How can social enterprises impact health and wellbeing?

Key words: social enterprise; community food initiatives; health and well-being; food poverty; structuration theory

Abstract

Purpose -The objective of this paper is to examine the impacts of social enterprise on individual and community health and well-being. It focuses on community food initiatives, their impact on the social determinants of health and the influence of structure on their outcomes.

Design – Using an interpretive qualitative approach through case studies focused on two community food social enterprises, the research team conducted observations, interviews and ad-hoc conversations.

Findings - Researchers found that social enterprises impacted all layers of the social determinants of health model but that there was greater impact on individual lifestyle factors and social and community networks. Impact at the higher socio-economic, cultural and environmental layer was more constrained. There was also evidence of the structural factors both enabling and constraining impact at all levels.

Implications – This study helps to facilitate understanding on the role of social enterprises as a key way for individuals and communities to work together to build their capabilities and resilience when facing health inequalities. Building upon previous work, it provides insight into the practices, limitations and challenges of those engaged in encouraging and supporting behavioural changes.

Value - The paper contributes to a deeper insight of the use, motivation and understanding of social enterprise as an operating model by community food initiatives. It provides evidence of the impact of such social enterprises on the social determinants of health and uses structuration theory (Giddens, 1984) to explore how structure both influences and constrains the impact of these enterprises.

How can social enterprises impact health and wellbeing?

Introduction

A growing body of research is seeking to better understand the relationship between poverty, inequality and health (Lund, 2015). The link between socio-economic circumstances and health is well established (Walsh *et al*., 2010) with multiple statistics revealing the effects of poverty on all forms of inequality including food inequalities. The Scottish Index for Multiple Deprivation identifies those parts of Scotland suffering most from poverty and its effects. Forty-two percent of Glasgow's 'datazones' are in the lowest 15% bracket of Scotland's most deprived areas (SIMD, 2012). As such, a much larger portion of Glasgow's population live in income deprivation compared to the rest of Scotland (Shipton and Whyte, 2011). The inequalities in health faced by the more deprived areas of Glasgow are often represented in differences in life expectancy: males in affluent areas of the city live 13.9 years longer than those in the most deprived areas while women live 8.5 years longer (McCartney, 2010). However, poor physical health is only one component of overall health and wellbeing. Anxiety and mental health outcomes have been argued to be indisputably linked to poverty (Burns, 2015) and more broadly, poor eudemonic well-being (Ryan and Deci, 2001) has been shown to be a consequence of impoverishment.

This link between individual health outcomes and socio-economic contexts has led to a shift in the focus of discussions on health and wellbeing from a position where ill-health was located in personal functioning to a position where wellbeing is located in the opportunities provided by society for social integration and participation (Baumgartner & Burns, 2014). One approach which may provide such opportunities is that of social enterprise. These local organisations may provide a means of working with individuals, households and communities to build their capabilities and resilience when facing health inequalities (Sonnino and Griggs-Trevarthen, 2012). Yet, there is a dearth of literature which characterises these enterprises or their impact on individual and community outcomes (Roy *et al.* 2017, Wilson *et al.*, 2015).

The aim of this paper is to examine the impacts of social enterprise on individual and community health and wellbeing. Specifically, we are interested in finding evidence of social enterprise in the community food sector impacting on the social determinants of health and understanding the structural determinants which enable and constrain the ability of social enterprise to impact on health and wellbeing.

The paper begins with a discussion of the impacts which social enterprises' can have on health. We identify structuration theory (Giddens, 1984) as a theoretical lens to inform this discussion. This lays the foundations for our empirical case study approach. The paper contributes to debate about the *"wave of euphoria and optimism"* (Bull, 2008: 272) surrounding social enterprise in light of calls for more critical application to the study of social entrepreneurship (Dey and Steyaert, 2010) by assessing the impact of two social enterprises in Glasgow on the wider social determinants of health.

Health Improvement & Social Enterprises

In the UK, high profile reports including the Black Report (1980), the Acheson Report (1998) and the Marmot Review (2010) have identified the need to address health inequalities (unjust differences in health between different social or population groups) by looking more widely at those social factors that can impact health. These reports identify a growing need to appreciate that the effects of inequality are less to do with the individual and more an outcome of societal opportunities, influenced by broader structural dynamics. A commonly used model which depicts these social determinants of health is that of Dahlgren and Whitehead (1991), shown in Figure 1.

