. & BRUNEEL, J. 2014. The Social and Economic Mission of Social Enterprises: Dimensions, Measurement, Validation, and Relation. *Entrepreneurship Theory and Practice*, January.
- STEYAERT, C. & KATZ, J. 2004. Reclaiming the space of entrepreneurship in society: geographical, discursive and social dimensions. *Entrepreneurship & Regional Development*, 16, 179-196.
- SWIDLER, A. 1986. Culture in Action: Symbols and Strategies. *American Sociological Review*, 51, 273-286.
- TANU 1967. *The Arusha Declaration and TANU's Policy on Socialism and Self Reliance*. Dar Es Salaam: Tanzania: Publicity Section, TANU, Dar Es Salaam.
- TANZANIA, U. R. O. 1991. *The Private Hospital (regulation act no 6)*.
- TANZANIA, U. R. O. 1999. *The Tanzania Development Vision 2025*. In: COMMISSION, P. (ed.).
- TEASDALE, S. 2010. Models of social enterprise in the homelessness field. *Social Enterprise Journal*, 6, 23-34.
- TEASDALE, S. 2012. What's in a Name? Making Sense of Social Enterprise Discourses. *Public Policy and Administration*, 27.
- TEASDALE, S., LYON, F. & BALDOCK, R. 2013. Playing with Numbers: A Methodological Critique of the Social Enterprise Growth Myth. *Journal of Social Entrepreneurship*.
- THE CIC REGULATOR. Undated. *The benefits of A Community interest CompAny (CiC)* [Online]. Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/266895/10-1388-community-interest-companies-benefits-of-a-cic-leaflet.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266895/10-1388-community-interest-companies-benefits-of-a-cic-leaflet.pdf) [Accessed 02/02/2016].
- THORNTON, P. 2013. *RE: Question re: Institutional Logics*. Type to WATSON, L.
- THORNTON, P. H. & OCASIO, W. 2008. Institutional Logics. In: GREENWOOD, R., OLIVER, C., SUDDABY, R. & SAHLIN-ANDERSEN, K. (eds.) *The Sage Book of Organisational Institutionalism*. Sage.
- THORNTON, P. H., OCASIO, W. & LOUNSBURY, M. 2012. *The Institutional Logics Perspective: A New Approach to Culture, Structure, and Process: A New Approach to Culture, Structure, and Process*, Oxford University Press.

- TWAVEZA. 2016. *About Twaweza* [Online]. Available: <http://www.twaweza.org> [Accessed 29/1/16].
- UK GOVERNMENT 2012a. NHS and social care act.
- UK GOVERNMENT 2012b. Public Services (Social Value) Act 2012. Chapter 3. *In: THE STATIONERY OFFICE (ed.)*.
- UK GOVERNMENT. 2016. *Community Interest Companies business activities* [Online]. Available: <https://www.gov.uk/government/publications/community-interest-companies-business-activities> [Accessed 2nd April 2016].
- UNICEF. 2012. *Statistics* [Online]. Available: [http://www.unicef.org/infobycountry/tanzania\\_statistics.html](http://www.unicef.org/infobycountry/tanzania_statistics.html) [Accessed 16/1/2016].
- UNISON 2007. *In the Interests of Patients? The impact of the creation of a commercial market in the provision of NHS Care*. Revised edition
- UNISON 2010. *Social Enterprises in Primary Care*. Unison.
- UNITED NATIONS. 2014. *Human Development* [Online]. The Global Economy. Available: <http://www.theglobaleconomy.com> 2015].
- UNITED REPUBLIC OF TANZANIA 1977. *The Private Hospitals Regulation Act*.
- UNITED REPUBLIC OF TANZANIA 2003. *National Health Policy*. *In: MINISTRY OF HEALTH (ed.)*.
- UNITED REPUBLIC OF TANZANIA 2014. *Basic Demographic and Socio economic profile 2012*. *In: POPULATION AND HOUSING CENSUS NATIONAL BUREAU OF STATISTICS MINISTRY OF FINANCE DAR ES SALAAM AND OFFICE OF CHIEF GOVERNMENT STATISTICIAN PRESIDENT'S OFFICE, F., ECONOMY AND DEVELOPMENT PLANNING ZANZIBAR (ed.)*.
- UNITED REPUBLIC OF TANZANIA 2015. *Thematic Report on Fertility and Nuptiality*.
- WAGNER-TSUKAMOTO, S. 2007. Moral agency, profits and the firm: economic revisions to the Friedman Theorem. *Journal of Business Ethics*, 70, 209-220.
- WALT, G. & GILSON, L. 1994. Reforming the health sector in developing countries: The central role of policy analysis. *Health Policy and Planning*, 9, 353-370.
- WHITE, J., O'HANLON, B., CHEEE, G., MALANGALILA, E., KIMAMBO, A., COARASA, J., CLLAHAN, S., LENEY, I. R. & MCKEON, K. 2013. *Tanzania Private Sector Assessment*. Bethesda MD.
- WHO/UNICEF. 2013. *Access to drinking water* [Online]. The Global Economy. Available: <http://www.theglobaleconomy.com> 2015].
- WILSON, F. & POST, J. E. 2013. Business models for people, planet (& profits): exploring the phenomena of social business, a market-based approach to social value creation. *Small Business Economics*, Apr 40.3, 715-737.
- WOODMAN, P. & TEMPLE, N. 2011. Exporting social enterprises. A survey of overseas trade by UK social enterprises - and how to foster its growth. *In: BRITISH COUNCIL AND SOCIAL ENTERPRISE UK (ed.)*. London.
- WORLD BANK. 2012. *Education spending* [Online]. The Global Economy. Available: <http://www.theglobaleconomy.com> 2015].
- WORLD BANK 2013. *External resources in health*. 30/1/16.



