Social Policy & Society (2014) 13:3, 457–467
© Cambridge University Press 2014 doi:10.1017/S1474746414000104

Social Innovation: Worklessness, Welfare and Well-being

Michael J. Roy*, Neil McHugh and Clementine Hill O'Connor*****

**Yunus Centre for Social Business and Health, Glasgow School for Business and Society, Glasgow Caledonian University*
E-mail: Michael.Roy@gcu.ac.uk

***Yunus Centre for Social Business and Health, Glasgow Caledonian University*
E-mail: Neil.McHugh@gcu.ac.uk

****Yunus Centre for Social Business and Health, Glasgow Caledonian University*
E-mail: Clementine.HillOConnor@gcu.ac.uk

The UK Government has recently implemented large-scale public-sector funding cuts and substantial welfare reform. Groups within civil society are being encouraged to fill gaps in service provision, and 'social innovation' has been championed as a means of addressing social exclusion, such as that caused by worklessness, a major impediment to citizens being able to access money, power and resources, which are key social determinants of health. The aim of this article is to make the case for innovative 'upstream' approaches to addressing health inequalities, and we discuss three prominent social innovations gaining traction: microcredit for enterprise; social enterprise in the form of Work Integration Social Enterprises (WISEs); and Self Reliant Groups (SRGs). We find that while certain social innovations may have the potential to address health inequalities, large-scale research programmes that will yield the quality and range of empirical evidence to demonstrate impact, and, in particular, an understanding of the causal pathways and mechanisms of action, simply do not yet exist.

Keywords: Social Innovation, self-reliance groups, microcredit, public health.

Introduction

One of the most notable successes of the UK welfare state since its inception has been the significant increase in average life expectancy and improvement in population health (Shaw *et al*., 2005). However, these improvements have not been shared equally: accompanying the trend of ever-widening income inequality since the end of the 1970s, health inequalities – preventable and unfair differences in health status between social groups, populations and individuals (Whitehead *et al*., 2001) – have increased. While mainstream public health initiatives have continued to aim to impact upon individual risk factors, such as smoking, diet, alcohol and exercise, many public health experts would claim that a key requirement in narrowing inequalities would be to act on the material circumstances of the most vulnerable members of society (Marmot, 2010). If low income, social exclusion and hopelessness contribute to poor health, there is an argument for working on the 'causes of the causes' of such factors through more holistic, community-based, interventions (Chief Medical Officer for Scotland, 2011; McLean and McNeice, 2012). There have been a number of moves in recent decades to supplement a public health focus upon individual pathologies and risk factors with greater awareness of the

https://doi.org/10.1017/S1474746414000104 Published online by Cambridge University Press

importance of social relationships, purposeful activity, community processes and social contexts in creating health (Bambra *et al*., 2010; Hanlon *et al*., 2011) and, even very recently, reducing worklessness has been presented as an important means of addressing the social gradient in health (Bambra, 2014).

At the same time, the concept of 'social innovation' (SI) has come to the fore. Paradoxically, SI has been presented as both an 'anchor concept' for cross-disciplinary research (MacCallum *et al*., 2009) and as a somewhat amorphous and contested term. SI is described variously as: 'the generation and implementation of new ideas about how people should organize interpersonal activities, or social interactions, to meet one or more common goals' (Mumford, 2002: 253) and 'new ideas that meet unmet needs' (Mulgan *et al*., 2007: 5) across different layers of society (Moulaert *et al*., 2013). SI has been particularly championed to combat social exclusion: this is the case at both domestic and EU policy levels, but also further afield, such as in the US, where an Office of Social Innovation and Civic Participation has been created.

Meanwhile, unemployment is currently running at around 7.8 per cent in the UK, equivalent to 2.5 million of the economically active population without a job (Office for National Statistics, 2013). The deleterious impact of worklessness on public health is well documented: employment not only provides income but a sense of control and of purpose, which are important influences on health (Marmot, 1999). Being without a job critically undermines the ability of citizens to access money, power and resources; factors identified by the World Health Organisation as among the high level 'social determinants of health' (World Health Organisation, 2013).