INSERT FIGURE 1 HERE

This model highlights the multi-layered nature of health determinants and depicts causal relationships between: lifestyle choices; social networks; working and living conditions; and economic, political and environmental factors at global, national and local levels. Mounting understanding of the multiple effects of these issues is leading to growing pressure for appropriate interventions in research, practice and policy which seek to address and improve deprivation arising from inequalities created by structural dynamics (Bambra *et al*., 2010). Frieden (2010) hypothesises that addressing meso and macro determinants will have a greater impact on health than approaches which concentrate on micro dynamics. Interventions however, tend to focus on modifying people's lifestyle factors (Bambra *et al.*, 2010), ignoring wider structural influences. The impact of any health intervention may therefore be dependent on which of the 'layers' of the Dahlgren and Whitehead's (1991) model are the focus of such interventions.

One type of intervention that may have the potential to influence health and wellbeing is that of social enterprise (Roy *et al.*, 2017, Roy *et al*., 2014). While significant energy has been applied to the definition and meaning of social enterprise (Shaw and De Bruin, 2013), it remains a contested concept (Teasdale, 2011). Social enterprises reflect diverse and heterogeneous forms of organisations which adopt various structures and use multiple activities to address the social needs of many different client groups (Shaw and Carter, 2007). In the absence of an agreed definition, common characteristics of social enterprise have emerged and debate principally coalesces around both the primacy of social aims and the centrality of trading (Teasdale, 2011). This is reflected in the most widely agreed definition: *"a business with primarily social objectives, whose surpluses are principally reinvested for that purpose in the business or community rather than mainly being paid to shareholders or owners,"* (Department of Trade and Industry, 2002). This definition suggests that social enterprises adopt approaches which differ from those of traditional charitable organisations, principally by the adoption of an entrepreneurial mind-set which encourages self-sustainability through trading to address specific social goals.

The UK Government's (Department of Trade and Industry, 2002) strategy for social enterprise identified a number of objectives to which they could contribute. These were:

> *"Helping to drive up productivity and competitiveness; contributing to socially inclusive wealth creation; enabling individuals and communities to work towards regenerating their local neighbourhoods; showing new ways to deliver and reform public services; and helping to develop an inclusive society and active citizenship." (Department of Trade and Industry, 2002: 24).*

Support for social enterprise and positive reporting of its potential has continued to pervade governmental discourse and attract academic attention. Seanor *et al.* (2013: 325) note a grand narrative in the UK, in which "*organisations have been described as moving towards social enterprise with the image of a tide, a force that is irresistible yet positive*" yet they note a counter narrative to this which questions the over emphasis on economic drivers of social enterprise, and foregrounds community values and need to impact societal structures (Berglund and Wigren, 2012). Some organisations may resist this discourse due to a concern that it could undermine the achievement of social objectives (Doherty *et al.*, 2014). Bull (2008: 272) also note a need "*to highlight alternative views which are often in conflict with the wave of euphoria and optimism that is driving current theoretical development in the field of social enterprise and entrepreneurship"*.

More recently, respective UK governments have given significant focus to the potential of social enterprise in relation to healthcare (Roy *et al*., 2012). However, it is worth distinguishing between social enterprises which have spun off from the NHS through the Right to Request Scheme (Hall *et al.*, 2012) and those which have emerged as bottom up community-led initiatives. Arguably it is the latter that will tackle the wider social determinants of health through their less medically oriented roots due to what De Leeuw (1999: 261) calls *"community based action"*. Roy *et al*. (2014) suggest a causal pathway through which social enterprise interventions lead to the development of individual and community assets which, in the long term, deliver improved health and wellbeing through increased social capital and a sense of coherence (Roy *et al*., 2014). Social enterprises may operate at a grass roots level, aligning themselves to the needs of the local community (Cornelius and Wallace, 2013) and evidence suggests that using a community engagement approach with disadvantaged groups is *"effective in terms of health behaviours, health consequences, participant self-efficacy and perceived social support outcomes"* (O'Mara *et al*., 2013 pg. xv). The wellbeing generated from participating in a social enterprise may extend into participants' day-to-day community lives (Farmer *et al*., 2016).