- WORLD BANK. 2014a. *Annual percentage growth rate of GDP* [Online]. The Global Economy. Available: <http://www.theglobaleconomy.com> 2015].
- WORLD BANK. 2014b. *Government spending* [Online]. The Global Economy. Available: <http://www.theglobaleconomy.com> 2015].
- WORLD BANK. 2014c. *Health spend per capita* [Online]. The Global Economy. Available: <http://www.theglobaleconomy.com> 2015].
- WORLD BANK. 2016. *Population Growth (Annual %) by country* [Online]. Available: <http://data.worldbank.org/indicator/SP.POP.GROW> [Accessed 15/1/16].
- WORLD HEALTH ORGANISATION 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*. Geneva: World Health Organisation.
- WORLD HEALTH ORGANISATION 2008a. *Closing the Gap in a Generation. Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva.
- WORLD HEALTH ORGANISATION 2008b. *Primary Care, Putting People First*, Geneva, WHO.
- WORLD HEALTH ORGANISATION 2008c. *Primary Health Care - Now More than Ever*, Geneva, World Health Organisation.
- WORLD HEALTH ORGANISATION. 2010. *World Malaria Report. United Republic of Tanzania and Zanzibar Country Profile*, [Online]. Available: [http://www.who.int/malaria/publications/country-profiles/profile\\_tza\\_en.pdf?ua=1](http://www.who.int/malaria/publications/country-profiles/profile_tza_en.pdf?ua=1).
- WORLD HEALTH ORGANISATION 2013. *Report on the Global Tobacco Epidemic. United Republic of Tanzania Country Profile*.
- WORLD HEALTH ORGANISATION. 2014a. *Country Profile: United Kingdom of Great Britain and Northern Ireland* [Online]. Available: [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=TZ&LAN=EN&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=TZ&LAN=EN&outtype=html) [Accessed 15/1/2016].
- WORLD HEALTH ORGANISATION. 2014b. *Country Report: Tanzania* [Online]. Available: [https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=TZ&LAN=EN&outtype=html](https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=TZ&LAN=EN&outtype=html) [Accessed 15/1/2016].
- YIN, Z., BROWN, A. E., HUGHES, G., NARDONE, A., GILL, O. N., DELPECH, V. C. & CONTRIBUTORS 2014. *HIV in the United Kingdom 2014 Report: data to end 2013*. London: Public Health England.
- YOUNG, R. 2006. For what it is worth: Social value and the future of social entrepreneurship. In: NICHOLLS, A. (ed.) *Social Entrepreneurship: New Models of Sustainable Social Change*. Oxford: Oxford University Press.
- YUNUS, M., MOINGEON, B. & LEHMANN-ORTEGA, L. 2010. Building Social Business Models: Lessons from the Grameen Experience. *Long Range Planning*, 43, 308-325.
- ZEHAVI, A. 2011. A Reform Less Ordinary? Historical Institutionalism, Punctuated Equilibrium, and Mental Health Care Privatization. *Administration & Society*.
- ZIEGLER, R. 2010. Innovations in Doing and Being: Capability Innovations at the Intersection of Schumpeterian Political Economy and Human Development *Journal of Social Entrepreneurship*, 1, 255-272.

ZILBER, T. B. 2006. The Work of the Symbolic in Institutional Processes: Translations of Rational Myths in Israeli High Tech. *Academy of Management Journal*, 49, 281-303.

## **Annex A Personal perspectives on social enterprise**

The way in which actors blend the different ideas of community logic into their practice, illustrated through this research contributes to knowledge which can be of use to practitioners in both countries. This section takes a personal and practitioner view.

### **Practitioner perspective**

This research project draws on my experience as a social enterprise practitioner and in health system management. I approached the project with an open mind about whether or not social enterprise was a passing phase in health policy, subject to political whim and as likely to disappear as flourish. Like many senior managers in the NHS, without ready access to policy makers the policy making process appeared opaque. At times, there seemed to be no logic to it, with policies and Department of Health initiatives showering down upon those of us responsible for implementing the full range of new ideas as they arose. Often with tight timescales, and, at that time, money to invest, we had to make sense of policy, bringing together policies in different ways in the context of the particular circumstances of our geographical areas of responsibility. After I left the NHS in 2004, and choosing to refocus my career on supporting social enterprises to leave the NHS, nothing seemed to change in relation to the policy making process, although there was clearly a passion amongst many actors for a new logic to be brought into the NHS. Perhaps, naively, we believed the narrative espoused by policy makers, but lacked the experience to implement the vision. Our attempts were sometimes ill judged.

This research project has made a significant impact already on my ability to support health professionals and managers to form and manage social enterprises. I have a better understanding of the meaning of the term, and feel that I have successfully disentangled the competing interpretations of the term over time.