The question therefore arises: could SI be a means of enhancing individual and community health and well-being by reducing social exclusion? To explore this question we draw upon three examples of social innovations from civil society which work to address unemployment and/or to mitigate its consequences, namely: microcredit for enterprise, Work Integration Social Enterprise (WISE) and self-reliant groups (SRGs). In doing so, we consider whether there is a case for framing such innovations as 'upstream' means of tackling the social determinants of health (McKinlay, 1974).

Microcredit for enterprise

What is microcredit for enterprise?

Among the several functions of welfare, provision in the UK acts as a form of 'safety net' during 'socially critical periods', such as unemployment, so as to reduce an individual's vulnerability and reliance upon the market (Bartley *et al*., 1997). Unemployment can be a turbulent experience for individuals as it is often accompanied by lower income and heightened risk of varying forms of social exclusion. Successive welfare reforms and changes in public perceptions towards claimants have corroded the ability of the UK welfare state to shield individuals from some of the detrimental factors associated with unemployment which can lead to poor health (Baumberg *et al*., 2012; Corlett, 2012). Leading researchers in public health, including Marmot and Wilkinson (2006), argue that rather than just 'safety nets,' policy 'springboards' are required to offer individuals opportunities to 'improve their lot' and re-enter the labour market in an improved position from whence they came. One such 'springboard' which has been proposed is microcredit for enterprise.

https://doi.org/10.1017/S1474746414000104 Published online by Cambridge University Press

Microcredit is the issuance of small, collateral-free loans, typically extended to those excluded from mainstream financial institutions for either enterprise or personal purposes, aimed at addressing social, and particularly financial, exclusion. Microfinance Institutions (MFIs) are commonplace in developing countries, where they emerged from the need to combat financial market inefficiencies that tend to discriminate against the poorest members of society. Characterised by innovative lending and operating models, such as group lending, targeting women, progressive lending, relationship banking and flexible, public and regular repayments, it is claimed that MFIs have transformed the 'unbankable' into the 'bankable poor' (Weber, 2004).

Success in reaching those previously excluded has led to the increasing use and adaption of such lending practices by institutions in more advanced economies. In the UK, certain Community Development Finance Institutions (CDFIs) – such as fair finance, and the soon to be launched Grameen UK – offer (or will offer) products resembling microcredit for enterprise. These institutions are conceived as socially oriented, not-for-profit, initiatives that act as a bottom-up tool for community development, with the aim of mitigating financial exclusion and having a positive impact upon the lives of individuals.

The potential for impact

Microcredit for enterprise has the potential to reduce an individual's material constraints, and to possibly improve their psychosocial outlook through their engagement and interaction with the lending institutions themselves and the creation of their own microenterprises. Thus, it has been proposed that microcredit has the potential to address the determinants of health (Mohindra *et al*., 2008; Donaldson *et al*., 2011). However, there is a substantive gap in knowledge about the mechanisms through which policies and interventions, such as microcredit, that attempt to act 'upstream', can impact upon health and well-being.

Hypotheses and research proposals

Academic research on microcredit in developing countries is maturing. This is a consequence of a rise in quality of microcredit evaluations (Duvendack *et al*., 2011), general acceptance that microcredit is not a 'silver bullet' (Leatherman and Dunford, 2010) and calls for the implementation of more rigorous empirical testing to assess the impact of microcredit (Hulme, 2000).

The search for more robust research designs has led the microcredit sector to look for study designs from other disciplines. In particular, evaluators have looked to the field of medicine, where the randomised controlled trial (RCT) is the recognised 'gold standard' for its ability to lead to an understanding of whether a cause–effect relationship exists between a treatment and an outcome (Sibbald and Roland, 1998). The importance and difficulty of understanding this causal relationship has been recognised in the microcredit sector (Armendáriz de Aghion and Morduch, 2005), and prominent individuals within this sector have embraced this research design (Karlan and Zinman, 2010; Duflo *et al*., 2013). So far, this approach has only been applied to microcredit in developing country settings and there remain firm practical (cost and implementation) and methodological concerns (external validity) associated with this research design (Odell, 2010).

https://doi.org/10.1017/S1474746414000104 Published online by Cambridge University Press

The transfer and implementation of this research design to a developed country setting, such as the UK, raises ethical and feasibility considerations. Ethical issues relate to denying potential customers access to credit, so that they might serve as a control group. Additionally, 'overlending' to boost borrower numbers could be a concern as the market for microcredit for enterprise in a developed country is relatively smaller than in a country such as India (McHugh *et al.*, forthcoming). Innovative research designs are thus required to evaluate microcredit for enterprise in developed countries.