Social enterprises may be able to empower and integrate people (Lloyd, 2004) and tackle exclusions of disadvantaged groups (Teasdale, 2010). A key reason for this is that social enterprises are typically created by those located within communities who, as a consequence of being embedded locally, possess the credibility (social networks and reputational capital), to encourage community support for their social mission and objectives (Jack and Anderson, 2002; Shaw and Carter, 2007). Even without 'health improvement' as an explicitly stated mission, social enterprise interventions may lead to gains in health and wellbeing (Roy *et al*., 2012). Ridley-Duff and Bull (2015) suggest that social enterprises offer an alternative to government-led interventions by creating a more socially embedded, equitable economy. Roy and Hackett (2016) agree that social enterprises offer an alternative means of reducing the health inequalities often attributed to the neoliberal capitalist approach (Roy and Hackett, 2016). This echoes the conclusions of an earlier review in which Roy *et al*., (2014: 191) suggest, "*the potential of social enterprise and other civil society actors to focus impact upon upstream social determinants of public health requires continued theoretical and conceptual development and crucially – further empirical work to help inform and test initiatives that may arise from such thinking."*

More recently Mason *et al*. (2015) considered a wider view of the relationships between social innovation (including social enterprise) and the promotion of health equity. While they use a different framework, their determinants of 'individual health related factors', 'daily living conditions' and

'socioeconomic, political and cultural context' resonate with the layers of the Dahlgren and Whitehead (1991) model. Their review of the available evidence promotes social enterprise as an upstream response to the social determinants of health which play a role primarily at the levels of individual behaviours and daily living conditions. An additional type of social innovation 'social movement' has been identified as having the most significant known impact on socioeconomic, political and cultural factors (Mason *et al*., 2015). This may call into question the impact that social enterprise can have on these structural determinants. However these findings may be limited by evidence predominantly from 'work integration social enterprise' which create pathways of employment for people otherwise disadvantaged in the labour market (Spear and Bidet, 2005). This dominance of one particular form of social enterprise may contribute to the finding that the impact was primarily at the individual and daily conditions level. As such this paper, by considering this limitation, engages with bottom up community led social enterprise to investigate if this is more widely applicable.

Theoretical underpinning

Structuration theory (Giddens, 1984) is a useful lens through which to consider social enterprises that aim to improve health by highlighting the impact they have on the different layers of the Dahlgren and Whitehead (1991) model (Figure 1). Structuration theory questions the dualism of structure and agency. Structuralists believe that social structure determines individual choice, downplaying the extent to which individuals can exert agency to make choices that are independent and free willed (Nicholls and Cho, 2006). In contrast, the 'agency' perspective believes that individuals have creative and disruptive abilities; thus suggesting that social structures are fluid and can be changed (ibid). In developing structuration theory, Giddens (1984) sought to build a social theory which avoided both subjectivism and objectivism (Stones, 2005). Instead he argued that agency and structure interact and so both influence both individual behaviour and broader societal structures. Developing this, Nicholls and Cho, (2006 pg. 110) have argued that agents are *"neither powerless nor omnipotent relative to the social context in which they operate"*. Giddens identifies three interrelated elements of structure: domination (power), signification (meaning) and legitimation (norms). These elements of structure may both enable and constrain the ability of the social enterprise to impact on the social determinants of health.

Structuration theory has been used in the social enterprise field (Mair and Marti, 2006; Haugh, 2012) but only in a handful of studies. It has also been considered within entrepreneurship more generally (Sarason et al 2006). When applied to social entrepreneurship, it is argued that studies have tended to

focus on the heroic individual social entrepreneur engaged in social transformation (Dey and Steyaert, 2010). This approach has been criticised for being neglectful of structural influences, giving too much attention to the entrepreneur at the expense of the context (Jones, 2015, Venkataraman and Sarasvathy, 2005); a focus on chronic disease and individual lifestyle factors dominating the approach (Macintyre *et al*., 2002). Yet, in both fields, increasingly, the role of structure is attracting attention. The emergence and political ascension of social enterprise in UK policy has been attributed to the interplay between agency and structure with the socio-political and economic context allowing social enterprise to emerge to the fore as a means of tackling social needs (Sepulveda, 2015). Institutional, temporal and market environments have been found to be important dimensions of context which can assist and constrain entrepreneurs' behaviours and actions (Shaw and De Bruin, 2013). Similarly in public health Roy (2016: 8) notes *"recent attempts to redirect the attention of public health theorists and practitioners back towards structural and environmental influences on health and health behaviours."*

Structural elements are therefore impacting the fields of social enterprise and public health. Social enterprises will deliver more effective health interventions if they change those structures that negatively impact on health, however to achieve this such enterprises must have agentic capabilities. As Steinerowski and Steinerowska-Streb (2012: 172) neatly sum up, there must be *"potential for a duality, where the agent and the structure co-construct"*. Structuration theory is used to consider the role of structure and agency in determining the effectiveness of social enterprise as a health intervention by highlighting the elements of the structure that both enable and constrain this capability. Although structuration theory has come under strong and influential criticism (Stones, 2005), it is not the purpose of this paper to test the theory. Rather, similar to the approach undertaken by Steinerowski and Steinerowska-Streb (2012) the paper accepts the theory and uses it to explore the role of structure *and* agency in nurturing and developing social enterprise as an effective vehicle for improving health and wellbeing.