I am better able to work with senior management teams and Boards in my capacity as an interim CEO to effect both material and cultural change within social enterprise organisations. Boards of social enterprises have particular

difficulty overseeing the performance of a social enterprise. Whilst financial and other instruments are available which have common definitions and meanings, the same is not found for social value. In my practice, I concur with Raghda El Ebrashi (2013) who point to the need for social enterprise Boards to consider, in their strategic and oversight roles, how social value is realised. Boards continually interpret and reinterpret the mission in relation to the current trends and changing circumstances, to identify and manage risk. In my practice, I now have more breadth of understanding on the way in which health equity can be brought into Board level discussions on mission, performance and risk.

Having the opportunity to interview policy makers, some of whom were extremely influential in advocating for social enterprises to have a confirmed place in the health system, I now have a much better understanding of how policy is formulated; the relative power of different actors and how they exercise that power. What was unexpected for me was the number of different types of actors influencing politicians in the Labour government up to 2010. Whilst I was hoping at the start of the research project to understand how they exercised their power, not only were policy makers unwilling to divulge that information at interview, but also it became clear that this topic was so large it could form a separate research project in itself. Whilst I knew, before I started the research project that there is no common currency for measuring social value or standards, undertaking this research has reinforced my understanding of what others have found ie that innovation is socially constructed and contingent on the system context (Chew and Lyon, 2012).

Yet, the comparison of England with Tanzania yielded unexpected benefits. Becoming immersed in a different cultural context, and exploring different meanings of social enterprise, enabled me to create some distance from the English context. This “objectivity” allowed me to develop the business strategy theme in this research by leveraging the data across both health systems. It also allowed some conclusions to be drawn which were more robust than would have been the case if I had restricted my research to England. In particular, I was able to compare the institutional context more rigorously and how this constrained or enabled different organisational strategies. I can build on this learning to explore, in my practice, how policy environments can be shaped to

enable organisations which aim to make a social impact to flourish. This is a potentially new market for me. I would like to explore how tools, such as the diagnostic tool outlined in this research, could be developed further.

### **Personal practice**

The academic process has improved my critical reasoning and contributed to a more flexible, personal outlook on the role of the market in health systems in relation to the state. Arguments, even amongst health policy makers and managers persist about the relative merits of a market and how it should be designed. I feel better able to argue for a managed state market, with greater democratic accountability of the state to its citizens. The role of for profit health care organisations, however, will continue to challenge policy makers, the debate being rooted in ideology rather than the evidence base. This research has not resolved this dilemma in my own mind, but I feel better able to consider the logic of the argument from both sides.

My fieldwork in Tanzania built on my earlier career when I undertook research in Sri Lanka and India as a public health nutritionist and anthropologist before making a career shift into the NHS in England. In Tanzania, it meant that when there was no running water or limited privacy in my accommodation arrangements, I was almost expecting it. The facilities were a 'step up' from Sri Lanka, where, for example, I bathed in the local stream with the villagers, had no running water and cooked over a fire. However, although experiencing the Civil War in Sri Lanka, which erupted in the middle of my fieldwork in the early 1980s, I was less prepared for the day to day challenges of managing my personal safety in Tanzania. Whilst in Sri Lanka, I happily walked during daylight hours in towns and villages, often alone, and felt safe travelling on public transport, this was not the case in Tanzania. I hired a driver to take me to meetings so that I could travel securely.

Whilst in Tanzania, I took the opportunity to visit areas of interest. I spent a weekend in Zanzibar and went on holiday with the family I was staying with in Dar Es Salaam to Arusha. This latter trip included a safari to one of the national parks organised by my landlady's brother, who works as a guide. We stayed with his family, and also met the extended family including parents, sisters, cousins and friends. I experienced middle class Tanzanian life, which is

sometimes precarious. Lack of state support systems and a suggestion of clientelism in employment meant that the extended family was important to support those family members who experienced difficult life events eg death of a parent, divorce, unemployment etc. This was an important context for my research, as it highlighted the way in which health inequalities and the policy environment are linked over time and which, in turn, impact upon individual's life chances from all social economic groups.

There were undoubted advantages being an older woman with experience of health system management. I was more credible when meeting with policy makers in both countries than I would have been at a younger age. Certainly in England my experience and networks opened doors which might otherwise have been closed. In Tanzania, many interviewees said they had enjoyed taking part in the study and wanted to talk for longer than they had allowed. From a personal perspective, I felt that I gained a lot from talking to colleagues many of whom faced similar challenges to those that I had experienced in my working life.

## Annex B Definitions of statistics used

Statistic	Definition
GDP per capita (\$)	<i>World bank definition:</i> GDP per capita is gross domestic product divided by midyear population. GDP is the sum of gross value added by all resident producers in the economy plus any product taxes and minus any subsidies not included in the value of the products. It is calculated without making deductions for depreciation of fabricated assets or for depletion and degradation of natural resources. Data are in current U.S. dollars.
Annual percentage growth rate of GDP	<i>World bank definition:</i> Annual percentage growth rate of GDP at market prices based on constant local currency. Aggregates are based on constant 2005 U.S. dollars. GDP is the sum of gross value added by all resident producers in the economy plus any product taxes and minus any subsidies not included in the value of the products. It is calculated without making deductions for depreciation of fabricated assets or for depletion and degradation of natural resources.
Human Development Index	Human development index measures three basic dimensions of human development— long and healthy life, knowledge, and decent standard of living. Four indicators are used to calculate the index: life expectancy at birth, mean years of schooling, expected years of schooling, and gross national income per capita.
Household consumption	<i>World bank definition:</i> Household final consumption expenditure (formerly private consumption) is the market value of all goods and services, including durable products (such as cars, washing machines, and home computers), purchased by households. It excludes purchases of dwellings but includes imputed rent for owner-occupied dwellings. It also includes payments and fees to governments to obtain permits and licenses. Here, household consumption expenditure includes the expenditures of nonprofit institutions serving households, even when reported separately by the country. Data are in current U.S. dollars.
Government spending	<i>World bank definition:</i> General government final consumption expenditure (formerly general government consumption) includes all government current expenditures for purchases of goods and services (including compensation of employees). It also includes most expenditures on national defense and security, but excludes government military expenditures that are part of government capital formation. Data are in current U.S. dollars.
Labour	<i>World bank definition:</i> Unemployment refers to the share of the labour force that is without work but available for and seeking