A financial diaries approach, undertaken in developing countries and now implemented in the USA (Collins *et al.*, 2009; USFD, 2013), could be adapted to evaluate the impact on social exclusion or health and lay the groundwork for further long-term quantitative evaluations. Longitudinal evaluations could be more successful at capturing impact as the same recipients are followed and monitored continuously over time (Goldstein, 1968), which is an advantage over the RCT approach.

The complexity of conceptualising microcredit for enterprise as an intervention with a wider social impact necessitates an awareness of learning from evaluations conducted in developing countries. Transferring this knowledge, while continuing to apply and develop innovative research methods, would move this incipient field forward, potentially leading to assessments of whether microcredit could be considered a useful and cost-effective mechanism for addressing certain social determinants of health (Donaldson *et al.*, 2011).

Work Integration Social Enterprises (WISEs)

What are WISEs?

Similarly to the concept of social innovation, the focus upon 'social enterprise', and the closely related terms 'social entrepreneur' and 'social entrepreneurship', has significantly increased in recent years (Defourny, 2009). While recognising that social enterprise is a 'contested concept whose meaning is politically, culturally, historically and geographically variable' (Teasdale *et al.*, 2013: 1), a social enterprise, as taken here, is a business with social objectives whose surplus revenue is reinvested for these purposes (Dees, 1998; Borzaga and Defourny, 2001). Different conceptualisations of social enterprise exist throughout the world (Defourny and Nyssens, 2010; Kerlin, 2010), but, broadly speaking, social enterprises can be divided into: those driven by an ideological commitment to collectivism and democratic process; and those for whom the primary motivation is meeting social goals, but which adopt a hierarchical and individualistic organisational structure common in the private sector (Teasdale, 2010). The former, arguably more emancipatory, model is common to most WISEs or 'social firms'.

WISEs are a specific type of social enterprise with the core purpose of workforce development and/or job creation for disadvantaged populations (Spear and Bidet, 2005; Vidal, 2005; Warner and Mandiberg, 2006). They may also combine a mission to address social exclusion (Teasdale, 2010, 2012) with providing a product or service needed by society (Ferguson, 2012).

The potential for impact

In contrast to traditional supported employment efforts aimed at disadvantaged individuals, such as people with mental illness, WISEs neither encourage conformity

https://doi.org/10.1017/S1474746414000104 Published online by Cambridge University Press

to a particular job description nor setting (Krupa *et al*., 2003). Rather, WISEs utilise a community economic development approach which, it is claimed, neutralises labour-market conditions of individualism, competition and profit, all of which create a climate of disadvantage (Warner and Mandiberg, 2006). In such a way, WISEs can help to ensure a fairer distribution of, or access to, resources, build social capital, provide an opportunity for disadvantaged and marginalized groups to expand their social networks, facilitate social trust and co-operation and strengthen existing peer support groups (Ferguson, 2012).

Although there is potential for WISEs to impact upon the social determinants of health, it cannot automatically be assumed that this will result in all instances. A range of organisations (including some WISEs) in receipt of UK Government Work Programme contracts have been guilty of 'cherry picking', or 'creaming', clients (Johnson, 2013). In other words, instead of focusing their attention on those most in need, such as those facing multiple and/or complex disadvantages, they have focused instead on those closest to the labour market in order to achieve outputs dictated by Government-driven Payment by Results (PbR) contracts (Rees *et al*., 2013). The perverse outcome of this is widening disadvantage and increasing costs in the long run. This highlights how funding can dictate how an organisation operates, which could result in 'mission drift' and transformation of potential impact (McHugh *et al*., 2013).

