



Promoting health equity through social innovation

An evidence summary

FAIR FOUNDATIONS HEALTH EQUITY SERIES



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Introduction

Background

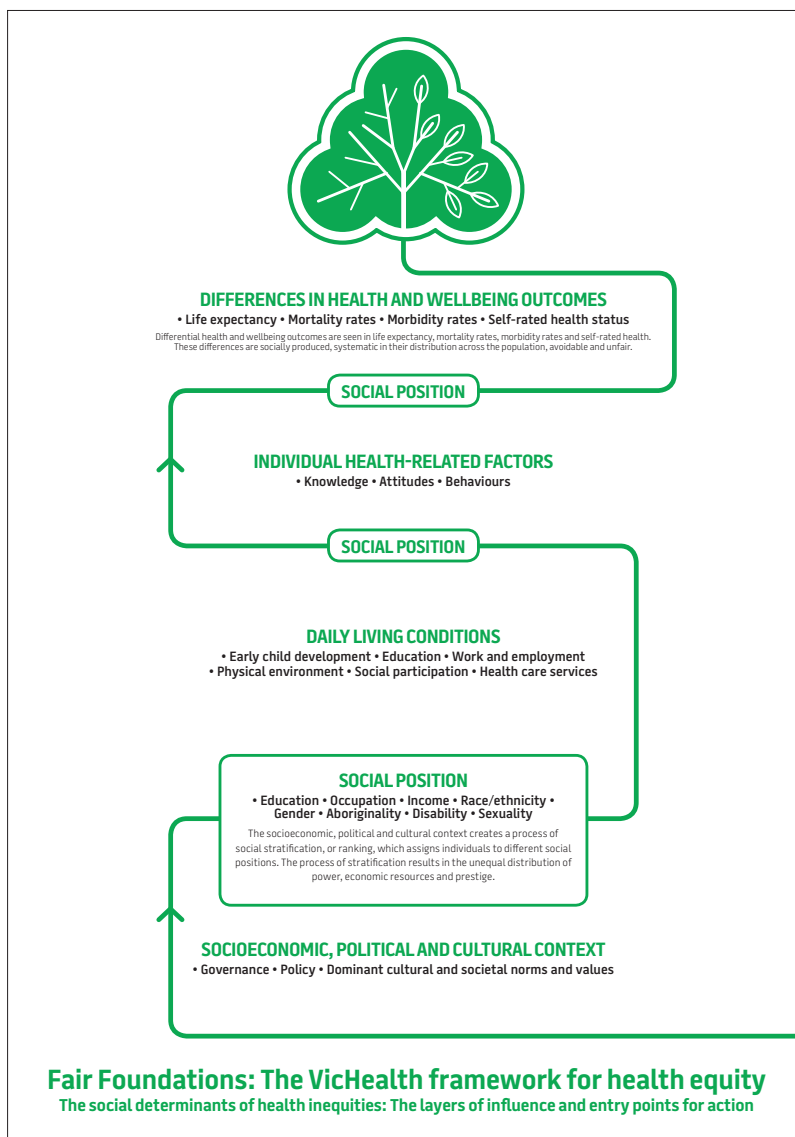
There has been growing interest in recent years in the potential for social innovations to transform people's lives. Social innovations are novel solutions to social problems that simultaneously seek to be more effective, efficient, sustainable or just than previous or existing solutions, and to benefit society as a whole rather than private individuals. A social innovation can take the form of a product, production process or technology; however, it can also be a principle, a piece of legislation, a social movement, an intervention or some combination of these. It may involve an entirely original idea or, more commonly, the application of an existing innovation to a new industry, social need or market.

Social innovation is well suited to addressing complex social challenges and holds significant potential for addressing health inequities. However, despite a well-established body of descriptive accounts of the relationship between social innovations and health equity promotion, the evaluative evidence base is relatively limited. 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. It also reflects the complexities of valid measures of change for wicked social problems. There is an urgent need for greater valuing of evidence – in terms of research, sharing of practice knowledge, and evaluation – to enable the diffusion of social innovation and its impacts in the health equity domain.

Health equity is the notion that all people should have a fair opportunity to attain their full health potential, and that no one should be disadvantaged from achieving this potential if it can be avoided.

Health inequities are differences in health status between population groups that are socially produced, systematic in their unequal distribution across the population, avoidable and unfair.