Method

As discussed at the outset, the Scottish Index for Multiple Deprivation identifies the city of Glasgow as notably impoverished compared to Scotland as a whole (Shipton and Whyte, 2011; SIMD, 2012) with acute health challenges particular to the city (Walsh *et al*. 2010). Reflecting this situation Glasgow has a high saturation of social enterprises tackling the city's inequalities (GSEN and Social value lab, 2013). Roy (2016) also notes that tackling health inequalities has been central to Scottish Government policy agendas, resulting in actions aimed as catalysing 'untapped strengths' within Scotland's communities.

This paper focuses on community food initiatives in Glasgow which reflect characteristics of the wider social enterprise sector. They employ a range of diverse activities with community cooking groups, local growing projects, community cafes, food co-ops, community shops and farmers markets amongst others. The aims of such projects differ hugely, but improving health is a key social objective either explicitly, by improving the supply of healthy food and increasing cooking skills, or implicitly by providing opportunities for community participation. Some network organisations in the sector have produced guides and briefings which suggest local projects could consider adopting a social enterprise approach (Sustain, 2005; Scottish Community Diet Project 2006). Both our case organisations are operating in areas of multiple deprivation but with very different contextual characteristics as outlined below.

The purpose of this paper is to examine the impacts of social enterprise on individual and community health and wellbeing. It asks the following questions: What evidence is there of social enterprise in the community food sector impacting on the social determinants of health? What elements of structure enable and constrain the ability of social enterprise to have these impacts? The project adopts an interpretivist, qualitative methodology involving case study research focussed on two bottom-up, community-led social enterprises. As Roy (2016:4) discusses when *"research aim is to move beyond surface appearances to explore the processes involved, it is appropriate to study individuals in context"*. Case studies are suited to studying contemporary, real life, complex phenomena (Yin, 2008). They provide tools to investigate phenomena within their natural context and thus elicit detailed explorations (Hoaglin et al, 1982). Following Canniford and Shanker (2013), this study uses a range of collection methods. Two researchers spent five days in the field interviewing and observing each of our participating social enterprises as well as drawing on secondary data and field notes. This range of methods allowed engagement with social entrepreneurs, managers, nutritionists, drivers, volunteers and end users.

The use of two case-studies was informed by existing work on the collection of qualitative data (Karataş-Özkan, 2011). By adopting a two case design, researchers were able to collect fine-grained data and acquire detailed insights into the effects of the multiple, combined factors related to wellbeing within each case. The paper also identifies and considers patterns across each of the cases which are operating in areas experiencing similar degrees of multiple deprivation.

The case-study phase included three sets of interviews. Two of these interviews were with the managers of each of these social enterprises and the third was a group interview with an employee (a

nutritionist), a service user and a volunteer. The latter took the different format of a group interview as it was felt the volunteer and service user may have been more reluctant to engage without the presence of the staff member from the organisation. The interviews were non-directive whereby questions were not pre-planned although the objectives of the research were known to both researchers and participants (Gray, 2004) and interviews were also anchored in observations within the context (Merriam and Tisdall, 2015). This format was deemed appropriate as it allowed respondents to talk freely around the subject (ibid). Interviews of between 45 minutes and 1.5 hours were audio recorded, with participants consent, and were recorded to allow "conversation to flow, eye contact to be maintained and interaction to occur" (Wilson, 2012: 108). After each interview, the researchers discussed initial impressions and observations, taking notes to crystallise the main themes emerging (Bryman and Bell, 2007). Additional insights into the case studies was gained through observations during the 5 days in the field and ad-hoc conversations with users and volunteers of the organisations. Following Merriam and Tisdell (2015) these observations allowed the researchers to experience the context first hand and the interviews to be anchored to what had been observed. To gain a deeper understanding of the field, two further interviews were conducted with representatives of national organisations, one supporting social enterprise and the other supporting community food initiatives. This diversity of qualitative collection methods further allowed for triangulation of emerging findings throughout the data analysis (Merriam and Tisdell, 2015).

