

Evidence review: Social innovation for health equity promotion

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VicHealth Evidence Review

Social innovation for health equity promotion

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1.0 Background

The role and impact of social innovations in transforming the lives of individuals and communities have been a source of popular interest in recent years. As interest in the transformative effects of social innovation grows, so too do questions regarding the nature of social innovations and the empirical evidence of their outcomes and impacts. In keeping with its strategic purpose, the Victorian Health Promotion Foundation (VicHealth) is particularly interested in the effects of social innovations on the promotion of health equity. The purpose of this paper is to comprehensively review the available evidence regarding the relationship between social innovation and health and wellbeing, with a particular focus on impacts on health equity.

1.1 Defining social innovation

Social innovation is a broad term used to denote a variety of practices, interventions and activities. Common definitions of social innovation variously characterise social innovation as new and improved solutions to wicked social problems (Phills et al., 2008) or as cross-cutting relational processes that improve institutional responses to complexity in relation to social issues (Mulgan et al., 2007). Social innovations have also been described as being social in both its means and its ends, in that they simultaneously meet social needs and create new relationships (Mulgan et al., 2007; Bureau of European Policy Advisers [BEPA], 2010). For the purposes of this paper, social innovation is defined as:

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

As Phills et al. (2008, p. 36) observe:

A social innovation can be a product, production process, or technology (much like innovation in general), but it can also be a principle, an idea, a piece of legislation, a social movement, an intervention, or some combination of them.

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

Social innovation is widely, but not exclusively, linked with public sector reform (see Mulgan et al., 2007; Leadbeater, 2007), with a particular focus on new approaches to service design characterised by cross-cutting collaborations (within and between sectors) and organisational forms consistent with the creation of hybrid (social, environmental and financial) value (Battilana & Dorado, 2010). With regard to the latter, social enterprise has been consistently linked to social innovation as a new type of business for social purpose and as a form of organising consistent with new public governance (Osborne, 2006), in which there are changing relationships between governments, civil society and private business in the design and implementation of public policy. In the context of US health care reform, Christensen et al. (2000) have argued that disruptive innovations – including both new low-cost technologies and new business models that challenge the status quo – are required to raise health care quality for all, and that government and industry need to create an enabling environment in which such disruptive innovations can take root.

Drawing on the literature, we have operationalised the concept of social innovation to include four dimensions:

1. social movements;
2. service-related social innovation;
3. digital social innovations; and
4. innovative forms of social enterprise.

Each of these dimensions is defined in the respective sections of the review findings.

1.2 Defining innovation

In order to effectively operationalise the concept of social innovation, we also need to clarify how we are utilising the term ‘innovation’. For the purposes of this review, we use the definition from the Centre for Business Innovation of the Conference Board of Canada:

The process through which economic and social value is extracted from knowledge through the generation, development, and implementation of ideas to produce new or improved strategies, capabilities, products, services, or processes
(Conference Board of Canada, n.d.).

The Conference Board identifies four dimensions of innovation – radical change (or breakthrough innovations) to goods and services; radical change to processes (including production and marketing processes. We also include here organisational structuring); incremental change to goods and services; and incremental change to processes (Conference Board, n.d.). Consistent with many definitions of both commercial and social innovation, we recognise innovation as including both origination of innovation (which is relatively rare) and adoption of innovation (including the application of existing innovations to new industries, new social needs and new markets).

2.0 Report aims

The aims of this report are to:

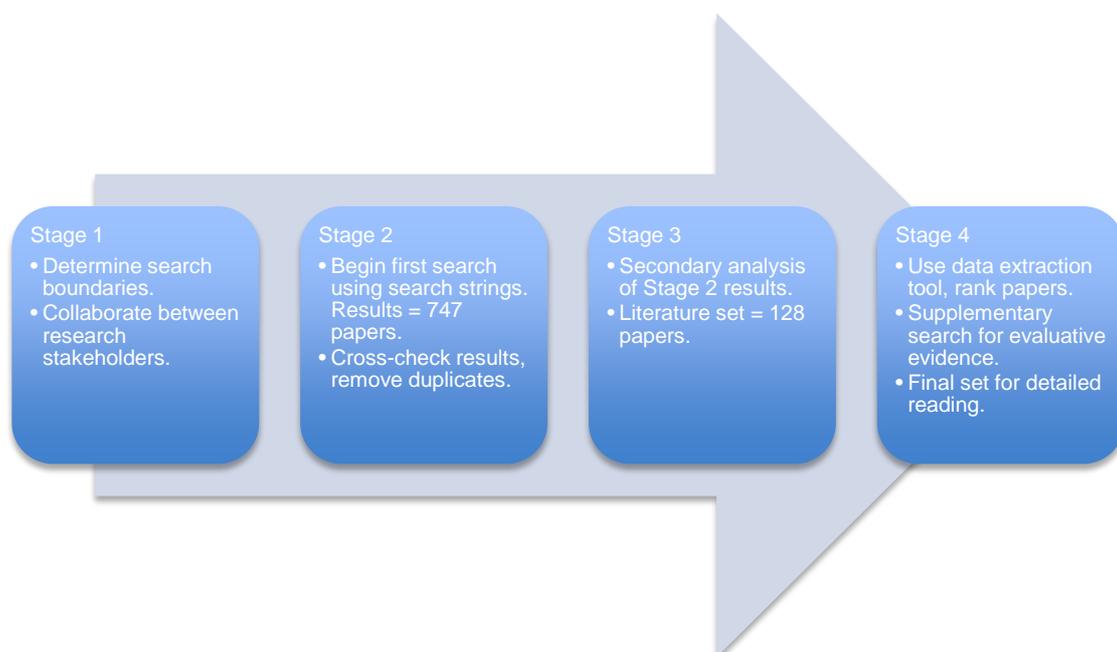
1. Review the evidence arising from scholarly and grey literature regarding social innovations that focused on improving health equity and/or that affected changes in health equity as a result of their implementation;
2. Identify implications for health equity promotion practice;
3. Identify limitations and gaps in the evidence and the implications for future research, evaluation or data collection; and
4. Identify key individuals and organisations pioneering new products, programs, approaches and models of social innovation/support of social innovation internationally.

We have utilised Fair Foundations: The VicHealth framework for health equity (VicHealth, 2013) to organise our analysis of the evidence. The Fair Foundations Framework is a tool for analysing and determining key trigger points to effect health equity and its promotion. It categorises the social determinants of health inequities as three layers of influence: the socioeconomic, political and cultural context; daily living conditions; and individual health-related factors (VicHealth, 2013). These three levels and the interactions between them are utilised to organise our analysis of the available evidence regarding emergent examples and impacts on health equity of the four types of social innovations and the implications for health equity promotion.

3.0 Methods

In order to perform a rapid and robust literature search, we adopted a four-stage process, as illustrated in Diagram One.

Diagram One: search strategy



In stage 1, we determined our search boundaries, which comprised the following themes: social innovation; health and wellbeing action agenda; health equity; social stratifiers;

socioeconomic, political and cultural factors; daily living conditions; health-related factors; and outcomes. These selections were based on VicHealth's Action Agenda, the levels of influence depicted in the Fair Foundations Framework and the research team's expertise on social innovation.

To ensure a comprehensive search, we included policy-level health equity literature that specifically addressed social innovation, to contextualise and connect policy with specific studies. We included a survey of websites maintained by supra-national institutions (such as the World Health Organization and Social Innovation Europe), and key government sources from high-income countries (including Australia, New Zealand, Canada, European major states and the US). The review includes scholarly research and applied case studies from the field. We excluded publications that were purely conceptual, except where they presented typologies or classifications for core concepts (for example, social movements). Existing systematic reviews were included, as well as research that sought to explain specific innovations in the practice of health equity promotion.

The full list of search strings and key words can be found in Appendix 1. Empirical publications produced from 2000 to 2014 were reviewed to limit the search to a timeframe when terms such as social innovation, inclusion and health equity have been popularised in public discourse. In cases where we drew on concepts that have a longer theoretical history – including, innovation, entrepreneurship and social movements – older publications are referred to where they are considered seminal to concepts discussed. Stage 2 of the systematic review process comprised a rigorous search of the identified engines and databases using the key words within the search strings noted in Appendix 1. Stage 3 involved a more focused analysis to isolate cross-disciplinary studies, and those that applied to multiple layers of the Fair Foundations Framework. To do this we used a power-search of the literature set within Endnote X7, focusing on the social innovation key words *alongside* the health equity and Fair Foundations Framework levels. This allowed us to identify those publications with the most relevant combinations of the key search terms. In Stage 4 we reviewed and ranked the papers remaining in the set using a data extraction tool (please refer to Appendix 2 for an illustration of how this tool was applied). We then undertook a supplementary literature search for evaluative evidence related to dominant exemplars of social innovation identified through this process.

A large number of social innovations were located across the three levels and entry points for action in the Fair Foundations Framework, 'socioeconomic, political and cultural context'; 'daily living conditions'; and 'individual health-related factors'. We have integrated the review with exemplars of social innovation relevant to each level, in order to illustrate and ground the analysis. In order to synthesise such variety across the literature, we broadly grouped our findings according to our operationalisation of the concept of social innovation: social movements; service-related or digital social innovations; and social enterprises. We did this with reference to the dominant emphases of the most heavily cited social innovation and social change research (e.g. Assink, 2006; Christensen et al., 2006; Leadbeater, 2000, 2004). It should be noted that these categories are conceptual constructs to describe primary differences rather than mutually exclusive classifiers and that there is some overlap between them for some examples included in the review. In order to broadly cluster the evidence and examples, we categorised them by their dominant approach (for example, the production of a service or the use of digital technology). Within each of the four broad categories, we examined the evidence with reference to the Fair Foundations Framework levels, in order to illustrate the cross-level effects of particular examples.

4.0 Findings

4.1 Social movements and health equity

In broad terms, social movements can be defined as 'networks of informal interactions between a plurality of individuals, groups and/or organisations, engaged in political or cultural conflicts, on the basis of shared collective identities' (Diani, 1992). Table One summarises the influence of social movements on health equity and the approaches through which these influences occur, using the Fair Foundations Framework.

Table One: social movements and health equity – summary of approaches and influence

FFF level	Source of innovation	Target of intervention	Example of impacts	Social movement exemplars	Implications for health equity promotion
Individual health-related factors	Affected people's knowledge Collective intelligence of communities	Affected people's attitudes and behaviours through collective consciousness	Increased self-esteem Self-efficacy (identity)	LGBTI identities, disability rights, feminism	Recognising value of individual knowledge and expertise Illuminating relationship between attitudes/ behaviours and institutional norms
Daily living conditions		Education	Increased participation in education	Feminism, disability rights	Maximising unrealised potential through increased participation
		Work and employment	Increased participation in employment Reduced pay inequality	Feminism, labour movements, disability rights	
		Health services	Community-based health and allied services	Health consumer movements	
		Physical environment	Universal design principles embedded in building codes	Disability rights	Reducing inequities through integrating user knowledge and service design
Socioeconomic, political and cultural context	Changing social position of affected groups within medical, political and legal institutions	Governance	New political parties	Environment	Collective approaches to institutional change
			Participation of new groups in politics and public service	Feminism, labour movements, civil rights, disability rights, LGBTI identities	
		Policy and regulation	Rights-based legislation	Feminism, labour movements, civil rights, disability rights, LGBTI identities	Wide repertoire of strategies to raise public awareness and mobilise public support
Cultural norms (societal attitudes, media)					

In terms of the Fair Foundations Framework entry points for action, many social movements have influenced the social-political, economic and cultural context by shedding light on the link between micro (or individual) experience and macro (or systemic) effects. Indeed, ‘the personal is political’ and ‘think local act global’ are mantras of the feminist and environment movements respectively (Burgmann, 2003). However, as forms of social innovation, social movements are typically characterised as playing a distinctive role at the macro level by redressing inequities produced by economic, cultural and socio-political contexts that drive social problems, including health inequities. In the case of traditional or ‘old’ social movements – that is, class-based movements concerned primarily with material needs of particular groups (Habermas, 1981) – one salient example is the modern cooperative movement. The genesis of this movement in the UK was in the failure of the transition from a feudal to industrial economic system to adequately provide food security and social welfare to those of the emerging working classes. The first modern cooperative – established by the Rochdale Society of Equitable Pioneers in 1844 – was explicitly concerned with providing safe food supplies to its members (Birchall, 1994). The primary innovation of the cooperative movement was its people-centred and purposefully democratic approach to economic organisation. Based on the principle of ‘one member one vote’, and later underpinned by a set of international principles that guide the movement (Birchall, 1994), cooperatives have played an enduring role in people-centred economics, with consumer cooperatives making substantial contributions to the provision of housing, childcare, financial services and food retail, for example, in Australia as they have in many communities across the world (Lyons, 2001). This form of economic organisation has been used to respond to: geographic inequities in access to goods and services; unmet service needs of particular social groups; and increasing economic self-determination of producers and workers within global markets (Craig, 1993).

Taking into account that innovation includes applying existing models to new settings, the cooperative movement is experiencing a renaissance as a people-centred organisational response to wicked problems related to environmental health and health services provision to specific geographic and demographic communities. It is notable that the cooperative form, along with other models of community ownership, is playing a growing role in the renewable energy industry in Europe (Cowell, Bristow, & Munday 2011; Warren & McFadyen, 2010). It has been noted by researchers that the cooperative business model overcomes a key market constraint of the take-up of this form of environmental technology:

community resistance. Communities that own the wind-farm assets are more likely to accept the presence of wind-farm infrastructure than those that do not (Warren & McFadyen, 2010). The well-established link between climate change and carbon emissions (Costello et al., 2009) suggests that economic change through industry-level transformation in the production of energy is necessary to redress population health inequities associated with environmental degradation.