Statistic	Definition
	employment.
Age Dependency Ratio	<i>World bank definition:</i> Age dependency ratio is the ratio of dependents--people younger than 15 or older than 64--to the working-age population--those ages 15-64. Data are shown as the proportion of dependents per 100 working-age population.
Government effectiveness	Government effectiveness captures perceptions of the quality of public services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government's commitment to such policies. The indicator is based on a list of individual indicators. (World Bank govindicators.org)
Voice and accountability	Voice and accountability captures perceptions of the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media. The indicator is based on a list of individual indicators. (World Bank govindicators.org)
Health spend per capita	<i>World bank definition:</i> Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation. Data are in current U.S. dollars.



### Annex C Politicians mentioned by interviewees

Politician	Role	Dates
Chris White MP	MP for Warwick and Leamington (Con) Led the Social Value Act through parliament	2010 to present 2010 to 2012
Baroness Glynis Thornton	Shadow Spokesperson Health CEO, the Young Foundation (social innovation think tank) Senior Associate, Social Business International (promotes social enterprises in UK and Europe) Adviser, The Social Investment Consultancy (TSIC works with the latest models of social enterprise, revenue generation, impact investment and venture philanthropy) Patron (formerly Adviser), Social Enterprise UK	2010 to 2012 2015 to present undated  undated  Interest as Adviser ceased 30 July 2015
Baron Darzi of Denham	Parliamentary under Secretary of Health (Labour) Chair, London Health Commission	2007 to 2009 2013 to 2015
Frank Dobson	MP for Holborn and St Pancras (Lab)  Secretary of State for Health  Shadow Minister for Health	1979 to 2015  1997 to 1999  1983 to 1987
Hazel Blears	MP Salford & Eccles (Lab)  Secretary of State for Communities & Local Government  Parliamentary under Secretary for Health	1997 to 2015  2007 to 2009  2001 to 2003
Lord Adebawale	Peer (Cross bench) CEO, Turning Point CEO, Centre Point CEO, Alcohol Recovery Project Board member, NHS Commissioning Board	2001 to present 2001 to present 1995 to 2001 1990 to 1995 current
Norman Lamb	MP North Norfolk (Lib Dem) Shadow LD Spokesperson (Health)  Minister of State (Department of Health)  Shadow Secretary of State for Health	2001 to present Jul 2015 to present 2012 to 2015  2006 to 2010
Patricia Hewitt	MP Leicester West (Lab)  Secretary of State for Health  Special Consultant to Alliance Boots and special adviser to Cinven (private equity company with	1997 to 2010  2005 to 2007  2008 onwards

<b>Politician</b>	<b>Role</b>	<b>Dates</b>
	interest in health)	
Alun Davies	MP Blaenau Gwent (Lab)  Welsh Assembly Mid & West Wales  Member of Health and Social Care committee	2007 to present
Liam Byrn	MP Birmingham, Hodge Hill (Lab)  Parliamentary Under Secretary (Health) Care Services	2004 to present  2005 to 2006
Ivan Lewis	MP Bury South (Lab)  Parliamentary Under Secretary (health) Care Services  Health Committee	1997 to present  2006 to 2008  1999
Lord Shipley	Peer (Lib Dem)	2010 to present
Baroness Liz Barker	Peer (Lib Dem)  Lords principal spokesperson on voluntary sector and social enterprise  Various mental health committees	1999 to present  2015 to present  From 2003

## **Annex D Diagnostic tool for policy actors**

The following sections describe the different domains and variables contained within each domain in more detail.

### **Social impact**

Measurement of social impact is needed to inform decisions such as when and how to scale up social innovations, accounting for change to stakeholders and governance, making change visible as an alternative way of measuring value to current methods. Measuring social value is a complex issue. A useful study was done by Grieco et al. (2015) who reviewed ways of measuring social impact and identified four main types of methods which they grouped into clusters. Three had retrospective timeframes, one could be used for ongoing measurement. The most complex measured qualitative and quantitative variables, some of which may contain more than 100 indicators, and were mainly used to verify that project objectives had been met, reporting to stakeholders. The other two clusters involved either quantitative or qualitative indicators of social impact. Whilst various methodologies could be used, the recognition by policy stakeholders of the role of organisations in achieving social impact through their organisational strategies is an opportunity which can be embedded in a systemic way to influence both government systems and health system capacity building. Social enterprise leaders interviewed for this research indicated that measurement of social value was difficult, although many were able to give examples of measurement, particularly those in Tanzania. Interpreting these results against the scale, I gave each country a score of 4 for this dimension. This was because there was some use of measurement, but all those interviewed recognised that more work needed to be done, both methodologically, to make measurement easier, but also to embed measures into day to day performance.