The social determinants of health inequities are the social determinants of health – or the health-influencing social conditions in which people are born, grow, live, work, play and age – and the social processes that distribute these conditions unequally in society.



www.vichealth.vic.gov.au/fairfoundations

Using this document

This evidence summary is intended to provide policy makers and practitioners in Victoria and across Australia with practical, evidence-based guidance on using social innovation to promote health equity. It is designed to be used alongside ‘Fair Foundations: The VicHealth framework for health equity’ www.vichealth.vic.gov.au/fairfoundations – a planning tool developed and published by VicHealth in 2013 to stimulate and guide action on the social determinants of health inequities.

Health inequities are differences in health status between population groups that are socially produced, systematic in their unequal distribution across the population, avoidable and unfair. In Victoria and across Australia, health outcomes progressively improve with increasing social position. This is known as the ‘social gradient in health’. Key markers of social position include socioeconomic status, gender, race/ethnicity, disability, aboriginality and neighbourhood characteristics. The underlying social structures and processes that systematically drive this social hierarchy, and in turn determine individual exposure and vulnerability to a range of everyday living conditions that can be protective of or damaging to health, are known as the ‘social determinants of health inequities’.

Common underlying drivers and determinants of health inequities are outlined in the Fair Foundations framework. This evidence summary is one of eight that use the framework to examine a specific health issue and its determinants (mental wellbeing, healthy eating, physical activity, alcohol, and tobacco use), or specific opportunities for action (through social innovation, settings-based approaches, or a focus on early childhood intervention as an upstream solution to health inequities over the life course). In many cases, the key social determinants of health inequities (such as education or employment) are also discussed as settings for action (e.g. schools, workplaces) within each summary.

This summary focuses on social innovations that have successfully impacted, or that show significant potential to address, health inequities if designed and targeted appropriately. It highlights best practice and priorities for action across all three layers of the Fair Foundations framework – Socioeconomic, political and cultural context; Daily living conditions; and Individual health-related factors – in order to support coordinated, multisectoral approaches.

How can social innovation promote health equity?

Much of the social innovation literature relates to the Individual and Daily living conditions layers of the Fair Foundations framework. While this reflects the highly context-specific nature of many forms of social innovation, nevertheless social innovations can successfully influence the wider Socioeconomic, political and cultural context to promote health equity. Much of the relevant available evidence at this level relates to institutional innovations within social-welfare systems, where radical changes in practice have been seen in failing or dysfunctional systems, or to enhancements made to existing systems that are intended more closely to meet community needs.

At the Daily living conditions level, much of the evidence refers to addressing systemic barriers to, and creating enabling environments for, health equity. There has been a particular focus at this level on intervention during the early childhood period. With regard to Individual health-related factors, all social innovations for health equity tend to 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.

This evidence summary focuses on four broad types of social innovation with the potential to address health inequities:

1. social movements
2. service-related social innovations
3. digital social innovations
4. social enterprises.

While many social innovations do not necessarily fall neatly within one of these categories, the typology is useful in identifying some of the key points of difference between innovations from a practice perspective.

Social movements

There is a long research history that views social movements as an approach to social change. Social movements are networks of interacting individuals, groups and/or organisations that pursue politically or culturally defined objectives – or engage in political or cultural conflicts – on the basis of shared collective identities. There tends to be a distinction in the literature between two broad categories of social movements:

1. class-based movements concerned primarily with the material needs of particular social groups
2. a wide range of democratically driven and identity movements that can be further classified according to their different 'mobilising potentials', ranging from 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, and lesbian, gay, bisexual, transgender and intersex [LGBTI] movements); and politics (exemplified by the ecology movement).

Class-based movements

A key contemporary example of a class-based social movement is the modern cooperative movement. Cooperative movements have been formed to respond to geographic inequities in access to goods and services, to fulfil unmet service needs of particular social groups, and to increase economic self-determination for producers and workers within global markets. In Australia, consumer cooperatives have made substantial contributions to the provision of housing, childcare, financial services and food retail.

Democratically driven and identity movements

A key innovation of this second category of social movements has been the way in which they give voice to, or shed light on, new forms of knowledge, and in so doing challenge social and environmental inequities reproduced through institutionally sanctioned sources of expertise. They have also used diverse, innovative communication forms and strategies to express movement objectives, mobilise public support and widen collective commitments to action.

The value of social movements

As forms of social innovation, social movements are typically seen to play a distinctive role at the macro level by redressing inequities produced by economic, cultural and sociopolitical contexts that drive social problems, including health inequities. Many social movements have influenced the social–political, economic and cultural context by shedding light on the link between the micro level (or the level of individual experience) and the macro (or the level of systemic effects). Second-wave feminism, disability rights and LGBTI movements, for example, have traced how people’s identities and related behaviours and attitudes are shaped by dominant cultures that ignore or stigmatise their experience. They have also drawn attention to the social conventions that inform scientific, legislative and economic institutions and the ways in which these, in turn, influence a wide range of daily living experiences, including employment opportunity, educational participation, and access to appropriate health and other social services.