Hypotheses and research proposals

As with the example of microcredit for enterprise, there is a paucity of evidence around the ability of social enterprises to impact upon the social determinants of health, simply because their potential in this regard has not (or has very rarely) been thought of in such a way before (Roy *et al*., 2013). That said, conceptual and theoretical development, informed by a systematic (integrative) review of empirical evidence on the impact of social enterprise-led activity on health and well-being (Roy *et al*., 2012) is well underway. There is some (albeit limited) evidence (see Krupa *et al*., 2003; Ferguson and Islam, 2008; Ho and Chan, 2010; Williams *et al*., 2010; Ferguson, 2012) that social enterprise-led activity can impact positively on mental health, self-reliance, self-esteem and health behaviours, and can also build social capital and reduce public stigmatisation by demonstrating that members of marginalized groups can be capable, productive workers and valued members of society. There is also a body of evidence (see, for instance, Lomas, 1998; Kivimäki *et al*., 2000) that suggests that such factors influence individual and community health and well-being. There is, however, a clear need for more empirical research to better understand the causal mechanisms at work through social enterprises and other civil society actors upon a range of intermediate and long-term public health outcomes. In recognition of this gap, a five-year programme of research to evidence the impact of 'social enterprise as a public health intervention' has been funded jointly by the UK's Medical Research and Economic and Social Research Councils, to commence in January 2014 (Glasgow Caledonian University, 2013).

Self-Reliant Groups (SRGs)

What are SRGs?

SRGs are the result of a Church of Scotland initiated project called 'Wevolution' which seeks to offer an alternative model of community development for women in

https://doi.org/10.1017/S1474746414000104 Published online by Cambridge University Press

deprived areas of Scotland. Although renamed SRGs in Scotland, the SRG model is influenced by Indian Self Help Groups (SHGs), and retains much of the ethos of the Indian model. Facilitated by Wevolution, women from the same socio-economic backgrounds have organised themselves into groups of five to ten, meeting and saving small amounts of money on a weekly basis. Several groups have started to develop collective microenterprises, the capital for which has come from a combination of group savings and funds administered by local financial intermediaries, with the aim being to create employment opportunities for SRG members, many of whom have been unemployed for several years.

The potential for impact

While it is still too early to determine the impact of SRGs in the UK, some hypotheses can be proposed about their potential based upon the experience of SHGs in India. SHGs have been successful in bringing women together to encourage self-sufficiency and address problems as a community through the utilisation of group lending systems and by linking groups to a bank to access microcredit. This often enables women to start, or scale up, businesses, and the economic power gained from women's increased income has been shown to enhance their ability to address social problems in their communities (Tesoriero, 2006), including issues around access to medical care, agricultural management, education and political participation (Mohindra *et al*., 2008; Khatibi and Indira, 2011).

We cannot, however, simply assume that similar findings will be seen in the UK context; the welfare state, for instance, provides a level of financial security that people feel they may lose by moving into work, whether self-employment or otherwise. This fear is exacerbated when considering that members of SRGs are often single parents who also have to consider the cost of childcare if they move into work. The worry for many is that employment will not pay more than their benefits, and will not lead to a better standard of living (Ray *et al*., 2010). This may limit the impact of SRGs in the UK, just as welfare has, in some ways, limited the impact of microcredit for enterprise in the US (Schreiner and Woller, 2003).

There are, however, some facets of SRGs which, based upon research in the UK, we can tentatively suggest may well lead to improvements in health and well-being. SRGs operate an internal lending system using group savings, providing additional loan capacity which can act as a 'safety net' from which members can borrow for consumption purposes, rather than having to resort to credit from expensive money lenders. Access to affordable finance can reduce stress and worry and improve psychological well-being and physical health (Dobbie and Gillespie, 2010) and there is evidence that a reduction in financial related stress leads to more rational decisions regarding finances which, in turn, lead to an improved ability to manage money (Lenton and Mosley, 2012).

Research around the impacts of social capital also points to some potential impacts of SRGs. SRGs have the potential to enable members to form relationships within and between other SRGs, and with outside support agencies, thus expanding social networks. Support can be both emotional and practical, with a common aim to overcome or work across societal power gradients, which, it has been argued, is an important factor in health promotion (Szreter and Woolcock, 2004). Such bridging relationships across societal

https://doi.org/10.1017/S1474746414000104 Published online by Cambridge University Press

power gradients are recognised as being the hardest to gain, but will ultimately reap the greatest rewards over time (Hawkins and Maurer, 2010).