In the case of primary and allied health services, cooperative and mutual forms have been introduced by governments to spin-off municipal health services in England, and to create new multi-stakeholder businesses models that respond to the socioeconomic participation needs of people experiencing addiction and mental illness in Italy and Spain, for example (Thomas 2004). Cooperative models have also been adopted by communities – both geographic and communities of identity – to enable responsive service provision in the face of geographic inequities in access to health services. In this sense, cooperatively owned businesses are socially innovative in that they respond to gaps in commercial and government service provision. This iteration of cooperatives as vehicles for social innovation is discussed further in relation to social enterprise below.

So-called ‘new social movements’ (Habermas, 1981) – that is, democratically driven and identity movements that emerged in the late 1960s and early 1970s[§] – have also played historically significant roles in redressing health inequities for particular social groups. The literature is consistent in identifying that the main social innovation of new social movements has been the way they give voice to or shed light on new forms of knowledge – often based in the experience of movement activists themselves – which challenge social and environmental inequities reproduced through institutionally sanctioned sources of expertise (Cornish et al., 2014; Raphael, 2009). In short, new social movements challenge the social construction of expert knowledge and the institutional conventions arising from it. A second social innovation with which new social movements are associated is their use of diverse communication forms, or acts of cultural persuasion, in both expressing movement objectives and widening collective commitments to action (Burgmann, 2003; McCammon et al., 2007).

[§] New social movements are typically distinguished from more traditional social movements by their focus on cultural reproduction and values, rather than on struggles for material advances of particular classes (see Habermas, 1981).

New social movements focused on redressing health inequities have typically not been addressed by new social movement scholars (Brown & Fee, 2014; Scambler & Kelleher, 2006), although such movements have played a role in both addressing and bringing to global attention the social determinants of health (Narayan, 2006). Two studies have sought to identify taxonomies of social movements as they pertain to health and health inequities. Brown et al. (2004, pp. 52-3) suggest that social movements centrally organised around health cluster within three categories: health access movements, which seek equitable access to health care and better provision of health care services; constituency-based health movements, which address health inequities based on social stratifiers such as race, gender, ethnicity, class and/or sexuality; and embodied health movements, which address experiences of disease, illness and disability by challenging scientific conventions related to aetiology, diagnosis, treatment and prevention. They acknowledge that the organisational agendas of many social movement organisations work across their movement classifications. Scambler and Kelleher (2006, p. 224), responding to the limitations of such fixed classifications – given the fluidity of social movements – propose a typology of the ‘mobilizing potentials’ of new social movements that address health inequities. They identify these potentials as: rights (exemplified in the disability rights movement); users (exemplified in mental health consumer movements); campaigns (such as anti-smoking initiatives); identity (such as contemporary feminist movements); and politics (exemplified by the ecology movement) (Scambler & Kelleher 2006, p. 226). They suggest that individual movements call on multiple mobilising potentials at given times. We draw in broad terms on this typology in our discussion of specific social movements below.

Second-wave feminism has played a substantial role in influencing institutional changes in western societies – in particular, second-wave feminism has sought to reduce gender-related health inequities, to support women’s reproductive health and the prevention of violence against women and their children (Munch, 2006). These changes included successful campaigning for the introduction of legislation such as marital rape laws and the creation of domestic violence services and women’s refuges. In concert with other social movements, such as the civil rights movement, second-wave feminism also played a substantial role in the introduction of anti-discrimination and equal opportunity legislation in most western countries (Burgmann, 2003; McCammon et al., 2007).

The women’s health movement, which has its roots in the broader feminist movement, played an instrumental role in redressing gender-bias and its exacerbations of health

inequities for women in western countries, throughout the 1970s and 1980s. This role included: identifying and drawing into the public domain the limitations of medical trials based solely on male participants; challenging conventions of medical and allied health services; and raising public debate about women's unequal access to participation in education and employment (Munch, 2006).

In relation to the Fair Foundations Framework, the work of second-wave feminism and the related women's health movement typifies the functioning of many new social movements. With its emphasis on democratic participation and identity politics, contemporary feminism shed light on the iterative relationship between individual health-related factors and daily living conditions and the socioeconomic, cultural and political drivers of health inequities. With regard to individual health-related factors, second-wave feminism – like other identity movements, including disability rights and lesbian, gay, bisexual, transgender and intersex (LGBTI) identity movements – traced how affected people's identities and related behaviours and attitudes are shaped by dominant cultures that ignore or stigmatise their experience **. Second-wave feminism also drew attention to the gendered nature of conventions that informed scientific, legislative and economic institutions, and the ways these in turn influenced daily living of women in relation to employment opportunity, educational participation, and access to appropriate health and other social services.

With regard to social innovation, feminism recognised the knowledge of women, grounded in their life experience, as a latent resource to be mobilised in support of social change (Sobnosky, 2013; Raphael, 2009). To this end, sharing experience informally between women and formally through public disclosure in literature, the press and testimony to relevant institutions became an important campaigning mechanism for raising women's consciousness, representing collective needs for institutional change as part of a rights-based agenda, and designing new services with women and their children's needs at the centre (Sobnosky, 2013; Munch, 2006). Both a cause and effect of second-wave feminism was the increasing representation of women within institutions, including political, medical and legal systems, which contributed to change from within, as well as collective resistance from outside institutional frames (Munch, 2006).

** The negative health effects for individuals of such stigma are well documented. See, for example, research on the relationship between internalised homophobia and depression (Newcomb & Mustanski, 2010).

As one new social movement example, second-wave feminism stresses the function of diverse campaigning strategies as well as the linking of experiential knowledge to institutional effects for marginalised groups. Another recent example of the latter, which emphasises the organisational innovations of some social movements, is the people's food movement. While politics of food is not a new issue (Starr, 2010), nor confined to North America, the development in 2013 of the People's Food Policy in Canada provides an interesting case study of how some social movements engage in consensus building as a mechanism to influence cultural and political norms related to the socioeconomic, political and cultural context level of the Fair Foundations Framework. This initiative has involved the development of a detailed proposed policy framework to support food sovereignty and security in Canada. It was developed by establishing a 'network of networks' – that brought together at a national level province-based networks of alternative food initiatives (AFIs) – which integrated local-level experience into policy development through an iterative process of drafting and dialogue. This 'people's policy' was thus developed by linking local AFI knowledge and needs to a macro-level framework, with provincial networks acting as the mediating device (Levkoe, 2014). In this case, drawing a wider population into commitment to the mission of the movement (Offe, 1985) is a core tactic of movement actors. This is achieved by both publicising the process of consensus building and, similarly to second-wave feminism, linking localised knowledge to policy and governance demands. Given the contemporary nature of this case, its impacts cannot be determined.

The rise of online technologies has supported new campaigning strategies for social movement actors (Turner, 2013). Indeed, social movements are often depicted as path breakers in the use of digital technologies for social change, with the Zapatista uprising in Mexico in the mid-1990s acknowledged as being the first social movement to link local experience of injustice to global political pressure mediated through the internet (Russell, 2005). Online campaigning organisations, such as GetUp in Australia, utilise a variety of campaigning strategies mediated through online and mobile technologies (Vromen, 2014). Contemporary social movements thus share some characteristics with forms of digital social innovation discussed in Section 4.3. These strategies have resonance for health equity promotion as they are explicitly concerned with changing attitudes and behaviours in support of more sustainable and just social conditions.

There is clear evidence that some social movements have had significant impacts on the socioeconomic, cultural and political contexts that influence health inequities (Brown & Fee,

2014; Brown et al., 2004), consistent with breakthrough innovation. Many of these have resulted in institutional changes – including changes in policy, legislation and cultural norms that guide socioeconomic participation – that have substantially reduced health inequities for particular social groups. At the same time, some inequities remain unchanged or, perhaps more accurately, change has not kept pace with changing societal needs and institutional restructuring that (re)produces social determinants of health inequities. As Scambler and Kelleher (2006, p. 230) note, social movements do not necessarily hold to strategies of social structural transformation, but generate cultures of challenge to expert knowledge that contribute to ‘material, political and cultural changes that matter most for health, longevity and meaningful choice’. Raphael (2007) suggests that social movements are particularly important in reducing health inequities within liberal welfare regimes (discussed further in relation to service-related social innovations below) because market-oriented public policy activity in these regimes requires cultures of resistance rather than presentation of evidence to be responsive to change. It should be noted, however, that the wins for some social groups to which social movements have contributed may in some cases exacerbate health inequities for other groups. In the case of second-wave feminism, for example, the movement and its successes have been criticised for framing social determinants of health inequities around gender issues to the exclusion of other social stratifiers, such as race and ethnicity (Thomlinson, 2012). In a related vein, critics of contemporary food movements identify lack of consideration for the effects on the global South – including reduced demand for goods and reduced attention to global food politics – of new localism in food sovereignty developments in the context of globalised markets (see Starr, 2010).

The implications for health equity promotion of social movement experience are multiple. First, while it is possibly not desirable or feasible to initiate social movements in response to the myriad of issues informing health inequities, there is scope for health promotion practitioners to work with social movement actors in the advancement of change or to apply learnings from one movement context to other settings or issues (Brown et al., 2004). Second, one of the defining characteristics of social movements is their mobilisation of knowledge, people and public sentiment through a variety of campaigning and rhetorical strategies. Many of these strategies have resonance for communications and social marketing in relation to health equity promotion, whether inside or outside social movements. Recognition of the value of these strategies for public health and health promotion are embodied in the development of campaigning resource kits, such as the

action toolkit produced by Unnatural Causes (2008) to advance health equity. Finally, movement organisation, such as the network of networks approach reflected in the Canadian people's food movement, provides insights into different approaches to (formal and informal) organisational structuring to maximise the impacts of collective action. While much of this takes place in the realm of civil society in the case of social movements, cross-sectoral organisational innovations are also characteristic of service-led social innovation, which is discussed further below.

4.2 Service-related social innovations and health equity

Service-related social innovations seek to improve services that affect socioeconomic participation through: joined-up and cross-sectoral service design and delivery; people-centred models of service design and delivery; and design-informed thinking about the outcomes services seek to achieve.

Drawing on the Fair Foundations Framework, Table Two summarises the influence of service-related social innovations on health equity and the approaches through which these influences occur.

Table Two: service-related social innovations and health equity – summary of approaches and influence

FFF level	Source of innovation	Target of intervention	Example of impacts	Exemplars of service-related social innovation	Implications for health equity promotion	
<i>Individual health-related factors</i>	User knowledge and experience	Stimulate entrepreneurship	Increased financial literacy	Microfinance	People-centred and assets-based program models	
		Attitude change through intergenerational interaction	Increased self-esteem and self-efficacy (mixed evidence)	Homeless World Cup		
<i>Daily living conditions</i>	Unmet social needs	Early childhood	New relationships between parents, education professionals and students	Room to Play	Recognising importance of bridging (between diverse groups) as well as bonding (between peers) in strengthening equitable participation and service use	
		Parenthood	Increase knowledge of child-related health	Prevention Visits program		
		Housing	Better-designed housing	Mission Australia MISHA project		
		Household composition	Self-determination	Neighbourhood Mothers		
		Education	Increased participation in informal educational contexts	Parler Bambins		
		Employment	Increased opportunities for self-employment within communities	Fondazione Welfare Ambrosiano		
		Social relationships	Increased social capital (bridging)	Family by Family		
<i>Socioeconomic, political and cultural context</i>	System failure	Local policy frameworks	Increase in social welfare support	Health Council of Canada	Context-specific design as response to systems gaps/failures	
	Demographic shifts	Program design	Changes and improvement in public attitudes			
	Global economic restructuring	Public attitudes to social problems and marginalised people	Local economic systems	Increased cross-collaboration	NACCHO (limited evaluative evidence)	Joined-up responses across sectors and between levels of governance

Commonly identified health equity issues addressed within the reviewed literature on services-related social innovations included: childhood; obesity; physical activity; ageing; mental health; women's health; and sexual health. There is a strong emphasis identified in the literature on the need to tackle the structural causes of health inequities, which are often targeted by welfare state systems with varying degrees of success. Both in member and non-member countries of the Organisation for Economic Co-operation and Development (OECD), the evidence illustrates how systems have been developed (either within the system, or in its absence) to provide service-related social innovations. These might take the form of basic health care provision in remote locations, mHealth services or online peer-support networks for marginalised or at-risk communities. Importantly, each of these social innovations aims to reduce relative health inequities experienced by geographic communities or social groups. Some of the examples related to these issues – reviewed below – place a strong emphasis on the scalability of the social innovations they deliver. In many cases, however, there is limited ongoing research that explores how particular modes of service design and delivery can scale effectively and sustainably across different levels of influence within the Fair Foundations Framework.