While it is possibly not desirable or feasible to initiate social movements in response to the myriad of issues determining and impacting on health inequities, there is scope for learnings from one movement context to be applied to other settings or issues. 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. Finally, insights can be gained from looking at the organisational structure of effective social movements (whether formal or informal) in order to maximise the impacts of collective action.

Service-related social innovations

A second area with which social innovation for health equity has been widely linked is public sector reform. A range of social innovations have sought, in particular, to address gaps and inadequacies in mainstream health care service design and delivery 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 that services seek to achieve.

Service-related innovations in this sector have included basic health care provision in remote locations, mobile-health services, microfinance schemes and online peer-support networks for marginalised or at-risk communities. They have targeted a range of health issues, determinants and stages of the life course, including early childhood development, obesity, physical activity, ageing, mental health, women’s health, and sexual health.

Service-related social innovations can impact at all layers of the Fair Foundations framework; generally, however, they are most evident at the Daily living conditions level. Many programs and interventions developed at the local level tend to be driven by national and supra-national frameworks and action plans, such as the World Health Organization Commission on the Social Determinants of Health and the European Union Health Equity 2020 plan.

There is a strong emphasis in the literature, however, on the need for service-related innovation to tackle the structural causes of health inequities, which are often targeted by welfare-state systems with varying degrees of success. Many recent service-related social innovations have sought to respond to inadequacies and gaps in these welfare systems while, simultaneously, responding to changing demographic needs. These innovations have sought, with mixed success, to support and implement new ways of thinking at the governance and policy level, while delivering change at the other two layers of the Fair Foundations framework. In some countries, the most significant policy-level innovations have come from innovating through the development of national health insurance schemes to promote wellbeing outcomes for marginalised social groups.

Other interventions have been designed that innovate within existing social welfare platforms. This includes community-based, participatory approaches designed to overcome income- and location-based social exclusion.

At the individual level, there has been a particular focus among service-related social innovations on addressing inequities in health issues that attract social stigma, including sexual health, obesity and mental health. Social media, social networks and other technology-based delivery platforms have shown particular promise, although the place of community in the inception and implementation of service-related social innovations at this level appears to be as important as the adoption of the chosen media to deliver it.

Digital social innovations

Application of the skills and technologies of digital social innovation to health equity issues is a relatively new, and rapidly growing, area of practice and research. Digital social innovations use digital technologies to co-create knowledge and solutions to a wide range of social needs. They are predominantly delivered through online and mobile technologies and may make use of new technology trends, including open data infrastructure, open hardware and open networks.

Applications relevant to health equity include the use of collaborative community-based networks, open social innovation (a collaborative, decentralised approach to innovation enabling large numbers of people to interact and participate at relatively low cost), and digital fabrication (computer-controlled manufacturing) to develop low-cost health care devices and to engage users in their design and uptake. Communication innovations, such as online education, peer support and mobile-health interventions have been used to disseminate health services and information, and new digital technologies have been used to develop and deploy vaccines, and childbirth and reproductive devices on a mass scale in non-OECD countries.

There is currently little long-term evaluative evidence available on the impact of digital social innovations in the health care context due to the relative 'newness' of this area. Much of the evaluation evidence available is specific to communication platforms, and relates to impacts at the Individual and Daily living conditions levels.

Online and social media platforms, for example, appear to be effective in encouraging participation and creating safe spaces to inform, diffuse and discuss health issues, and in encouraging social connectedness. For particular health issues that attract social stigma, they can also serve as reliable resources for good-quality health information and preventive health promotion. Online chat rooms, for example, 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 'offline'.

Care must be taken, however, to ensure that digital platforms do not themselves become new sites of stigma. It is also essential that inequities in technology access and use be recognised and addressed in the design and implementation of digital social innovations.

Social enterprises

Social innovation has been consistently linked to social enterprise, both as a new type of business for social purpose and as a form of organising and public governance in which there are changing relationships between governments, civil society and private business. 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. Social enterprises often embed a community orientation at their core and, as a result, are able to respond to user and community needs in ways that public sector organisations often do not.