The process of data analysis commenced by converting all materials into NVivo. Each data set was then read through, starting with the interview transcripts, fieldnotes and secondary materials. This process of intertextual (Thomson and Holland, 1997) analysis was used to tack between data sources allowing for greater sensitisation to themes emerging from the field, rather than projecting predetermined meanings onto emic data (Thomson and Holland, 1997). Combining this work with extant understanding from structuration theory, one researcher developed a coding framework combining emic accounts from the data with etic understandings from the literature and considering how power, meaning and norms are combined with the micro, meso and macro levels of Dahlgren and Whitehead's (1991) model. Three members of the research team subsequently worked together to code the data. During this process of coding, the original framework was revisited to identify inconsistencies, clarify meanings and establish additional emergent codes (Fernald and Duclos, 2005). The codes that were most pertinent to the research questions were then further discussed amongst the team to draw out the key findings.

Cases

City North began as a food co-operative initiated by Glasgow University students in 2001 in response to a wave of asylum seekers being located to north Glasgow. Following a successful funding application, a full time manager was employed in 2006. In this area both male and female life expectancy is considerably lower than the Glasgow average. A high percentage of the population are living in income and employment deprivation and the proportion of children living in poverty is particularly high. Nearly a third of the population are claiming out-of-work benefits. City North operates a hub and spoke business model with three food hubs. There are four full-time employees and six part-time staff, including one driver, one nutritionist (who also runs one of the food hubs), one gardener and a volunteer co-ordinator. In addition, they recruit and support 40-50 volunteers on an annual basis.

City East covers ten percent of the most deprived communities in Scotland. It has a large geographical spread meaning that there are many areas on the periphery of small towns where lack of public transport compounds difficulties in accessing amenities (http://www.understandingglasgow.com, 2015). The case-study organisation has been in existence for 25 years and grew out of a federation of food co-operatives. It has now significantly extended its business offering and is larger in scope than Case 1 with 15 full-time employees (six of whom are drivers) and seven part-time members of staff (many of whom are funded via community job creation schemes).

Findings

Findings will first present evidence of the impact the case studies have on the different layers of the social determinants of health and an exploration, using structuration theory, of the elements of the structure that are enabling and constraining their agentic capabilities.

Impact on the social determinants of health

Individual Lifestyle Factors

Participants in both cases expressed that their social enterprise had had an impact on improving individual diets, either through increasing the availability of healthy food or by equipping people with the skills and knowledge required to eat a healthy diet:

> *"We do a lot of work with the children and evaluations with their families, diet diaries and the like; and we had 53% of the families saying that their children had increased consumption at home of fruit and vegetables." (City East, Manager)*

"…he's trying to change his life. He's been incredible, bad friends and all that and alcohol or whatever and he's now seen the transformational benefits of eating a healthy diet." (City North, Manager)

Recalling one of the participants at a cooking class one employee said:

"I remember somebody in their 70's that never cut a veggie before. She'd never ate veg in her life." (City North, Employee)

Promoting increased physical activity, alongside a healthy diet, was also important and the community garden at City North was an effective way to encourage more physical activity amongst users. Similarly, City East ran walking programmes with target markets:

"We were doing loads of work in the nurseries and starting buggy walks for the parents… they'd drop the kids at 9:30 or whatever, they'd go for an hour long walk, they'd go back have a healthy snack and then the kids were ready to collect." (City East, Manager)

Nutrition, physical activity and obesity are some of the individual lifestyle factors that can lead to poor health and inequality (Dahlgren and Whitehead, 2007). By promoting changes in these particular behaviours, both cases may be contributing to health improvement at an individual level. However, such changes may be considered modest and short term (Dowler, 2008) and the extent to which these outcomes lead to a significant change in people's diet is contested due to a lack of impact of the wider, structural determinants (Lambie- Mumford, 2013).

Other individual benefits reported were focused on *"getting out the house*". City North spoke of their involvement in employability schemes, giving people experience to put on their CV, and discussed an evaluation undertaken by a public health specialist who concluded *"your main outcomes are more mental health".* Both organisations also spoke of the health benefits which their volunteers experienced, particularly their more elderly volunteers.

Social and Community Networks

Participants in both cases felt strongly that they added to the social and community networks in their areas:

"On what I call social capital, definitely, that does happen within our project. We are building up more confidence in local people, taking a pride, coming out their house with someone that didn't even come out the house. And they are engaging with others in their community. So, they are contributing towards building stronger communities." (City North, Manager)

"… but more importantly it's about the socialisation at the co-op and almost all of our co-ops will have a kettle as well. Folk will sit down at the Windsor Hall at the top here and they're sit there for half an hour. It may be the only contact they have so there's those issues"

Service users also spoke of the benefits of the social aspects and how this made people want to get involved:

"…but you were taking part in it… and there was this whole social thing being built up within it too and that was great, which is why Sarah said 'I want to be a part of it' (City North, Service User/volunteer)