Early discussions of social innovation identified the welfare state – with its focus on social rights and social protections – as a form of government-led breakthrough social innovation (Mulgan et al., 2007). In its early iteration, the welfare state responded to the perceived limits of social support previously provided through civil society, which was viewed as too parochial, too charitable in orientation and too inefficient to meet social needs on a scalable level (Mulgan, 2006). Evidence related to the relative impacts of the introduction of the welfare state on population health inequities is not readily available. However, as first identified by Esping-Andersen (1990), welfare state regimes differ markedly across world regions. Research that has comparatively evaluated the relationship between welfare regimes and population health find that welfare regimes, or the political traditions with which they are associated, differ in their impacts on health equities at the individual health and daily living conditions levels, with those characterised by more redistributive policies associated with reduced infant mortality (Chung & Muntaner, 2006; Navarro & Shi, 2001), reduced inequality in employment status and self-reported health for women (Bambra & Eikemo, 2008). It is notable that emergent approaches to social innovation are typically characterised as responding to the inadequacies of the contemporary welfare state, which has become increasingly residualised across all regime types while simultaneously

responding to changing demographic needs of an increasingly mobile population and globalised economic system (Oosterlynck et al., 2013). Based on observations of 77 social innovation case studies across 20 European cities, the WILCO Consortium (2014) notes that one of the characteristic features of contemporary social innovations focused on social cohesion is their integrative approach. This includes integrating: government and non-government organisations, some of which have not traditionally been recognised as welfare actors; welfare and other policy fields, such as built environment, recognising the social effects that occur at the intersection between policy domains; and social and economic development. Furthermore, local-level social innovations are considered to be grassroots responses to gaps in welfare state provision, such as those seen in Central Europe (Kerlin, 2013). The emergence of new, local welfare systems in parts of Europe have precipitated rapid changes in existing institutional structures and created opportunities for innovations alongside or outside the emergent system (Andreotti et al., 2012).

Research relevant to the function of service-related social innovations typically targets the socioeconomic, political and cultural contextual level, with a specific focus on governance and policy. Studies of this type focus on the relationship between policy and political frameworks to understand the way that innovations are fostered in communities. Such fostering can occur through interaction between levels of governing (i.e. between macro, meso and micro levels). However, as a consequence, political-level actions aim to deal with complex social and cultural issues, meaning that political responses must also be complex in nature. Research shows that in relation to some social stratifiers – for example, gender, Aboriginality and ethnicity – long-term initiatives often fail to appropriately deal with core issues due to their complexity and institutional barriers (Cooke et al., 2007; Marmot et al., 2008).

In relation to governance and policy, national and supra-national frameworks appear to drive much of the programs and interventions that are developed at the local level. Initiatives include the World Health Organization Commission on the Social Determinants of Health (WHO, 2008) and the European Union Health Equity-2020 plan targeting 10 eastern European member states. Action plans such as these provide the over-arching political and conceptual frameworks within which the majority of social innovations – and related studies of them – targeting health equity outcomes are conducted. Importantly, it is from these frameworks that national-level directives and policies are often developed, and this leads to

consideration of downstream implementation, as well as upstream co-creation and co-delivery of services (Bason, 2010).

In some countries, the most significant policy-level innovations come from innovating through the development of National Health Insurance (NHI) schemes in order to promote wellbeing outcomes for marginalised social groups. For example, in Taiwan the development of one such scheme reports significant development of wellbeing among elderly women, reporting an increase in life satisfaction among this group and reducing disparities between previously uninsured men and women (Liao et al., 2012). Related research in Canada and Argentina has also highlighted the importance of policy environments in designing an effective and supportive framework to protect the wellbeing of women (in particular), to positively influence local level interventions (Piscopo, 2014) and, in the case of Canada, to provide support for improving daily living conditions for migrant families (Wilson-Mitchell, 2014). These approaches differ markedly from existing arrangements, because they re-direct resources and support to individuals and families not previously covered effectively by the prevailing system, thus making them more effective and efficient in both process and service to the user. These innovations seek to support and implement new ways of thinking (at the level of governance and policy), and delivering change (at the levels of daily living conditions and individual health-related factors).

Much of the emergent research on service-related social innovations focuses on environments characterised by weak institutions, largely those in developing economies (Aranda-Jan et al., 2014). This provides useful insights into how collaborative partnerships can succeed in the absence of welfare infrastructure in politically unstable contexts. For example, the Health Extension Program (HEP), developed and implemented in Ethiopia, improved health coverage in Ethiopia from 64% in 2004 to 92.1% in 2011 (Teklehaimanot & Teklehaimanot, 2013, p. 7). Also in Nigeria an innovative, school-based comprehensive sexuality education (CSE) curriculum has been successfully scaled and implemented nationwide (Huaynoca et al., 2014).

However, we also know from existing research that encouraging and sustaining innovations in primary health care is a central part of the challenge when addressing equity issues in developed economies (Sibthorpe et al., 2005). Especially important is the bringing together of three core elements: social relationships, networks and champions; political, social and

financial resources; and the motivation of agents in a prevailing system (Sibthorpe et al., 2005). Therefore, the implication for ongoing action to tackle systemic health inequities is institutional stability and sustained internal support to foster external networks (Starfield, 2007).

Established research shows that particular ethno-cultural communities experience significant social and health inequities in our society. For example, studies from Canada, Australia, New Zealand and the US show that Aboriginal communities are at a considerable health disadvantage regarding violence, tobacco use, alcohol and diabetes mellitus (Harris et al., 2006; Mobbs, 1991; Reading & Nowgesic, 2002; Ring & Brown, 2003). Although the gap is largely claimed to be 'closing', much more needs to be done to ensure that the dangers of endemic community decline are arrested and overcome (Cooke et al., 2007). There have been a number of responses to some of the complex issues preventing long-term political social and cultural change. For example, at the grassroots-level, targeted health interventions have been successfully implemented in Australia, involving participatory, self-determined health care program development (National Aboriginal Community Controlled Health Organisation [NACCHO], 2013). As part of the Close the Gap campaign, the Investing in Healthy Futures for Generational Change report seeks to tackle systemic issues at the broadest political level, integrating cultural competency into the framework to further shape the appropriateness of health action at the level of daily living conditions and individual health-related factors. For example, the 10-point plan developed by NACCHO focuses on key areas, including system reform, innovative health care, partnership, Aboriginal health leadership and workforce health. No evaluation data currently exists for the implementation of this plan, although a recent evaluation of the Close the Gap program in Victoria found increased awareness and understanding of Aboriginal community health issues within the broader health system, which also impacts daily living conditions at the community-level through innovations in access to universal health care (URBIS, 2014). As such, NACCHO seeks to provide a more effective and just innovation in the health care arrangements for, and health leadership in, Aboriginal communities.

The need to provide a scalable solution to address large-scale health equity issues is common across policy environments, irrespective of nations' stages of economic development. For example, in response to the obesity pandemic, which affects many

developed economies, longitudinal studies seek to understand how to address childhood obesity by focusing on energy-related child behaviours, and the socioeconomic status of parents (Badland et al., 2014; Canuto et al., 2013; Rube et al., 2014). Here, the innovation is presented in terms of the *approach taken* to a key health equity issue. The basis for determining the best approach often depends on the presence of a defined community, within which existing and new relationships can be built to co-deliver effective promotion and support (see, for example, Mantziki and colleagues' 2014 study of the Epode for the Promotion of Health Equity). Research on the scalability of social innovations frequently calls for a more prominent place for social entrepreneurs in making the scaling activity successful (Zahra et al., 2009). It should be noted that innovation is a characteristic of entrepreneurship but that not all innovators are entrepreneurs. Another characteristic of entrepreneurship is the development of sustainable ventures, with scale considered a core approach to this (Schumpeter, 1942). However, as the evidence and examples in the health equity research show, scaling appears to be supported by complex partnerships between the public sector, non-governmental organisations and communities. Therefore, scalability is not the sole preserve of social entrepreneurship, and there needs to be more careful analysis of the needs of communities, the feasibility of the project to scale up, and the desire and motivation of institutional actors in committing to scaling. The example below shows how scaling is not always needed to address structural issues (public sector failings) to make an impact on a defined community or social group. Rather, of principal importance is the quality (and legitimacy) of the *idea* that drives the process of change, resulting in social innovation. The quality of the idea might be appraised by partners, funders and communities by how it breaks old systemic service delivery pathways (ex-ante and/or ex-post), or creates new configurations for social action based on divergent thinking and unique collaborations. Its legitimacy might be gauged by its alignment with core stakeholder values, their level of participation in the delivery of change through innovation, and actual changes in health equity among beneficiaries.

*The **Prevention Visits** programme, based in Münster, Germany, is a social and political early intervention programme seeking to assist parents and children. Alongside the core aim of improving family relationships with the local Youth Office, this voluntary intervention scheme has now become firmly established in the local welfare regime. Having been designed and implemented from within the state system, the Prevention Visits programme illustrates how*

institutional contexts can accommodate innovations 'from within', supporting staff in responding to emergent or entrenched social problems in communities. The programme is an example of incremental service innovation that seeks to be more effective and efficient than existing arrangements.

(Source: WILCO, 2014 p. 140)

Other interventions have been designed that innovate within existing social welfare platforms, with a particular focus on daily living condition influences within the Fair Foundations Framework. For example, conditional cash transfer (or voucher) systems have been developed as a social safety net program for families affected by intergenerational poverty in Brazil, specifically the Bolsa Família program. The system was launched in 2003, following several years of systemic failure in reducing inequality in Brazil through the Unified Health System. Within five years of inception, the new system resulted in a '9.3% reduction in overall infant mortality rates ... declines in post neonatal mortality rates ... Programs like Bolsa Família can improve child health and reduce long-standing health inequalities' (Shei, 2013 p. 1274). Therefore, innovations in the design (or modification) of social welfare systems allow more at-risk individuals and families to circumvent existing barriers and difficulties in using the systems in place (Shei, 2013). This further reinforces the idea that socioeconomic, political and cultural context influences innovations in health equity that have significant and immediate impacts on daily living conditions and individual health-related factors.

Family by Family (FbF) is a network family support program based in South Australia, and is the result of a partnership between the Australian Centre for Social Innovation, the South Australian state government and Uniting Communities. FbF connects families together to provide a collaborative support network to enable families to learn how to make positive changes in their lives to break through endemic cycles of crisis. The premise behind the network is that many families suffer hardships that can drastically affect their daily lives and future ability to thrive. Also, the co-design and delivery of the service between community and public sectors creates an intelligent approach to dealing with complex social problems. Furthermore, a key goal for the program is to build community-level social capital from work that deals with both individual and daily living conditions level influences on health equity. To achieve its outcomes, the FbF program deploys a theory of change that identifies needs, implements an informal link-up between families to ensure matching of experience and needs, and measures resultant outcomes. A 2012 evaluation of the program found that

participant families benefited from the voluntary, informal nature of the link-ups, reported family members having greater levels of self-esteem and many believe their families are moving on from crisis. FbF represents an incremental innovation to existing family services that improves effectiveness, by reconfiguring both the processes by which the services are delivered, and the nature of the services.

(Source: Westhorpe, 2012)

The evidence review suggests that supportive (and collaborative) design approaches are often centrally important in fostering positive systemic changes to health equities. For example, a global study of best practice in built environment and transportation-focused physical activity research argues that innovative ‘translational research partnerships’ are required in order to tackle endemic issues related to low levels of physical activity (Trowbridge & Schmid, 2013). Specifically, these authors cite the importance of co-design as part of infrastructure development, specifically with the aim of developing health-related policy, decision-support and information tools. As Moulaert (2009) argued, focusing on place and space forces policy makers to recognise the importance of these factors on developing and sustaining social relations in communities. As the US organisation Kaboom! (2014) illustrates through their work on community-built playgrounds, community participation in the creation of a shared (and developmental) space has been central to the organisation’s and the playgrounds’ success. The organisation has built over 2000 playgrounds, providing convenient access to approximately 5.5 million children in US communities (Kaboom!, 2014). Consequently, they offer an effective and sustainable innovation to secure community participation in their work, which also represents a breakthrough relative to existing approaches to utilising public spaces.

Policy makers are also encouraged in the literature to broaden their scope when assessing *whose* health is the focus of the intervention (Grimm et al., 2013). For example, those individuals and groups who are marginalised in society often face disproportionate degrees of health inequity (Cattell, 2001; Marmot 2005; Marmot et al., 2008). Delivering services to some population groups – such as new migrant communities, transitory or displaced people – can pose many difficulties for mainstream services and service providers. Some examples of service-led social innovation seek to deliver community-appropriate services in ways that allow medical and other institutions to increase their knowledge of particular users’ needs, which is in turn used to inform service refinements. The MUN Med Gateway project is a

collaboration between medical students and a refugee settlement agency, the goal of which is to provide continued access to cross-culturally appropriate health care for refugees (Brunger et al., 2014). The project works by providing clients with access to the professional medical system in an effective, efficient and sustainable way. In turn, the project team collects important data concerning the health status of people previously unaccounted for in the system, leading to, for example, more effective cancer screening, immunisation and specialist referrals. The Gateway project illustrates how cross-sectoral communication and knowledge sharing – in this case between citizens, a community services organisation and medical services – can help to create, and be integral to reducing health inequities through, health care design and delivery. A wider effect of this service design was increased advocacy for the needs of affected communities through a variety of professionals and institutions. The project delivers much-needed access to mainstream health care, while making better use of professional medical workers (i.e. student doctors). This circumvents systemic health issues (transient workforces, poor funding) as well as equity issues (unaffordable health care, social disadvantages for migrants), while more effectively capturing evaluation data concerning difficult-to-reach communities. Thus the Gateway project delivers more effective and just services for migrant families – building on existing arrangements that serve the needs of both medical and patient participants in an efficient way.