From a health equity perspective, social enterprises can respond directly to gaps or issues in mainstream health-service provision, or target the broader social determinants of health inequities (by, for example, addressing gaps in provision of a wide range of social services, such as employment and work integration). In both cases, the introduction of social innovation constitutes a process innovation, where business model improvements are expected to deliver improvements in service design and availability.

There have been limited efforts to measure the impact of social enterprises on health inequities. Most research in this area has focused on financing and structuring of these new hybrid organisations, and on the public commissioning environment required to ensure their sustainability and effectiveness. Available evidence indicates that social-enterprise interventions can positively impact health equity at the Individual and Daily living conditions levels. Work integration social enterprises (WISE), for example, can allow for design of work settings that are responsive to the needs of particular social groups, and increase the latent benefits of employment (such as increased self-efficacy, self-esteem and social relationships). There is also some evidence that they can advance exposure and connectedness between WISE participants and their broader communities, as well as influence the practices of other local employers and organisations.

The evidence base is less positive regarding the impacts of individual social enterprises at the Socioeconomic, political and cultural level. There is limited evidence that individual social enterprises ameliorate systematic sources of social exclusion. In addition to focusing careful attention upon the design and governance of individual enterprises, effecting change at the Socioeconomic, political and cultural level may require second-tier social enterprises or 'peaks' that provide collective representation to governments and industry (as in the UK and Canada).

Common challenges faced by social enterprises seeking to address health inequities include accessing sufficient start-up finance, obtaining political support and on-the-ground development support, and addressing 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. Scaling is not always needed to address structural issues and 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.

Priority actions

Social innovations that have successfully addressed health inequities have tended to:

- simultaneously meet social needs and create new relationships (i.e. be social in both their means and purpose)
- respond to institutional failure and system shock
- cut across boundaries between sectors and disciplines and encourage interaction among different groups, including health and non-health sectors, and civil society, government and the private sector
- create new combinations from existing elements, and identify and use latent or unrealised value, including recognising the value of under-recognised or -utilised resources such as knowledge, labour, waste products and communities' financial capital
- involve people-centred program design and implementation
- apply non-traditional disciplinary insights to a particular area of policy or practice
- recognise the complex interplay between the causes of the causes of health inequities, and intervene upstream to address them
- involve integrated thinking and action, consistent with complex systems thinking, in order to maximise value and minimise problems arising from unintended consequences
- involve social and relational models of intervention
- be predicated on process innovations that involve user-centred design, partnership and collaboration
- demonstrate and communicate evidence of outcomes and impacts
- take place within environments where there is institutional stability and sustained institutional support for social innovation (including support for experimentation and adaptation; tolerance for emergent learning rather than exclusive interest in best practice; opportunities for integration; and fit-for-purposes funding and financing mechanisms)
- work across all three layers outlined in the Fair Foundations framework simultaneously, although a particular focus may be trained on one level.

In addition, all social innovations aimed at promoting health equity should consider these actions:

- Coordinate a blend of measures across all three layers of the Fair Foundations framework, with particular emphasis on, and investment in, the lower two layers to rebalance the current emphasis on individual-level health factors
- Seek to address both inequities in health outcomes and the wider social determinants of these inequities
- Incorporate explicit equity objectives
- Apply principles of proportionate universalism: interventions should be universal, but the level of support should be proportionate to need
- Ensure that targeted supports do not stigmatise particular groups
- Promote active and meaningful engagement of a wide range of stakeholders, and increase the diversity of representation at all stages of development and implementation
- Conduct a thorough assessment of the needs, assets, preferences and priorities of target communities
- Allocate adequate, dedicated capacity and resources to ensure sufficient intensity and sustainability
- Monitor and evaluate differential impacts across a range of social indicators to ensure that they achieve their objectives without doing any harm, as well as to strengthen the evidence base for future interventions
- Invest in equity-focused training and capacity building in both health and non-health sectors, from front-line staff to policy and program decision-makers
- Make strategies flexible and adaptable at the local level.

Priority evidence gaps

- Longitudinal, meta-evaluative and comparative evidence on the relative effectiveness of different approaches to social innovation in different contexts and over time.
- Understanding of the predictors of institutional barriers to social innovation.
- Analysis of the significance of organisational form to social innovation – How, why and in what contexts do distinct organisational forms offer relative advantages? Can particular organisational structures mobilise resources more effectively or legitimately than others? What might the trade-offs be between user-centred and multi-stakeholder models in terms of effectiveness, financial efficiency and scalability?
- Understanding of how particular modes of service design and delivery can scale effectively and sustainably across different levels of influence within the Fair Foundations framework.

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