As well as building up connections between people in the area, participants in both cases believed they were building connections with other local organisations. These connections were identified to be beneficial to the community as a whole and there were strong feelings that these impacts were more important than the individual health behaviour change that involvement in the organisation brought about:

"So yes there are almost certainly more benefits that aren't related to diet through food co-ops than there is just the diet stuff. It's almost the diet as an incidental." (City East, Manager)

Although these benefits were considered extremely important by both service providers and users, participants believed this was not the sort of impact that would be reported back to funders because *"funders require us to report on their things" (City North, Manager).*

General Socioeconomic, cultural and environmental conditions

To consider the impact on the outer 'layer' of the social determinants of health model, the particular issue of food poverty was discussed. Food poverty is defined as *"an inability to acquire or eat an adequate quality or sufficient quantity of food in socially acceptable ways (or the uncertainty of being able to do so)*" (Dowler and O'Connor, 2012: 44). Although food poverty is not routinely measured

in the UK, the perception amongst health professionals (Ashton *et al*., 2014) is that its prevalence is increasing (Douglas *et al*., 2015). City East were more explicit about their role in tackling food poverty than City North. However the representative from one of the support organisations suggested that social enterprises may not always recognise how their activities help to tackle food poverty.

> *"There is some organisations that are very clear that they are tackling food poverty but there is other ones who may not be aware that they are contributing to it" (Support Organisation Representative 2).*

Food poverty has, to some extent, become synonymous with food banks; organisations that distribute free emergency food parcels. Therefore, other strategies and activities that social enterprises offer to address this issue may not be recognised as such due to this narrow version of what food poverty is. City East ran their own emergency food aid programme, providing food parcels to those in need. The number of referrals they received was four times more than expected, which they attributed to high levels of unemployment and welfare reform, putting a strain on their funding. Although not identical, their model was similar to that of the large network of foodbanks which operate in the UK. These foodbanks have received growing media (Wells and Caraher, 2014) and political attention due to significant growth in the number of outlets and the number of users in recent years (Trussel Trust, 2015). However, there was significant concern that this approach was not effective in addressing the longer term issues of people in food poverty:

> *"Because all we're really doing here is giving free food away… it's not about a long term interaction with people." (City East, Manager)*

> *"Because do you know what, that's just alleviating the problem through other means and when that money finishes the problem is still going to be there. So it's kind of tricky, they got money for so many parcels, food parcels like… It's like that… you've still got a cut underneath it. That's the very same thing, you just put a plaster on it." (City North, Employee)*

These findings echo the limited extant literature on this topic which questions the efficacy of food projects in tackling food poverty given that the heart of the problem arises from economic and circumstantial barriers (Kennedy, 2001). Douglas *et al*. (2015) found that community food projects felt that their work was being undermined or ineffective as the underlying causes of food poverty were still present and unaddressed. Other authors believe food projects are a quick fix' which cover the lack

of fundamental change that is needed (Dowler and Caraher, 2003), diverting attention from the real determinants of the issue (Caraher and Coveney, 2004).

There was more optimism from support organisations that such projects can, and do, play a role in addressing food poverty:

> *"We don't deny that people are in extreme food poverty but we need to understand what that food poverty is and will food parcels get them out of it or will it simply get them through an occasion of it. Whereas developing skills in cooking classes or improving access through the co-ops or informing Government policy to say 'the initiatives on their own are not enough', people need adequate income, they need communities to be better planned, they need better behaviours from retailers. It's all part and parcel of the solution." (Support Organisation Representative 1)*

Each of our case studies demonstrated some impact on the social determinants of health which concurred with previous literature. Evidence suggested the building of individual and community assets which Roy *et al*. (2014) argue can lead to improved health and wellbeing. They also chime with the review of Mason *et al*. (2015) which concluded that social enterprises appear to have their greatest impact on the individual behaviours and daily living conditions. However, it is apparent that their impact on higher level socioeconomic, cultural and environmental conditions is more constrained; a frustration identified by both case studies. There was more optimism from support organisations that social enterprises can and do play a role in addressing food poverty and that by bringing their work together these organisations can broker wider impact with policy makers (Stam, 2010).

Enabling and constraining impact of structure on the agentic capabilities of social enterprise

Structuration theory identifies three elements of structure: domination (power), signification (meaning), and legitimation (norms) (Giddens, 1984). Giddens (1984) refers to domination as "resources", both economic and human, and groups' signification and legitimation together as "rules" (Stones, 2005). Considering the rules and resources imposed upon and available to each case study will highlight the elements of the structure that affect their agentic capabilities to impact on health.