*The **Health Council of Canada (HCC)** developed an Innovative Practices Evaluation Framework to gauge the effectiveness of innovative practices leading to “positive health outcomes and/or health care system performance” (Health Council of Canada, 2014, p. 1). This framework was developed to support the institutional work aimed at fostering innovative practices within the system. Consequently, the Framework categorises innovations as either emergent, promising or leading, and emphasises inclusivity of coverage. This approach offers value at the sociopolitical level since it recognises the need to understand the effectiveness of health care innovations, alongside stage of development and the relevance to targeted communities. The Framework seeks to provide more effective support for developing incremental innovations in health services.*

(Source: Health Council of Canada, 2014)

One solution to the problems of achieving scaled responses to intractable health equity issues involves innovation using existing technologies to provide necessary public services, such as health. Mobile health (mHealth) projects, especially across the African continent,

have generally proved successful in delivering innovative approaches to health care provision, as part of a broader health system (Aranda-Jan et al., 2014). A notable Central American example is Medicall Home (2014) in Mexico, which is a health care system that provides low cost medical advice in the absence of a robust public health system. Medicall responds to public and private services failure, providing a much-needed service, while changing the platform for delivery to suit the broader political and cultural infrastructure (Akter & Ray, 2010). A further example from the Netherlands is Buurtzorg, which is a home care organisation. Its primary social innovation lies in its organisational structure. Buurtzorg is based on the self-organisation of care provision, initiated and run by a small number of nurses who were disaffected with dysfunctions in the prevailing system, i.e. the failure of the public sector to properly manage the delivery of core services to clients. Buurtzorg provides a more effective service by allowing district nurse networks, supported by a designated General Practitioner, to self-organise to ensure the more effective care delivery when, and where it is required. Consequently, by 2013 Buurtzorg's network of 6500 nurses provided care for 50,000 clients, and returned the highest satisfaction from clients and staff in the entire country. This satisfaction is largely driven by the close relationships that nurse networks form with their local communities, reducing care costs by as much as 40% (Nandram et al., 2014). Thus Buurtzorg operates more effectively and efficiently than dominant care services for communities, suggesting that breakthrough innovations in care network arrangements (i.e. processes) result in better provision.

To summarise, at the socioeconomic level, significant health equity challenges are met using a variety of service-related social innovations. Where existing welfare mechanisms are shown to be ineffective, innovations have been developed that have meaningful impacts on communities (Shei, 2013; Huaynocha et al., 2014). Indeed, to tackle systemic health inequity, social innovations often develop through strategically driven, cross-sector partnerships and open collaboration (Trowbridge & Schmid, 2013). This opens up the possibility for participatory, co-designed programs and policy environments, making them more responsive to the range of stakeholders affected by health inequity, including design processes inclusive of the knowledge and needs of marginalised individuals and groups in society, who are often most affected by health equity issues (Marmot 2005; Marmot et al., 2008). A major issue that remains is how to scale up health equity innovations (Westley & Antadze, 2010), although some stand-out case studies exist (such as Medicall, 2014). This

knowledge would provide some significant evidence-based decision-making support to organisations that assist developmental social innovations. Further research that traces at a macro level how social innovations diffuse through social, organisational and institutional networks would provide clearer empirical evidence of the function of relationships within and between groups in successful diffusion, and scaling, of social innovations.

With regard to the relationship between social innovations and health equity promotion at the level of daily living conditions, several health equity influences present as recurrent themes in the evidence review, including: income; housing and neighbourhoods; early childhood and families. For example, one study explored complex issues concerning income, geography and early childhood, and an innovative approach to providing opportunities to learn for children in 'hard-to-reach' families (Evangelou et al., 2013). Room to Play is a drop-in centre in the UK, focusing on flexible modes of delivery to support parents and children by re-asserting the role of parents as the most important educators in the child's life. By focusing specifically on young parents, and locating the centre in the heart of a city deeply hit by unemployment, the centre was able to show how considerations of location, space, relationships and curriculum could be deployed to attract targeted family groups. The impact of this centre over a three-year period was the effective modelling of appropriate parenting behaviours and fostering social connections between families at risk of mental illness (Evangelou et al., 2013).

As with the evidence of practice examined in relation to the socioeconomic, political and cultural level of the Fair Foundations Framework, issues addressed by social innovations at the daily living conditions level of the health equity system are often multi-faceted problems arising at multiple intersections within the system. The interplay between factors, which is characteristic of complex systems, creates both wicked challenges and new opportunities for social program design.

SecondBite is a nonprofit organisation based in (and providing services across) Australia, bringing food security relief to families and communities. SecondBite redistributes surplus food, providing increased food security for communities as well as helping partners and donating organisations to reduce their waste. They achieve this goal through the implementation and evaluation of two core programs. First, their corporate partner Coles supermarket works with SecondBite to redistribute surplus food from its stores, providing an

estimated 13 million meals for targeted communities. Second, SecondBite's Community Connect program involves direct supply of surplus food to community organisations. In so doing, SecondBite acts as a conduit between food producers and families in need. As of 2013, SecondBite has provided food to 192 community groups and contributed to environmental benefit through greenhouse gas and water reduction impacts. Inter-organisational collaborations and cross-sector collaborations are at the heart of SecondBite's value. The breadth of SecondBite's impact means that they provide a breakthrough innovation that is effective and efficient in creating sustainable food security for at-risk communities. The redistributive nature of their service also illustrates the just impact of their work.

(Source: SecondBite, 2014)

An example of this process in action is the MOM program, a US-based home-visit service for children in urban, low-income environments designed to promote 'child health through regular paediatric visits and enhancing school readiness through developmental screenings and referrals to early intervention' (Radcliffe et al., 2013, p. 153). The MOM program managed to retain 89% of children and provide three years' health promotion and early intervention. Such programs are common in the literature (see Wallerstein 1992; Labonte & Laverack, 2001; Merzel & D'afflitti, 2003; Evangelou et al., 2013), which typically assesses how programs effectively demonstrate a significant impact on the health equity issue under study. A recent systematic review of home-visiting programs for vulnerable families and children, however, concluded that the evidence of what works in these programs is either contradictory or unavailable, making it difficult to isolate what differentiated more effective from less effective approaches (Moore et al., 2012).

Parler Bambins is a breakthrough innovation in early intervention programmes to develop language skills in children aged 3-34 months. Having originated from a trial in 2005, and supported by local councillors, this intervention is based on the premise that language skills are directly related to wider issues of education (and social) inequalities. The social dynamic underlying these problems is the changing way that parent and childcare assistants interact with children, favouring group, rather than individual interactions. Thus, the programme encourages language skill development in young children by providing a space for direct conversation between children and childcare professionals, including workshops for children requiring extra support. The programme's success has resulted in research that further supports the intervention type, which in turn provides support for policy makers seeking to

embed this approach in policy frameworks, underscoring the effectiveness of this innovative programme.

(Source: WILCO 2014, p. 77)

As we can see from the above examples, the challenges inherent in reducing inequities in early childhood life stages, and between families, may be tackled through social innovation, although the evidence remains mixed. These inequities also extend beyond childhood, into teenage and young adulthood, where individual health-related factors, such as self-esteem, both inform and are informed by choices that affect equity in health and wellbeing (Ahn, 2011). This is demonstrated in relation to the issue of youth unemployment. Existing research is consistent in the finding that unemployment (a social determinant of health) is linked to health equity among young people (see Comino et al., 2003; Axelsson et al., 2007; Kjellstrom & Mercado, 2008). It is unsurprising that emergent social innovations are currently practised to prevent or reduce the impact of youth unemployment, particularly in contexts where stages of national economic development or economic shocks effected by global financial problems have exacerbated youth unemployment overall (BEPA, 2010). Yet, similar to interventions that respond to other systemic problems – such as long-term unemployment, intergenerational unemployment and homelessness – social innovations that address youth unemployment need to redress core structural causes of the problem. The readiness and ability of public sector actors to respond to emergent causes of inequity (e.g. post-Global Financial Crisis) or ongoing local challenges (e.g. geographic economic inequities; out-migration of populations from rural areas) have been seen to be critical to mobilising resources in upstream and downstream innovations.

Lille Metropolis initiated a support scheme for housing self-renovation, run through the non-profit organisation Companion Builders and three local housing organisations. The purpose of the scheme was to address direct and associated issues with poor quality housing, including revitalising run-down housing stock and focusing on individual and family benefits through self-renovation. The benefits for local people include building self-esteem, practical skills training and the participation of volunteers in the projects. The innovative context comprises incorporating self-renovation into local council housing policy to align with other urban policies, to encourage new ways of addressing daily living conditions as well as individual health factors exacerbated by poor living environments. Consequently, the local

council administration has been able to sense the complexity of a problem in the daily living conditions of citizens, and mobilise innovative services that build social capital and address the problem itself. These services are the result of new thinking in 'process', in particular across policy domains, and represent an incremental social innovation because they reconfigure existing resources to produce more effective and just outcomes for service users. (Source: WILCO, 2014, p. 73)

Further studies emphasising collaboration between different organisations – particularly at the interface between research and practice – as an important component in delivering socially innovative health promotion include Patterson et al. (2014), who show how a University-Community partnership provides effective interventions to help reduce homelessness. The collaboration works because the University partner provides a management information system that collects and makes sense of data on homelessness in the community. Community-based research is then used to tackle issues identified by the partner, and more effectively targets the issues as they specifically relate to a defined locality. Further studies have highlighted how academic health centres have collaborated with several institutional partners (such as schools and primary health facilities) to reduce health inequities at the level of daily living conditions. An important feature of this approach is equal participation between all partners and mutually beneficial collaborations (Crosby et al., 2013).

*The **Fondazione Welfare Ambrosiano** is an example of cross-institutional collaboration and flexibility in delivery based on sudden economic shocks to communities. This Foundation, based in Milan and surrounding areas, is the result of city government and trade unions collaboration. Funds that were donated back to the Milanese Municipality by the trade unions have been largely set aside to fund innovative local welfare projects. In particular, the ongoing impact of the Global Financial Crisis on local people, regarding falling incomes leading to social disadvantage is off-set in the short-term through micro-credit. This credit is used as either 'social' credit to alleviate issues related to loss of employment (in conjunction with long term institutional social support); and credit for self-employment opportunities. Furthermore, funds are allocated for training, workshops and research into better understanding of local social needs. This directly relates to health equity at the socio-economic and daily-living conditions levels, showing how institutional collaboration can be effective in the short term to alleviate causes of inequities. The breadth of impact also suggests that the collaborations represent a more effective, efficient and just processual*

response to the needs of socially disadvantaged communities.

(Source: WILCO, 2014, p. 248)

These new forms of organising both make more efficient use of available social, physical and knowledge resources and assist with mobilising additional resources that may be typically out of reach to particular geographic communities or social groups. The Good Gym (2014) illustrates the role of partnerships in creating positive health behaviour changes. By linking in with the popularity of personal fitness, the Good Gym works by teaming up runners with ‘coaches’ in local communities, with the specific goal of alleviating loneliness and isolation experienced by older people. Through getting people out of traditional gyms and into community spaces to perform volunteer work, the Good Gym manages to promote several core health equity issues, and connect people in communities who would not normally interact. The service itself represents a more effective, incremental innovation, working alongside existing support systems for older citizens. The US-based Community Leadership Institute (CLI), for example, develops leadership training for community leaders in partnership with a University Faculty. Over a two-year period, the CLI produced 41 graduates, many of whom have applied skills learned through the collaboration (such as program evaluation and grant writing) back into community health centres. The outcomes include new health grants in excess of \$3 million, as well as new strategic partnerships in key areas, such as obesity and child mortality.

Neighbourhood Mothers is an example of social innovation that explicitly addresses two Fair Foundations Framework levels: daily living conditions and individual health-related factors. This intervention is based on a mentoring and support model for (mostly) immigrant families, providing advice and access to health services and other linked family-based issues. Essentially, the mentors are fellow community members who have ‘passed’ a six-month course before working with new community members. Participants are referred as ‘neighbours’ or ‘community members’ – focusing on a different (friendly) strategy that differs from existing local government provision. That said, Neighbourhood Mothers also works within the prevailing welfare system as an early intervention phase for hard-to-reach immigrant families. The model has proven effective at assisting mothers by increasing knowledge on child-related health, as well as providing a safe social network space for participants. Neighbourhood Mothers is a good example of an innovative service that is more effective and just than existing, local government approaches. The service represents an

incremental innovation, since it works within the existing welfare framework.

(Source: WILCO, 2014, p. 125)

In summary, at the daily living conditions level there are several health equity issues that present commonly in available research on service-related social innovations. As a source of social innovation, collective intelligence of those disproportionately disadvantaged by health inequities is a significant resource. As targets for intervention, housing and neighbourhoods, early childhood, social networks and geographic exclusion are common to many of the cases documented. The complex and systemic nature of these issues means that they present significant challenges to social innovators, who have to approach health problems from new and unique angles. Commonly, community-based, participatory approaches are designed and implemented to overcome challenges such as income-based (Radcliffe et al., 2013) and location-based social exclusion (Evangelou et al., 2013).