The second variable, inclusion in policy, is needed to assess how effectively social impact measurements are included in policy processes at all levels of the health system. It might be used to inform commissioning services at regional and national levels, or policy review and formation cycles at different levels in

the health system. I gave England a score of 5 because social enterprise is recognised as a type of organisation in health policy, albeit a politically contested term. I gave Tanzania a 1 on this score, because none of the policy makers interviewed for this research recognised the term, nor the potential role of social entrepreneurship in a health service market.

### **Government systems**

My approach to this section of the diagnostic tool takes the holistic view on social determinants of health ie that there is a social, political and economic context to health inequalities. This means tackling power inequalities, social status and connections, or class inequality (Scott-Samuella and Smith, 2015, Raphaela and Bryant, 2015) and the formulation of integrated policy. (Hendriksa et al., 2014) Multi faceted and interconnectedness of complexity of health systems (Adam and Savigny, 2012), within a socio political and open systems context are important factors in the adoption of innovation. (Atun, 2012). The three dimensions to this domain reflect three themes from this research.

The first is whole system governance mechanisms which hold policy makers to account for the social impact of their policies on the health system, from the organisational perspective of social enterprise. This dimension assumes that the core characteristics of social enterprise are 'true'. In practical terms, if social enterprises do have a distinct logic from other organisation, then this raises governance issues for the management of the health system as a whole. For example, a review of the right to request programme in England in Chapter 7.5 identified whole system governance issues such as the need for a failure regime in the health system to maintain services to clients/patients if social enterprises fail. There also needed to be a clearer balance of risk sharing between the state and social enterprises.(Anderson et al., 2011) My assessment of the governance mechanisms in England and Tanzania assumes that the logic of social enterprise is linked to achieving national policies on health equity and that policy makers can be held to account. Using the diagnostic tool, a score of 4 for England and 2 for Tanzania I justified on the basis that the contribution of social enterprises to health equity could be evidenced through policy narratives in England, and there was evidence, as reported by policy implementers interviewed for this research, that some policy

makers, through their commissioning of services at regional level attempted to build health equity as a consideration into their strategies. No similar evidence was found in Tanzania. More effective governance mechanisms would hold policy makers to account for the social impact of their policies in the health system.

This research demonstrated how important it was to integrate social enterprise with health system priorities and policies. The second dimension to this domain, therefore focuses on how effective this integration is within Government systems which I have labelled *inter departmental planning*. In this research the idea of social enterprise was resisted by some actors within the Department of Health in England. Other Government departments such as the Treasury resisted changing financial regimes which would support social enterprises. Whilst policy will always be contested the degree to which different actors contest the changes which need to be made to the environment to promote the idea of social enterprise and achievement of health equity needs to be acknowledged and managed. In Tanzania the cross government technical working groups were viewed by policy actors as effective in influencing policy. However, by not being aware at a policy level of the potential role of social entrepreneurship in the health economy, social entrepreneurs interviewed for this research, raised different concerns to those in England. I therefore gave both Tanzania and England a score of 5, for different reasons. There is more work to be done in both countries to work across government to develop plans which aim to address the social determinants of health, recognising the social impact of organisations within policies.

The third dimension, *financial systems*, provide incentives for organisations to deliver social value. This research showed how difficult it was for social enterprises to attract investment in Tanzania. In England, the Government supported the investment infrastructure through specialist funds and to support organisations to manage change, for example, in the capacity and capability of their teams to transition to social enterprises which would be independent of state control. Interviewees comments in Tanzania on the importance of beneficial tax treatment through their not for profit status was compared to those in England who raised concerns about the lack of beneficial tax treatment. I

therefore gave England a score of 6 and Tanzania a score of 5, reflecting the significant concerns raised by those interviewed for this research on access to investment capital to grow their social enterprises. On balance, I felt that the relative disadvantages of the tax environment in England to social enterprises were less important compared to having access to investment capital.

### Health system capacity

Each of the 7 dimensions in this domain draws on the themes of capability and capacity of individuals as social entrepreneurs and the dynamic between them and the environment within which they work. Table D.1 below summarises the description and scores attributed to each dimension.

Table D.1 Scoring each dimension for the domain health system capacity

Diagnostic question	Dimension	England (2014)	Tanzania (2015)
Is knowledge about social impact and how this is achieved shared effectively between actors? Eg commissioners, policy influencers, social enterprise leaders, patients, general public	Knowledge sharing	2	2
Is social entrepreneurship recognised as a leadership competency by policy makers?	Social entrepreneurship	6	1
Is there clarity and accountability about lobbyists logic for change and how this is incorporated into health policy?	Stakeholder management	5	7
Is there a mechanism at policy level to incorporate social enterprise business models with policy outcomes	Business model alignment with policy outcomes	3	5
Composite measure	Market	4	2
Is there freedom to associate and freedom to comment on policy	Civil Society	9	9
Are there processes and structures in place to support social entrepreneurs to develop their skills and competencies, learn from each other	SE Support	6	3

### Knowledge sharing

Knowledge sharing to support the implementation of social enterprises and to further strategies to address the social determinants of health were important in

both Tanzania and England. In Tanzania, expanding their business models to increase market share was an explicit strategy of all the organisations leaders interviewed for this study. Sharing of knowledge between teams within the organisation and with other organisations was celebrated. In England, the Department of Health invested in infrastructure to support knowledge sharing including the Social Enterprise Forum, and use of the media through the continual publication of success stories and the evidence base, although the latter was anecdotal until the agenda was shifted towards the benefits of employee control. Measuring the problem, evaluating action and expanding the knowledge base, developing a workforce that is trained in the social determinants of health, raising public awareness of the social determinants of health is an explicit principle for action by the WHO to achieve health equity (World Health Organisation, 2008a pg 26). This research indicates that social enterprise and social entrepreneurs can contribute to this knowledge base but there is a lot more that can be done. The score of 2 for both countries reflects that more can be done by governments in supporting social entrepreneurs to share learning about how the environment can be designed to promote health equity.