Organisational legitimacy is often considered in terms of conformance to extra-organisational institutional arrangements and forms (Nicholls, 2010) however, the community food sector exhibits

variable understanding and adoption of the social enterprise term and model. Representatives from the support organisation noted that some social enterprises clearly and explicitly recognise themselves as such whereas others do not. There was some confusion and 'fuzziness' around some of the terms:

> *"We work with a lot of food co-ops and there are barely any that are actual co-operatives… But we work with community shops across the country that invariably are co-operatives but don't use the title… on their own branding 'community shop' is what people need to know*" *(Support organisation representative 1)*

The idea of *"what people need to know"* suggests that the social enterprise element of such organisations is not a priority when creating their character or brand. Therefore despite the positivity surrounding social enterprise in the UK, it may be that community food organisations do not see social enterprise as something that is important to their customers and rejecting this term may enhance the embeddedness of such organisations and foster legitimacy (Jack and Anderson, 2002). Participants also gave examples of working to embed themselves in the local community; discussing one of the staff members, the City North manager observed:

> *"…she'd go meandering round the scheme…she suddenly went off with a local person…but that was her way of building up links."*

Both case studies also demonstrated some resistance and uncertainty about the social enterprise approach, expressing concerns about the impact this might have on their social mission. Their understandings of social enterprise had a key focus on the enterprise rather than the social element of the term and they delineated between different parts of their organisations in terms of their strategic aims. Thus they made a clear distinction between their social and trading activities with the trading undertaken to cross subsidise their wider operations. City East operated a structure of having a separate trading arm which was set up as an independent operation as they felt the balance of trading verses social activity was, at that time, *"getting a bit out of kilter"*. In times of greater social need City East felt they had to scale down their trading activity:

> *"Since then the level of extreme food poverty in Scotland, in Lanarkshire in particular, has got so high that that equilibrium [between charity and trading] has balanced itself out again." (City East, Manager)*

City North suggested that to generate income they would need to target the '*city centre'*, which would involve carrying out the trading side of the operation outside the target geographical area for their social activities. They were considering the trading opportunities available to them and, at the time of research, were planning to recruit a business development manager to take on this role. Similarly, this was seen as a separate part of the organisation with the manager stating:

> *"There's no way the charitable side can take a hit on any of this stuff…" (City North, Manager)*

Others in the organisation were concerned about the impact and stress this move towards business development might have on the social side of the organisation. City East participants articulated that for them to be entirely self-sufficient through trading they,

> *"…would need to put so much emphasis on developing sales that we would cease to be a charity in my view" (City East, Manager)*

Existing literature recognises both the contested nature of the term social enterprise (Teasdale, 2011) and the concern that the trading activity inherent in social enterprise may negatively impact on social objectives (Doherty et al, 2014). The case studies provide evidence in support of this. How this impacts the agentic capability of social enterprises can be argued in different ways. By resisting the grand narrative described by Seanor *et al*. (2013) as organisations exhibiting a strong and positive desire to move towards being more enterprising, the case studies may contribute to a revision of the 'rules', allowing them to change the prevailing structure. However, it may also limit their ability to harness the current policy climate in the UK which nurtures and promotes the concept of social enterprise (Steinerowski and Steinerowska-Streb, 2012). If the legitimacy of these organisations is questioned both their sustainability and also their level of influence on the wider structural conditions will be constrained, ultimately compromising the extent to which they can positively impact on health.

A further norm was the specific reporting requirements of funders. For these reports, impact was measured using quantitative methods such as numbers of people attending events, number of courses run, number of pieces of fruit consumed etc. These measures give little understanding of how cases were impacting on individual and community health. It has been recognised that social impact can be long term, complex and difficult to objectify (Ruebottom, 2011). The cases consider that their reporting methods are often inadequate in capturing such impacts. City East has tried to extend their agency by developing links with a nutritional course in a local university who provided support with evaluations.

However these tended to extend only as far as the interests of nutritionists and considered pre-and post-behaviour rather than broader health evaluations. Case participants consider that supplementary methods are needed. City North encouraged sessional workers to capture comments during events,

> *"However what I put in about a year and half ago was a weekly feedback thing from our sessional staff because sometimes the gold that you need is within something that two people have had in their conversation." (City North, Employee).*

Reporting norms expected by funders constrained the broader impact measurement, frustrating the case studies by failing to capture their full impact. However, the case studies undertook some additional data collection, complementing the traditional reports with qualitative information through videos and case studies. Case participants believed that even traditional funders are increasingly recognising the growing importance of this 'softer' data and this has influenced what they regard as the 'right' way to assess impact to their funders. This demonstration of agentic capability to influence the reporting expectations may change the norms of the sector and increase legitimation of the organisations. Ultimately this will allow a stronger message to be conveyed as to the impact and benefit of these organisations which may improve their sustainability and level of power in impacting the social determinants of health. Furthermore changing the norms of reporting allows organisations to better demonstrate their impact, giving them access to more resources both economic and human.