*Mission Australia's **MISHA project** was a two-year scheme to address homelessness among 74 men in Western Sydney. The innovative thinking behind this approach lies in how the project aimed at bringing together a complex arrangement of services, while also providing workable solutions for individuals and delivering capital efficient funding per client.*

Identifying the problem of homelessness often uncovers multiple issues and needs that often create an endemic cycle of short-term solutions to a long-term problem. Over the two-year period, MISHA successfully broke the cycle by addressing multiple issues and providing ancillary services alongside housing support. For example, the integration of case management and psychological support into the system offers participants the chance to deal with factors that contribute to homelessness, such as mental health disorders, substance abuse and lack of social support. MISHA also found that dealing with the participants in this way decreased their reliance on human and welfare services by 24%. This project illustrates the transformative potential of new thinking to address complex problems, enabling individuals to overcome long-term determinants of health inequity, while also serving the interests of multiple stakeholders. MISHA showcases an effective, efficient and just innovation in tackling multiple issues related to homelessness, providing a breakthrough (patter-breaking) innovation in the process of doing this.

(Source: Conroy et al., 2014)

Also, significance is attached to the type of collaborative partnerships driving the innovation, for example, Universities and research faculties working with community organisations (Patterson et al., 2014). Existing research offers evidence largely based on cross-sectional or ‘snapshot’ studies of pilot programs (e.g. Evangelou et al., 2013) utilising non-comparable methodologies. These lack longitudinal insights and potential for aggregating evaluative knowledge. Extended collaborations between research providers and community and public sector organisations based on longitudinal projects could more coherently track the impact of social innovations on the daily living experiences of defined communities and social groups.

At the level of individual health-related factors, there is a range of evidence to illustrate different approaches to encouraging innovation in health equity promotion. Indeed, at this level individuals are most likely to experience systemic health disadvantages in ways that place them at an ongoing disadvantage in important areas of their lives (e.g. emotional and physical development – see Lynch et al., 2000). Research focused in this area illuminates complex, cross-category influencers on the determinants of individuals’ health, and service-related social innovations seek ways of dealing with issues that are more effective, relevant, efficient and convenient than previous approaches (Roy et al., 2014). The main issues focus of service-related social innovations at this level identified in the evidence review comprise sexual health, obesity and mental health. A number of studies report on the role of social media, social networks and other technology-based interventions in alleviating health issues and/or promoting health equity across social groups.

iTalk Library is a service, based in the Northern Territory, Australia, that uses story-telling through the medium of modern technology to address critical social and health equity issues. iTalk Library’s core mission is to transform the written word into stories, using an innovative software platform to encourage story development, collaboration and sharing. For example, stories concerning mental health cover all age groups and a range of cultural contexts. Through collaboration with partners in other sectors, including Beyondblue, they are also able to provide access to resources free-of-charge. As such, iTalk provides an effective and sustainable solution to address health equity issues, utilising existing technologies to provide service innovations.

(Source: iTalk Library, 2014)

In addition, the place of community in the inception and implementation of service-related social innovations appears in our review to be as important as the adoption of the chosen media to deliver it. An innovative, community-based delivery model for cancer patient care, prevention and treatment, for example, has done this by addressing the disparities in quality cancer care available based on race and socioeconomic factors. By building a community orientation into the core of the delivery model, including oncologists at health-centre level, this approach more effectively targets vulnerable communities affected by these disparities, who would normally be missed in health care prevention strategies that are designed without user involvement (Waldman et al., 2013). Prevention through participatory design and delivery has been shown to be an effective intervention for individual health matters that are now recognised as increasingly common, especially peer-based prevention interventions for mothers at high risk of depression (Reddy et al., 2009; Van Voorhees et al., 2011; Acri et al., 2014).

Sports-related social interventions are not new and their positive effects on social determinants of health equities are well documented (Magee & Jeanes, 2011). However, the innovation of the Homeless World Cup (HWC) rests in its large-scale international orientation and its efforts to influence behaviours and attitudes of players, spectators and the media. Established in 2003, the HWC is a world-class annual international football tournament that seeks to energise homeless people to change their own lives. The annual competition brings together national teams of people without homes, and supports local football programs of homeless people that operate throughout the year.

In 2011, the HWC included 64 nations and introduced the Women's Homeless World Cup. More than 50,000 players in over 80 nations are active year round in the activities of the Homeless World Cup (Schwab Foundation for Social Entrepreneurship, n.d.). At the level of individual health-related factors, research findings from an Australian study of participants in the HWC indicate that participation in this sports initiative had both intrinsic and broader social capital development effects for marginalised people (Sherry, 2010). However, another study of the experiences of a UK squad found that the competitive sporting elements of the cup served to reinforce experiences of marginalisation that resulted in use of harmful coping strategies, such as heavy alcohol use, to mitigate feelings of exclusion (Magee & Jeanes, 2011). These authors note that subsequent adjustments to the organisation of the HWC – including the expansion from one to six final awards – in part respond to the issues identified. In the case of spectator experience, additional research by Sherry, Karg and

O'May, (2011) found that the HWC played a role in stimulating bridging social capital, positively affecting spectators' attitudes towards homeless and vulnerable people. The HWC example illustrates an effective process-oriented innovation to raise awareness of homelessness and associated equity issues, while incrementally building on support systems for individuals affected by these issues.

The positive flow-on effects for community building and creating stronger social relationships are noted in the research, such as the Infant Feeding Information Team in the North West of England. Through effective partnering between participants and researchers over a six-month period, a four-step intervention created a more relevant and useful approach for at-risk mothers. Services such as this can succeed if they provide front-line staff who deploy the system with the necessary information to reinforce WHO breastfeeding guidelines at a local level (Dykes et al., 2012).

*The **Association for Self-Financed Communities (ACAF)**, based in Spain, provides micro-credit facilities for citizens using a self-financing communities model, which works by increasing the local availability of credit while also encouraging community building. This is especially acute in communities with large immigrant populations who often find themselves isolated in local society. The outcome of the credit can be for entrepreneurial or non-entrepreneurial projects, provided there is a joint and democratic ownership of the resultant project/organisation. ACAF has provided credit of €132,000, with over 500 members and 3500 indirect beneficiaries. This approach offers a more sustainable service and process innovation in credit availability, leading to incremental improvements to the system supporting migrant-centred projects that encourage community participation.*

(Source: Winkomun, 2014)

A widely cited social innovation based on people-centred service design is that of microfinance. With its origins in the work of the Grameen Bank in Bangladesh, microfinance has expanded substantially, both in scale and geography, over the last 25 years. In developed economies, the primary functions of microfinance are to provide access to affordable and safe finance for people that are typically excluded from accessing mainstream financial services. This has been applied to personal finance for individuals and households who experience barriers to accessing mainstream credit, as well as business finance for under-represented micro-entrepreneurs – particularly women and people from culturally and linguistically diverse backgrounds (Westall et al., 2000). There is a vast

literature on microfinance in developing economies, yet relatively little on the effects of microfinance in developed economic systems (Dale, Feng, & Vaithianathan, 2012; Estapé-Dubreuil & Torreguitart-Mirada, 2010). In developing economies, available macro-analyses suggest that microfinance does reduce income inequality within national populations (Hermes, 2014) but the significance of this effect differs according to different studies, with some suggesting the effect is minimal (Hermes, 2014). One comparative analysis that included both developing and developed economies finds that positive effects of microfinance for the poor are substantially more significant in developing economies (Saeed, 2014). In developed economies, however, there is substantial evidence that lack of access to safe and affordable finance is both unequally experienced (Firestone, 2014) and can have compounding effects on social determinants of health, including access to secure housing, employment participation and escape from domestic violence (Postmus, Plummer, McMahon, & Zurlo, 2013; Speak, 2000). Evaluation evidence from Good Shepherd Microfinance's No Interest Loans Scheme, which provides personal debt finance to low-income households and has served more than 125,000 people over 30 years, suggests that this program improves clients' financial capabilities and has a direct positive effect on their economic and social outcomes (Centre for Social Impact, 2014). Dale et al. (2012) suggest that, while documented evidence of the social impacts of microfinance in developed economies remains scant, a value of this particular scheme in a market-driven financial services system is that it provides participants with an opportunity to rehabilitate their credit history with mainstream lenders, by documenting their performance with regard to successfully meeting loan obligations.

In relation to individual health-related factors, the literature indicates that social media and online approaches generally are an effective platform for interventions. For particular health issues that attract social stigma, online and social media can be developed as a reliable resource for good-quality health information, and also preventive health promotion (Rhodes et al., 2010). Social media has paradoxical effects here, given that it has the acknowledged role of exacerbating social stigma (O'Keeffe & Clarke-Pearson, 2011). At the same time, advances in our understanding of both the platform and the user behaviour and participation behind it, offer break-through innovative uses for social media. For example, regarding health information provision in areas such as childhood health, social media can effectively facilitate training for health workers across the system (McInnes & Haglund,

2011; Steele et al., 2013). This forms part of a systemic approach to reach and connect institutions (e.g. schools) and families with a key health issue in mind. In terms of preventive health care, especially with regard to mental health, organisations have utilised social media in interesting and appropriate ways, as Big White Wall (2014) and other similar organisations have shown. This is discussed further in relation to digital social innovations below.

4.3 Digital social innovation and health equity

Digital social innovation refers to:

A type of social and collaborative innovation in which innovators, users and communities collaborate using digital technologies to co-create knowledge and solutions for a wide range of social needs and at a scale that was unimaginable before the rise of the Internet' (Bria et al., 2014, p. i).

Most digital social innovations are mediated through the internet, or are enabled by new technology trends, including open data infrastructure, open hardware and open networks (Bria et al., 2014).

Table Three summarises the influence of service-related social innovations on health equity and implications for health equity promotion.

Table Three: service-related social innovations and implications for health equity promotion

FFF level	Source of innovation	Target of intervention	Example of impacts	Exemplars of digital social innovations	Implications for health equity promotion
Individual health-related factors	Individual knowledge and collective intelligence	Health status (e.g. social/mental health)	Increased self-esteem	Big White Wall	Recognising value of integrating and aggregating individual knowledge Digital technologies present new sites of stigma
	Individual experience of impairment	Self-knowledge	Increased self-awareness	Patients Like Me	
		Subjective measures of health	Increased self-efficacy and disease self-management		
Daily living conditions	Unmet technological needs	Transformative innovation and design	Improved social connections	Fablab Amsterdam	Using new platforms to engage users in design and take-up of solutions Unequal technological access and use remains a barrier
		Technological empowerment	Creation of peer networks		
		Affordable health care	Enabling innovation in health care (e.g. low-cost prosthesis design and manufacture)		
Socioeconomic, political and cultural context	Not enough current evidence available		Mass immunisation programs in non-OECD countries	PATH	Tolerance for experimentation

Key factors for success of mHealth innovations are the level of stakeholder collaboration (Gerber et al., 2010), government involvement (Mecheal, 2009), technology effectiveness (Kumar et al., 2013) and adaptation to local contexts (Aranda-Jan et al., 2014).

The potential systemic impact of digital social innovations is greatly anticipated, but currently under evaluated (Bria et al., 2014). In their recent report on digital social innovation, Nesta documents a large number of highly diverse, and effective, digital social innovations. Many of these approaches adopt and apply a broad and interoperable conception of 'digital': open knowledge, open data, open networks and open hardware (Bria et al., 2014, p. 36). Thus, they illustrate how hardware can be operationalised through knowledge, and the resultant data used to provide open access to innovative hardware. Bria et al. suggest that unlocking the untapped potential of digital social innovations could transform industries, including health care.

Fablab Amsterdam is a social enterprise 'fabrication laboratory', and is part of a global network of similar organisations. Their aim is to bring 'technological empowerment to peer-to-peer based technical training', emphasising principles of open innovation and community-based collaborative learning to design and create much-needed improved technologies (Bria et al., 2014, p. 106). For example, their Fablab Cares program develops technologies by collaborative learning from individuals with physical limitations to create low-cost alternatives to existing expensive health care devices in developing economies. One such output was a low-cost prosthesis (under \$50), and was created through open hardware networks. By providing a range of modern and traditional equipment, designers are able to learn and apply design and manufacture techniques via a hands-on approach. This is consistent with Christensen and colleagues' (2000) call for low-cost disruptive innovations in health care. Fablab showcases how innovations in digital fabrication can directly influence health equity at the individual and daily-living conditions levels. The organisation's commitment to addressing the most critical challenges in society, especially for marginalised individuals, provides impacts for multiple stakeholders. Participants benefit from building new social networks, learning and applying skills in an informal environment, and contributing valuable resources to communities in need. Recipients benefit from the products of open innovation, directly subverting the barriers to affordable health care and health devices imposed by proprietary developers of this technology. Thus, Fablab is an

excellent illustration of *process-oriented* innovation that aims to produce *transformative effects* from their fabrication laboratory. These innovations are more *effective* and *efficient* (i.e. open innovation, collaborative learning), and also *just*, since Fablab encourages people formerly excluded from participating in technological training that can transform their lives.

While descriptive evidence of growing activity in digital social innovations is easily found, the relative ‘newness’ of many digital social innovations and their implementation means there is little current long-term evaluative evidence of impact in health care contexts (Bria et al., 2014). Some isolated examples, such as mHealth, offer insights into good practice but do not provide evidence of operating across the open hardware, knowledge, data and network categories. Indeed, much of the evaluative evidence of the impacts of digital social innovations identified through this review is specific to communication platforms.

For example, Discoverables (2014) is a UK-based web platform developed by the charity Spark & Mettle for young people to recognise and develop their skills (called ‘powers’), and offering a portal for employers to work with young people with ideas and talent.