### ***Social entrepreneurship***

Social entrepreneurship in itself is an important capability. The ability of social entrepreneurs to develop business models which linked social and economic objectives was found in this research in the following attributes:

- Innovation: linking organisational strategies and business models (Tanzania and England)
- Commercial partnerships (England and Tanzania)
- Ability to link social value with social impact and to inspire others
- Management and leadership including partnership development eg KCMC
- Influencing change eg structures in England and Tanzania
- Ability to manage ambiguity. The health system is a fuzzy concept; social entrepreneurs need to be able to manage this by identifying how this ambiguity offers opportunities to further the social mission. In this research the three different types of social enterprise (Holistic, Health

care and Lifestyle) each took different perspectives on how they met clients' health need and the scope of health in relation to the health system.

The results of this research therefore reflect others. Meyskens et al. (2010), for example, found a statistically significant relationship between the success of social entrepreneurs and resource based relationships. Of importance to the application of this diagnostic tool, therefore, is how this research illustrated the importance of context within which social entrepreneurs work. Interviews with policy implementers in Tanzania demonstrated that not only does difficulty accessing financial capital limit social enterprises ability to acquire resources to develop services and products but also, in a more positive way, that partnership development enables all types of resources to be acquired and managed efficiently while enhancing the legitimacy of the social enterprise and its dynamic capabilities. The diagnostic tool proposed here explicitly links these success criteria to the context within which social entrepreneurs work. Whilst social entrepreneurship was recognised as a leadership competency by policy makers in England, this was not the case in Tanzania. Although this research was able to evidence examples of social entrepreneurship in the health system in Tanzania, policy makers interviewed for this study did not recognise the term social enterprise nor the role social entrepreneurship might play in a health market. I therefore scored England higher than Tanzania, recognising that more can be done in England to build this capability in the health system.

### ***Stakeholder management***

Stakeholder management was an important aspect of social entrepreneurship in this research, particularly how policy actors managed the narratives which described the logic underpinning the principles of social enterprise. This research demonstrated how the logic of the health system was contested. The mutual/social enterprise debate over time in England saw staff engagement gain prominence over social value in discussions on social enterprise.

Voluntary sector and charity leaders in the 1990s who advocated for developing alternative income sources by taking on government contracts was a precursor to social enterprise emerging in health policy in 2006. What the English case study also shows is how the narratives which focused on social change became



diluted over time. Policy makers did not follow through to incorporate the contribution social enterprises could make to policies focused on health equity. In contrast to England, arguably, the technical working groups in Tanzania were perceived to allow lobbyists a platform for arguing for change. All those interviewed for this research were very clear about the policy processes in Tanzania to consider and account for policy change, whilst those in England, expressed dissatisfaction with both the clarity of policy processes and their accountability. I therefore gave Tanzania a higher score than England, for stakeholder management, recognising that this may be viewed as highly contentious.

***Integrating social enterprise business models with policy outcomes***

However, the policy environment in England including an alignment of resources, an appetite for change in the new Labour administration, particularly amongst some influential politicians and a reason for change (eg reducing state management of health services, allowing competition through the market, advocacy of stakeholders) enabled social enterprises to emerge in health policy between 2006 and 2010. The organic approach to policy formation, which allowed policy makers the freedom to experiment with ideas, learning from experience also created an environment within the NHS which allowed the development of competencies in market management and new ways of organising to address health inequalities through social enterprises. Whilst this openness to ideas amongst policy makers in the 1990s and between 2000 and 2006 allowed NHS staff to form their own social enterprises, after 2006, the design of the market in health care services did not incentivise sufficiently achievement of health equity for social enterprises to differentiate themselves in the market.

In contrast, in Tanzania, interviewees demonstrated how the health system design supported them to develop business models which contributed to policy outcomes. Whilst social enterprise was not a recognised term in Tanzanian health policy, social enterprise leaders identified several ways in which the design of the health system supported them to achieve their social missions including flexibility in rules concerning charging for services, different ways in which they could improve access to care and improving the capabilities of

health care workers. I therefore gave Tanzania a core of 5 compared to England's score of 3.