Discussions concerning food poverty highlight a perceived lack of domination or power for the case studies. Nicholls (2010: 616) paper on the legitimacy of social entrepreneurship recognises different pressures on organisations and notes one of these can be a *"process by which powerful external actors, such as state or resource providers, forced organisations towards uniformity".* City East's experience of getting funding to distribute emergency food parcels demonstrates this process,

> *"So we did… our intentions were honourable as food bank's intentions are honourable but are they perpetuating a system where the national response is, "well if you have a problem go to the church hall and somebody will give you some food for a few days." (City East, Manager)*

Case participants recognise that trying to solve the problem with emergency packages of free food was not necessarily an effective one but, as it was becoming an entrenched response, it was what they were expected to do. In this respect they were solidifying a norm which they did not feel was satisfactory. The fact that the high levels of food poverty were attributed to unemployment and welfare reform led

to some anger that the problem was being forced upon people and those causing the problems (i.e. the Government) should be the ones to fix it:

> *"But there is this whole political agenda, are you just doing what should be the government's work?" (City East, Manager)*

According to Giddens (1984) agents are knowledgeable, purposeful, reflexive, active and capable of making a difference. An agent ceases to be such if they cannot exercise some sort of power to make a difference. Both above comments convey a powerlessness to tackle the problem of food poverty with both domination and norms being elements of the structure that was imposing significant constraints on the case studies and their ability to impact the higher level social determinants of health.

Implications and Conclusions

This paper shows that social enterprise can have an impact on the social determinants of health but that this remains predominantly at the levels of individual and community. This supports and extends Mason *et al*. (2015) by demonstrating how structural elements may influence this impact. Impact on the wider layer of general socioeconomic conditions was less evident, as demonstrated by the example of food poverty, whereby domination and norms dictated how the social enterprises responded to the issue. This lack of power was a frustration and concern for the case studies and evidenced significant constraint imposed by the structure. Support organisations by building networks and linking the smaller organisations with policy makers may offer some promise of increasing the agency of the collective of community food organisations. This has a key implication for policy since social enterprises cannot tackle all of the social determinants of health alone rather these organisations should form part of a complementary network of public, economic and third sector business models to create a more encompassing strategy for tackling health inequalities. The 'fair food transformation fund' recently introduced by the Scottish Government (Scottish Government, 2016) recognises the agentic role of community food initiatives and makes now an ideal time to implement a broader approach of the kind suggested in this paper. The findings are supportive of complementary approaches to addressing the effects of poverty and inequality, indicating that broader, societal approaches which encourage inclusion and address structural inequalities are likely to be more impactful in their efforts to redress inequalities created by broader structural constraints. Accepting this, it is likely that initiatives which both address structural constraints while providing local communities with the skills and capacities needed to identify and implement local solutions to addressing inequalities are likely to have broader societal impacts.

There is uncertainty and resistance to the term 'social enterprise' however the concept has strong potential for impact. When taken alongside the case studies' clear distinction between trading and wider social priorities this paper further challenges the grand narrative of social enterprise in the UK as a "*force that is irresistible yet positive*" (Seanor *et al*., 2013: 325). This has a clear implication for practice in the field by demonstrating a need to change the norms and legitimacy around the term social enterprise. The organisations within this project incorporated a wide suite of activities demonstrating flexibility and an understanding of the many complex factors that influence health and responding to these in context appropriate ways. Therefore by adopting, more universally, the term social enterprise and extending its scope to reflect the multiplicity of practice locally embedded organisations, like community food initiatives, can achieve greater impact by channelling more extensive resources and accruing the credibility and trust needed to encourage local clients to engage with their interventions.

Finally we contribute to the body of extant research by building on the growing body of work that discusses the potential impact of social enterprises on health and wellbeing by demonstrating the complexity of the impacts that organisations can have across micro, meso and macro levels of social determinants of health model (Dahlgren and Whitehead, 1991). We recognise that the, Glasgow based, two case study approach in this paper limits the generalisability of the findings and as such concur with others that yet further research is needed to gauge the ways in which social enterprises can impact on wellbeing and the support mechanisms needed to ensure their impact is as effective as possible (Roy *et al*., 2014).

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