Discoverables is innovative for two reasons. First, it brings together a number of users with similar interests, but who do not normally interact: teenagers with no or very little awareness of their skills or what is expected of them in the work place; and employers who are looking for young talent but, for various reasons, do not effectively capture or develop it early enough. Second, the interface allows registered employers to search for users who have achieved particular tasks to a significant level of competence, and creates a safe environment for feedback and further discussion. Discoverables therefore helps young people to self-determine their skills through a participatory survey, facilitating positive skills building in young people by posing ‘missions’ to users so they can construct an evidence base that develops talent and self-confidence. On average, Discoverables users self-report perceptions of happiness 83% higher than the UK average (Discoverables, 2014). Similarly, Ambition Lab seeks to address issues of unemployment among younger people through a blend of research and digital technology. Their experimental approach, which includes film-making, public debate and a ‘Hackathon’ (involving ‘positive’ hackers, social investors, psychologists and experts to create digital solutions and concepts), actively encourages participation across socioeconomic backgrounds by focusing young people through relationships with schools. Although still in ‘beta’, this collaborative process seeks to build

the foundations for sustainable wellbeing through experiential learning. Discoverables is a good example of *incremental* innovation that creates *more effective services* for targeted users.

Trusted and safe environments such as schools are critically important to the lives of children, and can be the platform for many daily living innovations (Hargreaves, 2003; Moolenaar & Slegers, 2010). For example, Learn Sprout (2014) brings big data analytics into the classroom, simultaneously preparing learners with the necessary tools needed for future workforces, as well as offering insights for educators for at-risk students. Furthermore, Teamie utilises structured social networking technologies to create a mobile learning platform to encourage collaboration between school children, parents and teachers outside traditional classroom environments (Teamie, 2014). This innovation, based on software and cloud technology that minimises the cost to users and the educational system, connects schools and educators outside traditional geographic boundaries in a technologically savvy yet safe and effective way. Teamie has been adopted by schools in several countries, including Singapore, Indonesia and Malaysia, offering a low cost-per-use for students. This lowers the typical barrier common with existing collaborative platforms, which require significant up-front costs, ensuring that collaborative learning systems are more accessible (Muilenberg & Berge, 2005).

Redressing stigma associated with health inequity is often seen as the principal challenge for change-based strategies (Sen et al., 2002; Guttman & Salmon, 2004; Braveman, 2006). Social media and networks are used in social innovations to traverse the existing boundaries to remove this social stigma. For example, online chat rooms have been used, with some success, to provide an opportunity for individuals at risk of complex health issues who would not seek help or information 'off-line'. In the case of HIV risk behaviours, one study shows that chat room participants are more likely to disclose their lack of HIV knowledge in this environment. This offers incentive to organisations to develop prevention support and intervention delivery systems, via a medium appropriate to users' needs (Rhodes et al., 2010). An additional good example of innovative use of social media in relation to individual wellbeing is Big White Wall (2014), which is an online peer-support service designed to assist individuals over 16 years of age in dealing with mental health issues. Their services comprise digital assessment and different modes of support for peers to manage their symptoms and

conditions. The innovation at the heart of Big White Wall centres on providing *more effective* support systems, as part of an *incremental* innovation on existing social networking platforms (i.e. *services*). A review in 2009 (Big White Wall, 2014) found that the service is both effective (95% of users report feeling better, two-thirds of members would not otherwise have sought assistance) and efficient (saves £37,000 per 100 members).

Patients Like Me is an online peer-based data-sharing platform, for individuals and families affected by illness to share their experiences. More specifically, *Patients Like Me* works by connecting people, and since 2004 has developed a service for patients to report and manage their conditions, while allowing medical researchers and industry organisations access to the large evidence base. This combination of online peer-to-peer knowledge exchange and open access to anecdotal patient records creates innovative and productive relationships between users, carers and their families, and the medical profession. The major impact of *Patients Like Me* has been to raise awareness of the lack of connectedness between patients, and the inability of existing arrangements with medical professionals to encourage patient reporting of symptoms and experiences. Lober and Flowers (2011) found that *Patients Like Me* plays an important part in empowering ‘consumers’ of health care services, and that interactions with this platform ‘improved patients’ disease self-management’ (Househ et al., 2014, p. 54). The innovation focus here is on a more effective solution than current offerings, providing a transformative process via an online platform for users to improve self-efficacy.

(Source: Patients Like Me, 2014)

The literature suggests that the appeal of online presence is its effectiveness in encouraging participation, creating safe spaces to inform, diffuse and discuss health issues (Rhodes et al., 2010; Allender et al., 2011). For example, an Australian study of health informatics shows that health information websites can encourage social connectedness through locally based community events (Eysenbach, 2000; Eysenbach & Köhler, 2002; Kawachi & Berkman, 2001; Osborne & Patel, 2013). Steele et al. (2013) found similar results in a web-based service for school nurses to deliver tutorials on Child Health Matters, a scheme to support families affected by child weight-related health issues. However, the literature finds that, in order to properly engage communities, web-based interventions for health equity promotion should not assume equality of access to this information, and should acknowledge technological as

well as geographic barriers to access. This is a major equity consideration for designing health promotion interventions.

Often the most significant innovations take the form of technologies that provide radical, transformative changes to health knowledge and practices. An example is Advanced Technology Care Innovation, which focuses on assisting in providing health care support for older people in Italy (Lattanzio et al., 2014). Technology has a broader appeal to social innovators seeking to deepen their impact and change health behaviours (Gardner et al., 2007). PATH (2014), is an international non-profit organisation that exists to promote and foster 'transformative' innovation to promote health equity across all ages, and from individual to community health. It combines entrepreneurship, scientific research and on-the-ground support to collaboratively deliver medical interventions and health promotion on a global scale. One such example is PATH's work in accelerating the development and deployment of vaccines to provide equal access to childhood immunisation. For example, a partnership between PATH and the WHO, the Meningitis Vaccine Project, has helped to immunise people across 25 African countries since 2010. PATH also assists in the development of new technologies to address existing and emergent health inequalities, including childbirth and reproductive health devices. PATH's innovations are *more effective* and *efficient* than existing approaches (where they exist at all), represent *breakthroughs* in medical innovation and health care, and do so in both the *process* (i.e. systems providing on-the-ground support) as well as *products* (i.e. immunisation).

Yet, social media is not effective in isolation – it forms part of a holistic, strategic, community-centred approach to health equity (Waldman et al., 2013). Indeed, in some cases, the most significant effects on individual health-related factors come from developing and implementing technologies with a social impact. The innovation comes through organisations deploying new technologies with delivery modes appropriate to the context, such as PATH has managed with their vaccination program in Africa. The combination of new services and technologies, promoted using the most relevant media, appear the most popular at this level of the Fair Foundations Framework. However, as shown in the previous three sections, long-term evidence is largely absent in the social innovation space. In particular, evaluations of social enterprises such as Good Gym are not readily available, neither are they for programs affecting multiple family members – such as the infant feeding program (Dykes et al., 2012).

4.4 Social enterprise and health equity

Social enterprises are businesses that exist to fulfil a social (including environmental) objective and typically reinvest a substantial portion of their profit or surplus in the fulfilment of that purpose. Table Four summarises from the evidence reviewed the relationship between social enterprise and health equities, and the implications for health equity promotion.

Table Four: social enterprises and health equity – summary of approaches and influence

FFF level	Source of innovation	Target of intervention	Example of impacts	Social enterprise exemplars	Implications for health equity promotion
Individual health-related factors	Collective intelligence of communities	Beneficiaries' personal and vocational skills	Increased self-esteem Increased self-efficacy	Work Integration Social Enterprise (WISE)	Business models that integrate social and economic participation Recognising value of individual experience in business model design
Daily living conditions	Unmet community needs Discarded resources (physical and human capital)	Education	Increased participation in vocational education	WISE	Making use of latent or unrealised value (of people, materials and markets) Improving effectiveness through user design
		Work and employment	Increased participation in employment Increased economic participation	WISE Community-owned businesses	
		Health services	New health and allied services	Community-owned services Public Sector Mutuals	Retaining local assets through member ownership
		Physical environment	Improved social housing Improved civic spaces	WISE Community-owned businesses	

Socioeconomic, political and cultural context	Market or government service failure	Economic system	Improved local economic vitality	Community-owned businesses	Support for hybrid and cross-sectoral interventions Emphasis on participation in governance of initiatives
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The function of social enterprise as a socially innovative response to health inequities is twofold. First, social enterprise has been advanced in some jurisdictions as an alternative health services provider, responding to gaps in geographic and/or culturally appropriate mainstream service provision. Second, social enterprise may be viewed as a form of intervention that addresses the social determinants of health (Roy, Donaldson, Baker, & Kay, 2013). In each case, the introduction of social innovation constitutes a process innovation, where improvements to the business model are expected to deliver improvements in service design and availability.

The literature suggests that organisational choice is central to the delivery of many social innovations, increasingly in health-related fields (Gerometta et al., 2005; Zahra et al., 2009; Roy et al., 2014). For this reason, hybrid organisations such as social enterprises often work well because they embed a community orientation at their core, meaning they are able to be more responsive to user and community needs in ways that public sector organisations are not (Mair & Martí, 2006). Evidence suggests that these approaches to tackling a range of social and individual health issues contain great potential, but face significant challenges. These include (but are not limited to): better access to start-up finance (Sunley & Pinch, 2012; Bugg-Levine et al., 2012); robust political support (Alcock & Kendall, 2011); light-touch impact evaluation systems and on-the-ground development support (Denny et al., 2011). In some countries – for example the UK and South Korea – governments have adopted an explicit approach to promoting social enterprise as a mechanism through which to organise responses to primary health care services and related issues (Park & Wilding, 2013). Policy responses include developing markets for social enterprise through public sector commitments to social procurement (for example, the UK 2012 Public Services [Social Value] Act, which encourages local governments to purchase against a social as well as a financial

bottom line), and devolving services to public sector mutuals, discussed further below. In policy contexts where there are substantial commitments to a role for social enterprise in service design and delivery, there has also been investment into new intermediary organisations that provide developmental support (e.g. UK-based Young Foundation's 'Young Academy', and UNICEF's Innovation Lab [UNICEF, 2013]) and mobilise new forms of social finance (e.g. crowdfunding, the Centre for Social Innovation 'Catapult Microloan Fund').

With regard to the function of social enterprise as alternative health services providers, there are examples of both government and community-initiated developments in this area. In England, the 'Right to Request' and 'Right to Provide' initiatives under the Brown Labour and Cameron Conservative coalition governments, respectively, have encouraged the transfer of some National Health Services (NHS) to new social enterprises (Hall, Miller, & Millar, 2012). Asset transfers to these so-called 'spin-out' social enterprises in 2012 were around 900 million pounds, with 45 social enterprises established as a result of these initiatives (Roy et al., 2013). Research on the relative effectiveness of these social enterprises in response to health needs and health inequities is largely unavailable at this stage, with most research in the area focused on financing and structuring of these new hybrid organisations (Social Enterprise UK, 2013) and the public commissioning environment required to ensure their sustainability and effectiveness (Roy et al., 2013; Social Enterprise UK, 2013). Roy et al. (2013) do note that, relative to mainstream NHS providers, social enterprise spin-outs are much more community active, engaged in collaborative arrangements to devise and implement community care provision and more likely to involve users in their decision-making through democratic governance. Some evidence of potentially negative industrial effects of spin-out social enterprises has been identified, in which municipal staff have felt 'pushed' to devolution into new organisations where industrial standards may not be assured (Hall et al., 2012).

*A UK NHS spin-out, **City Health Care Partnership (CHCP) CIC** is a co-owned social business, which employs approximately 1400 people and provides 75 community-embedded health and social care services to more than half a million people in the Hull-East Riding region of England. CHCP aims to minimise acute care by taking an early intervention approach, promoting healthy lifestyles, and providing community-based treatment. Through its charitable foundation as well as its locally oriented services, CHCP reinvests all of its profit in the advancement of the communities it serves. Its innovation is thus in its business model*

and its related revenue use. A recent social return on investment evaluation found that, for every 1 pound invested, 33 pounds of value is produced, and user surveys indicate 96% client satisfaction with the services.

(Source: City Care Health Partnership, n.d.)

The Italian social cooperatives constitute another largely institutionally driven example of social enterprise in allied health and social service provision. Enabled by new legislation introduced in the mid-1990s to embed this organisational form in the Italian civil society landscape, Italian social cooperatives provide a wide range of social services (known as Type A social cooperatives) or foster integration into the workforce of people who are highly disadvantaged in the labour market (known as Type B social cooperatives). A unifying characteristic of both models is that they are multi-stakeholder organisations, with the legislation stipulating minimum requirements of representation of particular stakeholder groups – including workers, beneficiaries, volunteers and public institutions – in the governance of each organisation. Research on the effects of Italian social cooperatives suggests that their principal social innovation is the trust and bridging of social capital that is generated by their multi-stakeholder organisational form (Mancino & Thomas, 2005; Thomas, 2004). This innovation could be said to have been transformative, given the relatively widespread effects of the Italian social cooperative model. Mancino and Thomas (2005) find that the services provided by Italian social cooperatives have substantially responded to the inadequacies of existing social welfare, while the increased citizen engagement created by the ownership structure and widespread take-up of social cooperatives has improved socioeconomic participation of excluded social groups more generally.