### ***State managed health market***

The design of the market is therefore an important consideration for this diagnostic tool. I have suggested that this would be composite measure, of three dimensions (Table D.2)

Table D.2 Composite measure for market

<b>Dimension</b>	<b>Description</b>	<b>England</b>	<b>Tanzania</b>
Market - transaction / transformation; cooperation / competition	Do market mechanisms recognise the difference between transactional and transformational objectives? Is there clarity about when cooperation and when competition is required?	5	4
Market scope, regulation	Is the fluid scope of the market and associated regulation understood when setting policy for different client groups?	5	2
Market - currencies	Is there an agreed and proven currency for commissioning health care across all services	3	0
<b>Total</b>		<b>13</b>	<b>6</b>

The way in which a market is designed in a health system is important if health inequalities are intended to be addressed in this way. Learning from implementation of the Social Value Act (2012) in England suggests that it is not enough to legislate for change, but, echoing the concern of one policy maker interviewed for this study, commissioners need to have the competencies to transform health systems. People interviewed for this research argued that different commissioning approaches are needed to achieve social impact over different time frames for people with different needs. Concerns that standardisation and common bureaucratic and commercial practices expressed in the procurement process push health care organisations toward greater levels of homogeneity have been found by other researchers (Millar, 2012) Teasdale (2010), for example, showed how incentives based on outcome related payments may disincentivise organisations to take those with the most

complex needs concluding that different state contracting mechanisms have different impacts on social enterprises and homeless clients.

Part of this is how partnerships between organisations are designed to achieve social impact. Learning from this research has identified different ways of thinking about partnerships based on combinations of geography, staff, patients, commercial, citizens, and independent clinicians. The rules underpinning the market environment such as whether or not co-payments for state funded services are allowed in a health system influence the nature of these partnerships and the design of business models.

Markets need a currency to conduct transactions. In England, the limits of the payments systems in community health services, meant that many community health organisations, at the time when this research was conducted, still operated under block contracts, or contracts with volume rather than outcome currencies. Integration of social impact into commissioning systems could be evidenced by some of those interviewed for this study, but not all. Lack of readiness of the health system in England to commission for social value was highlighted in the National Audit Office report (Anderson et al., 2011) which recommended development of measurable objectives to evaluate the right to request programme but also that commissioners need to specify the benefits expected from commissioning social enterprise organisations.

Operation of a market may also require a certain level of development of data and IT infrastructure, available in many hospital and GP services, but not in other parts of the health system. Commercial skills which link financial planning, making claims against funders to reimburse activity although outside the scope of this research was mentioned by interviewees in Tanzania as an important feature of those NGOs which were perceived to be successful.

The scoring of each of these dimensions within the market, has been aggregated to form an overall composite score. A more sophisticated weighting of each dimension in relation to each other might provide an indication of perceived priorities for action. In the simple scoring method used here, the composite score reflects the emerging market in Tanzania, but also the work

still to do in England if the market is intended to address health equity policy priorities.

***Freedom to associate and comment***

The degree to which policy makers have permission from their electorate to change the scope, values and design of the health system is an important aspect of the fourth level of social enterprise logic, emphasised by (Saltman and Bergman, 2005). In England this research showed how the public and some unions contested the perceived privatisation of the health service. Civil society, the freedom to association and express views, was an important environmental consideration in the literature review of social enterprise in Chapter 2. In Tanzania, social accountability monitoring had been introduced. Although at a very early stage, this kind of thinking was not evident in England. Rather, accountability to society was embedded in legislative mechanisms to allow public influence through participation on dedicated committees, the Health and Wellbeing Boards.

An equally high score was given to England and Tanzania. Although imperfectly realised in each country, freedom to associate and comment on policy is possible in both countries. This is a core requirement for social enterprise to emerge, evidenced in the literature review and in this research. Although all policy actors had different views on the effectiveness of engagement mechanisms, none expressed concern at an inability to associate or comment on health policy.

***Social enterprise support***

The grey literature reviewed in this research, particularly the NAO report (Anderson et al., 2011) and NHS Mutual full report (Ellins and Ham, 2009) praised the level of support provided to NHS managed teams to set up their own social enterprises in England. The establishment of the Social Enterprise Unit to provide guidance, advice, make funding available to help groups formulate plans and start-ups were considered to make a positive impact upon the implementation of social enterprise policy. Support systems were therefore important in England to enable NHS staff to form social enterprises and is therefore the final dimension to this diagnostic tool.

What should not be underestimated is how the flow of information from these social entrepreneurs to policy makers' shapes policy in England. Fora such as the Social Enterprise Forum, facilitated by Social Enterprise UK, conferences and working groups are attended by social entrepreneurs, lobbyists and policy makers and continue to inform social enterprise policy in the health system.

This kind of support system was not evidenced in Tanzania through government, but was found in donor activity. This took two forms. One aspect of this was through the support provided by international NGOs to their country offices in enabling them to transition their organisations to social enterprises. The other was in explicit policy support provided through donor agencies such as Danida. I felt that there were more explicit processes and structures in place to support social entrepreneurs to develop their skills and competencies in the health system as a whole in England when compared to Tanzania, which was reflected in the score allocated to each country.

## **Annex E Detailed recommendations for policy actors and researchers**

I have added a category labelled 'researchers' because of the lack of evidence of the role and value of social enterprises in market based health systems. Many are inter-related and, where appropriate, they are cross-referenced.

### **Recommendations for health system policy makers**

Policy makers have an opportunity to align the social objectives of social enterprise organisations with policies to address health inequalities. This is an area of health policy which has yet to be fully explored. Achieving a social entrepreneurial culture requires change at systemic and organisations levels; achieving social impact is complex, with no simple cause/effect relationship. The following recommendations have been developed for policy makers who choose to embed the logic of social enterprise into health policy.