Community-driven models of social enterprise – often incorporated as cooperatives or community-owned companies limited by shares – are also emerging in the health services industry as a response to market and government failures to provide services to particular geographic communities or demographic groups. In the Australian context, a salient example is the National Health Co-op (NHC) (formerly West Belconnen Health Co-operative Ltd). NHC was established in 2006 by residents in a northern fringe suburb of Canberra, who were concerned about the persistent lack of affordable general practice and allied health services in the area. Following rapid growth in membership to more than 20,000 people and successful recruitment and retention of medical and allied health staff, NHC is now open in five locations, with regular clinics in additional areas (National Health Co-op, n.d.). The work

of the NHC is socially innovative in that it provides a more sustainable and just solution to meeting health care service needs in geographically excluded communities.

As an 'upstream' form of social intervention that addresses the social determinants of health inequities (Roy, Donaldson, Baker, & Kerr, n.d.; Roy, McHugh, & Hill O'Connor, 2014), the available evidence suggests that social enterprise plays a role primarily at the individual and daily living conditions levels of the Fair Foundations Framework. A dominant form of social enterprise in European, North American and Australian contexts is work integration social enterprises (WISE), which create pathways to employment or permanent employment opportunities for people who are disadvantaged in the labour market (Spear & Bidet, 2005). The primary social innovation of WISE is that they mediate gaps between mainstream employment services and the open labour market for particular social groups, thereby contributing to a more equitable and just employment system. There is a growing literature that suggests that, at the individual level, WISE are effective at increasing the latent benefits of employment (Jahoda, 1982), including increased self-efficacy, self-esteem and social relationships, for specific social groups such as newly arrived migrants and refugees (Barraket, 2013), people with a disability (Warner & Mandiberg, 2006), homeless young people (Ferguson & Xie, 2008) and people with mental illnesses and addictions (Krupa, Lagarde, & Carmichael, 2003; Lysaght, Jakobsen, & Granhaug, 2012). The research evidence is consistent in its findings that WISE can allow for design of work settings that are responsive to the needs – such as language, childcare support, task structuring, and wrap-around support – of particular social groups (Barraket, 2013; Ho & Chan, 2010; Krupa et al., 2003; Lysaght et al., 2012). Some studies also note that the day-to-day processes of doing business advance exposure and connectedness between WISE participants and their broader communities, and have some influence on the practices of other local employers and organisations (Barraket, 2013; Lysaght et al., 2012).

***Sorghum Sisters**, based in Melbourne, Australia, is a catering social enterprise that grew from a real need for migrant women to overcome barriers to employment and social engagement, as part of the AMES project to develop social enterprise to support migrants to Australia. Once established through partnership and support from state government departments in 2005, Sorghum Sisters provides a range of catering services that benefit those involved in the social enterprise, through its function as an intermediate labour market organisation. Furthermore, their services have several external beneficiaries, including consumers, clients and community needs. Part of the service proposition they offer is related*

to healthy eating among school children, and they provide a direct action, community-based approach to tackling issues that distort the health equity of young people (i.e. obesity). Thus, Sorghum Sisters is an excellent example of how a social enterprise can provide sustainable benefit for internal and external beneficiaries, remain community-centred and use its story as an important part in building community relationships.

(Source: Sorghum Sisters, 2014)

Examining a broader range of social enterprise models, Australian research has also found that social enterprise plays an under-recognised role in responding to market and government service failures in geographically disadvantaged communities, by mobilising under-utilised (social and material) assets (Barraket & Archer, 2010; Cameron & Gibson, 2005; Eversole, Barraket, & Luke, 2013). These studies are case-study based and do not shed light on the scope of this activity nationwide.

GoodStart Early Learning is a social enterprise created in 2009 by the Brotherhood of St Laurence, The Benevolent Society, Social Ventures Australia and Mission Australia in response to the corporate failure of private for profit firm, ABC Learning Centres. Its innovation rests in its business model and financing, and in its service approach. With regard to the former, GoodStart Early Learning is based on a syndicate model of social investment that leverages a mix of public, private and community sector resources through a consortium of partners and investors committed to quality service provision in early childhood education and care. With regard to service innovation, the consortium partners have taken an evidence-led approach to early childhood intervention to devise the social impact objectives that are delivered through the enterprise's services. GoodStart Early Learning owns and operates more than 650 early learning centres across Australia, serving 61,000 families and 73,000 children. Its mission is to provide high-quality, accessible, affordable, community-connected early learning. The social enterprise has been active in rebuilding trust with parents and communities served by the centres after the high-profile failure of GoodStart's commercial predecessor. The reputations and networks of the consortium partners have played important roles in meeting this challenge.

(Sources: Maack, 2013; Social Ventures Australia Consulting, 2013)

While available studies suggest that social enterprise interventions produce positive individual and daily living condition-level effects that inform health equities, they are either silent on (Ho & Chan, 2010), or critical of (Barraket, 2013; Cooney, 2011; Spear & Cooney, 2013), the impacts of social enterprise on socioeconomic, political and cultural contexts.

Barraket (2013), for example, notes of an Australian WISE program focused on health and wellbeing outcomes for refugees and migrants that it is effective at the individual and community levels but does little to ameliorate systematic sources of exclusion of these social groups from the mainstream labour market. In the US context, it has similarly been found that WISE predominantly operate in low-skilled industries and occupations, which potentially limits the ability of these organisations to mediate client transitions into more stable and meaningful employment in the open labour market (Cooney, 2011; Spear & Cooney, 2013). Other studies have found that design of WISE can lead to gender concentration that mirrors gender disparities – and, potentially, related income inequities – in some industries (Barraket, 2013; Ho & Chan, 2010). The implications of these findings for health equities are threefold. First, they suggest that care must be taken in the design of WISE – including industry selection, business modeling and governance – to ensure that exclusionary features of the open labour market are not simply replicated. Second, they suggest that changes to the socioeconomic, political and cultural context that influence health equities are not likely to be stimulated by individual social enterprises. Changes at this level influenced by social enterprises are most apparent in those jurisdictions – such as the UK and Canada – where second-tier social enterprises or ‘peaks’ provide collective representation to governments and industry. Third, the available evidence illuminates an ongoing source of tension between the perceived need to scale activities in order to scale social impacts while at the same time recognising that the success and design features of many social innovations are highly context specific (WILCO Consortium, 2014).

While the available research evidence is suggestive of positive impacts of social enterprise on health equities, particularly at the levels of individual health factors and daily living conditions, it remains relatively sparse (Roy et al., n.d.). A persistent theme in the nascent literature – both scholarly and evaluative – is that there have been limited efforts to measure social enterprises’ impacts on health equities or social impacts more broadly (Roy et al., 2013; Social Enterprise UK, 2013). Roy et al. (2013, 2014) suggest that collaborative programs of research that explicate the effectiveness, causal pathways and costs of social enterprise relative to other forms of service provision and community intervention are needed if we are to fully understand the potential impacts of social enterprise on health inequities.

5.0 Developing environments that support social innovation

Like commercial innovation, social innovation may be enabled or constrained by the quality of the environment in which it occurs. It is notable that, based on the volume of documented evidence of practice, this review suggests that the greatest concentration of social innovation activity is occurring *either* in contexts where there is significantly inadequate institutional infrastructure through developed welfare states, *or* where global economic shocks have generated substantial threats to national and regional economic stability. In the latter case, social innovation seems to abound where there are explicit policy frameworks – such as in the European Union – and financial investments in both practice and research (scholarly and evaluative).

The evidence reviewed in this report suggests that the social innovation system as it pertains to health equities involves a number of significant actors. These include: social innovators from all sectors; institutional entrepreneurs, who enable opportunities for experimentation and change within existing economic and political institutions; and intermediary organisations, that mobilise access to resources and link different groups together in support of new approaches. Universities, think-tanks and research institutions present in many of the examples canvassed here are significant contributors to developing the fast-moving field of social innovation, particularly in the area of digital social innovation (Bria et al., 2014).

6.0 Features of effective social innovation: implications for health equity promotion practice

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

Responding to institutional failure and system shocks – as indicated in this review, much of the early literature on social innovation in relation to health equities has focused on practice in developing economies. This in part reflects the function of social innovation as a response to failures of or gaps in institutional systems. Recent and fairly rapid growth of activity in OECD countries particularly in Europe is, in part, a response to region-wide shocks produced by the Global Financial Crisis. These trajectories suggest that a prevailing characteristic of social innovation is its responsiveness to failures or shocks of economic, social welfare and wider political systems.

Identifying and using latent or unrealised value – despite their diversity, most of the social innovations included in this review recognise and harness latent or unrealised value. This includes recognition of the value of: resources – such as people’s knowledge, labour, so-called waste products and communities’ financial capital – typically discarded or ignored by mainstream society; bringing different groups together to tackle a problem; and applying non-traditional disciplinary insights to a particular area of policy or practice.

The value of upstream intervention – a number of the social innovations reviewed here can be best characterised as upstream or parallel interventions, which recognise the complex interplay between the causes of the causes of health inequities. Thus, for example, the provision of safe, affordable and appropriate finance can have a substantial effect on housing and employment opportunities, which in turn influence health equities. Upstream interventions typically require new alliances and collaborations as well as new organisational forms.

Integrated thinking and action – consistent with complex systems thinking, many approaches to social innovation relevant to health equity promotion are designed with attention to the integration between elements in the system. This includes integration to maximise value and integration to minimise problems arising from unintended consequences. For example, in an analysis of contemporary social innovations across Europe, the WILCO consortium reported that many of the examples they identified operated at the intersection between social policy and urban planning (WILCO Consortium, 2014). This integration advances joined-up thinking, not just in the design of the intervention, but in the wider practices of those individuals and organisations involved in the process. It can also build consensus around particular interventions, which improves their effectiveness

(although, as noted by some, challenges in collaboration need to be appraised in light of the intended effectiveness of interventions) (Sørensen & Torfing, 2011; Suárez, 2011).

Integration may occur not just across policy domains or sectors, but also between different levels of the system. As illuminated in the review above, while different types of social innovation may be primarily focused on particular levels of the health equities system as depicted in the Fair Foundations Framework, very few address only one level, typically because they recognise interdependence between levels.

Social and relational models of intervention – the vast majority of social innovations reviewed in this report are social in both their means and their purpose. Social movements are a sometimes powerful form of collective action that affect people’s feelings of belonging and identity whilst also seeking to address institutional problems (Melucci, 1996). Many forms of innovative social enterprise embed sociality – through ownership, governance or production processes – in their business models. Emerging approaches to social innovations in service design are explicitly concerned with people-centred models and with rehabilitating or establishing social relationships within communities in a fast-moving world. Many, although clearly not all, digital social innovations draw on the crowd-sourcing capabilities and potential for connecting up afforded by online and mobile technologies. Through all of these examples, people and the relationships between them are viewed as both a significant source of new thinking for change and as a driver of new needs to which policy and programs must respond. A factor that differentiates many of the examples reviewed above from earlier social change efforts is a strong focus on developing bridging social capital – or links between diverse groups – as well as bonding social capital between participants.

Process matters – related to the feature above, most social innovations concerning health equity promotion are characterised by recognition of the relationship between process (of intervention design and implementation) and outcomes. They are often predicated on process innovations that involve user-centred design, partnership and collaboration, with the development of hybrid programs or organisations the most acute manifestation of these. Because of this, social innovations may have greater transaction costs than more traditional forms of intervention for health equity promotion. The prevailing logic – which is

tentatively supported by the nascent evidence – is that these increased costs also produce greater value in terms of system-wide shifts that improve health equities holistically and thus reduce (financial and social) costs in other parts of the system.

Demonstrating the evidence – the review of the evidence indicates there is relatively limited evaluative evidence of the impacts of contemporary social innovations. In part, this reflects a paradox of the effectiveness of social innovation; that is, by the time substantial change can be measured, the intervention may no longer be considered innovative. However, it also reflects relative immaturity in evaluation and impact measurement in some jurisdictions and the complexities of valid measures of change of wicked social problems. The currently available evaluative evidence, however, suggests that diffusion of social innovation is enabled by effective learning and communication of the outcomes and impacts of attempts to socially innovate.

A social innovation ecosystem – while the evidence of performance remains relatively sparse, emergent practice suggests that, like other forms of innovation, social innovation for health equity will be more prevalent and more effective where it occurs within an ecosystem that supports such practice. Factors that characterise such support include: support for experimentation and adaptation; tolerance for learning from emergence (consistent with complex systems) rather than exclusive interest in best practice (consistent with simple systems); opportunities for integration; and fit for purposes funding and financing mechanisms. As discussed above, jurisdictions where there is explicit support for social innovation invest in intermediary organisations and research knowledge to support the scaling of social impacts from these new arrangements.

7.0 Conclusions and recommendations

This systematic evidence review has examined the breadth of social innovations studies and reports, with reference to the Fair Foundations Framework, to consider the relationship between social innovations and health equity promotion. The review finds a well-established body of descriptive accounts of the relationship between social innovations and health

equity promotion and some evaluative evidence of outcomes and impacts. Many of the interventions studied interact with multiple Fair Foundations Framework levels, illustrating their dynamic nature and the complex responses required to tackle systemic health equity issues. It is notable that many social innovators identify various factors presented in the levels of the Fair Foundations Framework not just as triggers for action, but as resources to be utilised.

The review finds that some of the best-documented work of social innovation in relation to health equities is found in developing economies or in world regions affected by common health equity issues. Descriptive evidence of recent activity in Europe in particular has grown rapidly in the last four years in response to the effects of global financial challenges and changes to welfare state provision. If available evidence is a reliable indicator of current practice, this suggests that socially innovative practice is strongest where institutions – political, economic or cultural – are relatively weak or under strain.

As is clear from the review, there are several important focal areas for social innovations that align closely with the Fair Foundations Framework. Regarding the *socioeconomic, political and cultural* level, significant institutional innovations have emerged in social welfare systems. Radical changes in practice are seen in failing or dysfunctional systems, or enhancements to existing systems to more closely meet community needs.

There is moderate evidence, particularly in relation to developing economies, of the creation and scaling up of innovative health care service delivery that is social in both its means and its purpose. There is growing evidence in both developed and developing economies of activity (rather than outcomes) that suggests that institutional frameworks can be adapted to accommodate innovative solutions to promote system-wide changes in health equity programs. Although some research has explored the macro-level institutional influences that support social innovation (Kerlin, 2006), little Australia-specific data exists. A clearer understanding of the predictors of institutional barriers to innovation would assist decision-makers to target resources to systemic health issues more effectively.

At the *daily living conditions* level, innovations tend to address systemic barriers to health equity. Much of the evidence refers to creating enabling environments that aim to break through the factors that create inequities in community wellbeing. There is also a significant

focus on early childhood intervention as an upstream solution to health inequities over the life course. Innovations in this area are tackling recent phenomena that afflict children and young adults, such as challenges to good mental health. In order to fully operationalise these approaches, initiatives frequently involve cross-sector partnerships to maximise collaborative expertise and deepen impact. Such approaches appear to offer effective ways of addressing health inequities by filling gaps – or disrupting the status quo – in provision where prevailing systems fail. The major gap in research at this level is the significance of organisational form to social innovation. For example, can particular organisational structures mobilise resources more effectively or legitimately than others? And, what might the trade-offs be between user-centred and multi-stakeholder models in terms of effectiveness, financial efficiency and scalability? Although hybrid organisations have been highlighted in the literature as vehicles for social innovation (Battilana & Lee, 2014), more fine-grained research of the relationship between organisational form and health equity outcomes is needed to understand how, why and in what contexts distinct organisational forms offer relative advantages (Roy et al., 2013).

With regard to *individual health-related factors*, all social innovations reviewed act directly on individuals' knowledge and attitudes, while some also seek to influence the sense of personal identity and behaviours related to health and wellbeing. Importantly, all social innovations considered in this report identify the knowledge and experience of individuals – particularly those who are negatively affected by health inequities – as an important resource that enables better service design, improvements in medical and other forms of institutional evidence, and more responsive organisational structuring. However, the evidence also suggests that many existing studies are at piloting stage, and we lack longitudinal data in most cases that would show sustained impact on individual health-related factors (for an exception, see the regular impact reporting of the HWC). Further research that can trace the individual-level health-related impacts of social innovations over time would improve knowledge of what works in what contexts and why, which are important considerations for wider investment in these activities.

This review finds the greatest concentration of research on social innovation activity at the individual and daily living conditions levels of the health equity system, as depicted in the Fair Foundations Framework. This reflects the highly context-specific nature of many forms

of social innovation, particularly those that seek to address the needs of geographic communities and/or particular social groups in place. Research evidence of impacts is also primarily concentrated at these levels, with the exception of social movements, because of a longer research tradition related to this particular approach to social change. Research about social innovations that influence health equities identified through this review has typically been evaluative or case-study focused, with virtually no meta-evaluative evidence available, and very little comparative analysis across intervention types. This lack of evidence, along with the lack of longitudinal data discussed above, limits the efficacy of research findings to date. It seems that practice has outstripped evidence in the context of social innovations and health equity promotion. Greater valuing of evidence – in terms of research, sharing of practice knowledge, and evaluation – may assist in enabling the diffusion of social innovation and its impacts in the health equity domain.

7.1 Recommendations for planning and research

The evidence review suggests the following considerations for the planning of health equity promotion:

- People-centred program design and implementation – which positions the targeted individuals or communities at their core – should be a foundational feature of health promotion programs and policy. Such approaches need to recognise not just the importance of involving affected people in program design to support take-up and use, but the intrinsic value of their knowledge and experience in devising solutions to wicked problems.
- In addition to being people-centred, social innovation for health equity promotion must recognise the value of social relations between diverse groups in changing attitudes and behaviours. Bridging, as well as bonding, is an important dimension of effecting institutional-level changes that have real effects on individuals and daily living conditions.
- Elements of the Fair Foundations Framework should be considered not just as triggers for action and sites of intervention, but as potential sources of underutilised resources in designing health promotion programs.

- Greater collaboration across health and non-health sectors and between civil society, government and the private sector should be mobilised in support of health equity promotion.
- Health equity-related social innovations should typically be evaluated. Evaluations should be informed by all stakeholder interests and the wider value to health equity of open source knowledge sharing, where possible. Evaluation frameworks need to support innovation, by eliciting knowledge about process, valuing emergent practice and supporting learning through doing rather than focusing exclusively on best practice.
- Scalability of social innovations for health equity should be valued according to their potential for scaling social impacts. This may include scaling out (through replication), scaling up (by embedding interventions in wider policy frameworks and programs) and scaling deep (by diversifying responses to complex community needs).
- Investment in the social innovation system – including in social innovation intermediaries, professional development within the health promotion field and advancement of research – is needed if health equity social innovation is to meet its potential.
- Institutional frameworks need to be flexible and adaptable at the local level to allow social innovations to flourish.
- It will be important over time that program investments move beyond pilots to support long-term development if promised social impacts of social innovations are to be tested and achieved.

With regard to research to support health equity promotion through social innovation, we recommend that:

- Longitudinal, meta-evaluative and comparative research be supported to better understand the relative effectiveness of different approaches to social innovation and what works in which contexts and why.
- Funders of health equity-related social innovation work with social innovators, communities and researchers to devise indicators against which key health equity impacts can be reliably assessed.

- Relevant institutions provide appropriate access to routine data to support social impact measurement.
- Understanding the diffusion of social innovation be prioritised for future research.

Appendix 1 – Semantic themes and key words

Themes, key words and resources for the systematic literature search

This document provides a detailed overview of the key term search strategy (and key words) for the systematic literature review. This has been developed collaboratively by the research team to ensure comprehensive search coverage for social innovation(s) and health equity.

The proposed search strings are:

1. (1 – 31) AND (32-43) AND (44-51) AND (52-63) AND [(64-92) OR (93-96 - 115) OR (116-124)] AND (125-138).
2. (1 – 31) AND (44-51) AND (52-63) AND [(64-92) OR (93-115) OR (116-124)] AND (125-138).
3. (1 – 31) AND (32-43) AND (52-63) AND [(64-92) OR (93 - 115) OR (116-124)] AND (125-138).

Social innovation

1. social enterprise*
2. cooperative*
3. non-profit*
4. social business
5. community enterprise
6. charit *
7. philanthrop*
8. social invest*
9. social entrepreneur*
10. eco*
11. enviro*
12. social innovat*
13. social movement*
14. communit*
15. participat*
16. co-design*
17. co-creat*
18. collaborat*
19. innovat*
20. knowledge
21. technolog*
22. service-design
23. cross-sector*
24. partnership*

25. civil society
26. public sector*
27. integrated service*
28. collective impact
29. online
30. crowdsourc*
31. social media

Health and wellbeing: action agenda

32. Physical *activity
33. Tobacco use
34. Smoking
35. Alcohol
36. Mental Wellbeing
37. Early childhood
38. Health
39. Wellbeing
40. Diet
41. Nutrition
42. Sedentary behaviour
43. Obesity

Health equity

44. affordab*
45. access*
46. availab*
47. equit*
48. inequit*
49. inequalit*
50. equalit*
51. disparit*

Social stratifiers

52. Gender
53. Race
54. Ethnicity
55. Socio-Economic*
56. Education
57. Disability
58. Occupation
59. Aboriginality
60. Indigeneity
61. Sexual*
62. Migrant

63. Non English

Socio-economic, political and cultural contexts

- 64. politic*
- 65. policies
- 66. program*
- 67. system
- 68. process*
- 69. procure*
- 70. advocacy
- 71. economic*
- 72. cultur*
- 73. Government
- 74. socio*
- 75. norm
- 76. value
- 77. trade
- 78. investment
- 79. labour
- 80. education
- 81. land use
- 82. housing
- 83. transport*
- 84. infrastructur*
- 85. environment
- 86. agriculture
- 87. physical
- 88. welfare
- 89. insurance
- 90. health care
- 91. health promotion
- 92. ageing

Daily living conditions

- 93. income
- 94. housing
- 95. poverty
- 96. neighbourhood
- 97. neighborhood
- 98. work*
- 99. employment
- 100. early child*
- 101. school
- 102. social protection
- 103. social network
- 104. social connection

105. participation
106. social determinant
107. safety
108. evidence
109. social capital
110. social cohesion
111. homeless*
112. metro
113. regional
114. rural
115. remote

Health-related factors

116. knowledge
117. attitude
118. awareness
119. behaviour
120. behavior
121. eating
122. diet*
123. food consumption
124. health literacy

Outcomes

125. opportunit*
126. market*
127. change*
128. solution*
129. evaluat*
130. sustainab*
131. measure*
132. scale
133. grow*
134. effect*
135. impact
136. diversit*
137. renew*
138. resilience

Key resources

Search engines

- Google

- Factiva
- Scopus
- EBSCOHost
- Web of Science/Knowledge
- Cochrane Library
- PubMed

Appendix 2 – Data extraction tool

Author (Year)	Country/Region	Fair Foundations Framework layer	Methodology and approach	Social innovation focus	Health Equity focus	Quality (1 to 5 stars)
Woodward et al. (2014)	Liberia, Sierra Leone, West Bank Gaza, Somaliland	Socioeconomic, political and cultural context	Qualitative	E-health programs	Wellbeing in post-conflict communities	****
Canuto et al. (2013)	Australia	Daily living conditions	Mixed Methods	Program design	Physical wellbeing for urban-based Aboriginal and Torres Strait Islander women	*****
Liao et al. (2012)	Taiwan	Socioeconomic, political and cultural context	Case Study	National Health Insurance	Wellbeing among elderly women	*****
Piscopo (2014)	Argentina	Socioeconomic, political and	Case Study	National Health	Supportive policy	****

		cultural context		Insurance	environments	
Wilson-Mitchell (2012)	Canada	Socioeconomic, political and cultural context	Case Study (derived from quantitative study)	National Health Insurance	Migrant families	****
Teklehaimanot and Teklehaimanot (2013)	Ethiopia	Socioeconomic, political and cultural context	Case Study	Health Extension Program	Promote gender equality	*****
Huaynocha et al. (2014)	Nigeria	Socioeconomic, political and cultural context	Case Study	Scalable sexuality education program	Sexuality education	*****
Mantziki et al. (2014)	Europe-wide	Socioeconomic, political and cultural context	Case Study	Co-delivered promotion and support	Health equity promotion	****

Shei (2013)	Brazil	Socioeconomic, political and cultural context	Case Study	Bolsa Família conditional cash transfer system	Social welfare innovation	*****
Grimm et al. (2013)	UK	Socioeconomic, political and cultural context	Qualitative	Social innovation policy	Effective policy	****
Trowbridge and Schmid (2013)	USA	Socioeconomic, political and cultural context	Case Study	University-Community partnerships	Physical activity promotion	****
Brunger et al. (2014)	Canada	Socioeconomic, political and cultural context	Mixed Methods	Research-Community partnerships	Migrant health and wellbeing	****
Aranda-Jan et al. (2014)	Africa	Socioeconomic, political and cultural context	Systematic Review	Mobile health project	Accessible health care	*****

Evangelou et al. (2013)	UK	Daily living conditions	Mixed Methods	Place-based health care	Families, female mental health	****
Radcliffe et al. (2013)	USA	Daily living conditions	Qualitative	Family home-visit service	Mental health, child health	*****
Patterson et al. (2014)	USA	Daily living conditions	Qualitative	University-community partnership	Homelessness	*****
Crosby et al. (2013)	USA	Daily living conditions	Qualitative	University-community partnership	Community health care	****
Krska and Mackridge (2014)	USA	Individual health-related factors	Qualitative	Social networks, place-based strategies	Alcohol screening	****

Gabarron et al. (2012)	Norway	Individual health-related factors	Case Study	Social media, avatars	Sexual health, young adults	*****
Osbourne and Patel (2013)	Australia	Individual health-related factors	Qualitative	Online media health promotion	Remote and rural living	*****
Steele et al. (2013)	USA	Individual health-related factors	Qualitative	Online media for schools	Childhood obesity	*****
Waldman et al. (2013)	USA	Individual health-related factors	Case Study	Community-centred co-design	Cancer services	*****
Acri et al. (2014)	USA	Individual health-related factors	Qualitative	Service co-design	Depression, mental health	*****
Dyke et al. (2012)	UK	Individual health-related factors	Qualitative	Collaboration	Mother and child health	*****

Lattanzio et al. (2014)	Italy	Individual health-related factors	Case Study	Technology supported behaviour change	Ageing	****
Kidd et al. (2011)	Canada	Socioeconomic, political and cultural context	Case Study	Social enterprise	Various	*****
Park and Wilding (2013)	UK and Korea	Socioeconomic, political and cultural context	Qualitative	Social enterprise	Supportive policy, developing capacity	****

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