1. There is an opportunity for policy makers in both countries to explore how social value might be embedded into inter-departmental systems and how this integration contributes to the development of both countries. Examples of specific mechanisms and systems are tax, investment, or capacity building. If social enterprises are recognised as a distinct type of organisation with their own logic, policy makers and commissioners of services in both countries can argue for requiring these 'not for profit' organisations to demonstrate how they realise their social impact. Favourable terms of business, such as tax benefits can be tied more closely to their social impact.
2. If a focus of health policy is on addressing health inequalities as well as access to and quality of health services, the measurement of social value and how this is embedded in a structured way into health system capacity, needs consideration and negotiated across government departments in both countries. This can be done through developing methodologies which measure social value and building the capability of actors within health systems to use social value to demonstrate the need for change.
3. In Tanzania, building on the distinction between 'not for profit' and 'for profit' legislation, the way in which social enterprises (or organisations with a social mission) are integrated into this legislation can be clarified

further. This can be done by building on in-country capabilities in social entrepreneurship at a national policy level.

4. In Tanzania, further development of a market in health services will have implications for health system infrastructure in terms of the currencies used. The future design of a market can consider how social value is incorporated into procurement decisions.
5. Access to investment capital was clearly a problem for some Tanzanian social enterprises wishing to grow their organisations. Establishing social investment structures will support organisations with a social mission to grow their business models.
6. It was argued by those interviewed in both countries that social entrepreneurship is a different 'mind set' to that found in 'for profit' and state managed organisations.
  - a. Training and development of social entrepreneurs who lead or manage health services within the health system will create a talent pool within Tanzania. Policy makers can create an environment which recognises and values these skills. They can encourage universities and other educational establishments to build on entrepreneurship training already in place, applied to health system management for managers, clinicians as well as young adults.
  - b. In England, training and development is available in social entrepreneurship. The effectiveness of this training and how far it is embedded into national training schemes for managers, clinicians and others can be reviewed.
7. Sharing knowledge and learning, building up the role of evidence in policy making can be built into the current structures in both countries. More evidence is needed on the relationship between social enterprise strategies, their social purpose and how the health system context within which they trade needs to be developed to support their success. This can be done in partnership with researchers and practitioners at national and international levels to build cross-cultural understanding.
  - a. The technical working groups already offer policy actors a forum in Tanzania. Technical working groups can consider how the learning from social enterprises, with its distinct logic, can be continuously built into policy decisions.
  - b. In England, the gap in evidence on the impact of social enterprises on health inequalities can be addressed by balancing

the focus of attention at a policy level; creating a similar evidence base to that taken on staff engagement by assessing the social impact of social enterprises.

8. In both countries, strengthening visibility and evidence base in the state managed market to incorporate recognition of social impact in performance measures of service models commissioned. Related to this is transparency on the level of accountability expected by policy makers on the design of the market in health services.
9. In England a balance needs to be struck between the emergent, Darwinian approach to health policy making which allows innovation, and long term stability and direction. Management agency allows social entrepreneurship and social innovation. However, this research suggests that a more strategic approach to health policy which allows social innovation to emerge over the long term may also be required to support social enterprises to achieve broader social transformation at scale.

### **Recommendations for social entrepreneurs leading social enterprises delivering health care services**

The first six recommendations apply equally to Tanzanian and English social entrepreneurs. They focus on the dynamic which exists between social entrepreneurs and other policy actors to inform the design of the health system.

1. Continue to use leadership positions to influence the design of the health system, advocating for social impact to be fully integrated into health policy thinking and intergovernmental systems. Access and build social entrepreneurial capacity by influencing and participating in training programmes.
2. Continue to gather and publish evidence for social impact, working with researchers to build the evidence base.
3. Publicise how a culture of cooperation between organisations to achieve social impact can contribute to health priorities.
4. Build practical experience of balancing social and financial outcomes over time to inform how governance of social enterprises in health markets can be done successfully.
5. Recognise the breadth in structural and cultural organisational design articulated in the idea of social enterprise, using institutional entrepreneurial role to influence health policy formation.



6. Trial organisational planning framework described in this research to strengthen strategy, business planning and capability development.
7. For Tanzanian social entrepreneurs: consider how democratic forms of engagement which give clients and/or staff greater influence over strategic and operational decision making can benefit the organisation.

### **Recommendations for policy influencers**

In Tanzania and England, there is already advocacy by policy influencers on health system design and capacity. The following recommendations build on this work.

1. In Tanzania, advocate for developing institutional capacity which allows social investment for social enterprises wishing to grow their organisations
2. In Tanzania, contribute to market development by developing the capacity and skills to consider the strengths and weaknesses of novel social financing eg social impact bonds in a Tanzanian context. This is linked to recommendations 5 and 6 for social entrepreneurs and recommendation 1 for policy makers.
3. In England, learn from Tanzania on ways of integrating social accountability into regional and national decision making, going beyond the current structural approach to engaging civil society.
4. In England, build capabilities to contribute to the debate on the level of democratic accountability for health system design expected by policy makers, particularly in relation to market design.

### **Recommendations for researchers**

This research project has begun to fill a gap in the knowledge base about why and how social enterprise is used by policy actors to support health system reform. Comparing domestic health systems in this way posed a number of methodological challenges. Evaluating the idea of social enterprise and its contribution to health system development would benefit from much further research. Recommendations for researchers are:

1. Develop methodologies which support comparative studies, with validated tools to measure social impact.
2. Greater understanding is needed on how organisational strategies which aim to achieve a social impact can be integrated with health system capacity building policies.