Hypotheses and research proposals

Work is under way to establish an empirical evidence base for the impact that SRGs could have on addressing issues related to social exclusion, and thus health and well-being. A longitudinal ethnographic study is under way which will provide insight into the impacts of SRGs as directly experienced by those involved (Hill O'Connor, 2013). Although some progress has already been documented in relation to women's involvement in the groups, it is hoped that this study will soon yield testable hypotheses for further research, and shed light on the mechanisms and pathways by which such involvement might lead to enhancements in health and well-being.

Conclusion

The retreat of direct state provision in many areas of UK social policy in the cause of austerity (Sinfield, 2011) has led to an increased demand for civil society actors to provide support and attempt to fill the gaps, while simultaneously reducing the resources available to enable them to do so. This is likely to lead to considerable human, social and economic costs in the future (New Economics Foundation, 2012), particularly in places where the worst of the impact has fallen upon the most vulnerable, excluded and marginalised in society. A diverse body of evidence suggests that a dynamic and engaged civil society can enhance the relevance and acceptability of actions addressing the social determinants of health (Blas *et al*., 2008). However, if social innovation is ultimately to fulfil its true potential as an 'anchor concept for research in creative arts, human organisation, economic diversity, neighbourhood regeneration, regional renaissance, governance and other areas' (MacCallum *et al*., 2009: 2), then we agree with Grimm *et al*. (2013) that much more theoretical and conceptual development is required, particularly to apply it coherently to new disciplinary areas, such as in public health.

Furthermore, when focusing on specific SIs there is a need to apply a critical lens to assess the potential and realised impacts of the innovation (McHugh *et al*., 2013) and recognise that SI is not, in and of itself, necessarily socially positive (Nicholls and Murdock, 2012). Irrespective of the potential for SI and the attention it is currently receiving, particularly at a European policy level, the large-scale research programmes that will provide the necessary quality and range of empirical evidence to demonstrate impact upon health and well-being, and an understanding of the causal pathways and mechanisms of action, simply do not yet exist.

References

Armendáriz de Aghion, B. and Morduch, J. (2005) *The Economics of Microfinance*, Cambridge, MA: MIT Press.

Bambra, C. (2014) 'Tackling health-related worklessness: a "health first" approach', in L. Newby and N. Denison (eds.), *'If You Could Do One Thing . . . ': Nine Local Actions to Reduce Health*

https://doi.org/10.1017/S1474746414000104 Published online by Cambridge University Press

Inequalities, London: The British Academy, pp. 62–71, http://www.britac.ac.uk/templates/asset-relay.cfm?frmAssetFileID=13276.

Bambra, C., Gibson, M., Sowden, A., Wright, K., Whitehead, M. and Petticrew, M. (2010) 'Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews', *Journal of Epidemiology and Community Health*, 64, 4, 284–91.

Bartley, M., Blane, D. and Montgomery, S. (1997) 'Health and the life course: why safety nets matter', *British Medical Journal (Clinical Research edn)*, 314, 7088, 1194–6.

Baumberg, B., Bell, K., Gaffney, D., Deacon, R., Hood, C. and Sage, D. (2012) *Benefits Stigma in Britain*, London: Turn2us (Elizabeth Finn Care)/University of Kent.

Blas, E., Gilson, L., Kelly, M. P., Labonté, R., Lapitan, J., Muntaner, C., Östlin, P., Popay, J., Sadana, R. and Sen, G. (2008) 'Addressing social determinants of health inequities: what can the state and civil society do?', *The Lancet*, 372, 9650, 1684–9.

Borzaga, C. and Defourny, J. (eds.) (2001) *The Emergence of Social Enterprise*, London: Routledge.

Chief Medical Officer for Scotland (2011) *Health in Scotland 2010: Assets for Health*, Edinburgh: Scottish Government.

Collins, D., Morduch, J., Rutherford, S. and Ruthven, O. (2009) *Portfolios of the Poor: How the World's Poor Live on $2 a Day*, Princeton, NJ: Princeton University Press.

Corlett, S. (2012) 'Policy watch: fighting stigma and discrimination', *Mental Health and Social Inclusion*, 16, 3, 112–15.

Dees, J. G. (1998) 'Enterprising nonprofits', *Harvard Business Review*, 76, 1, 54–67.

Defourny, J. (2009) 'Foreword', in J. A. Kerlin (ed.), *Social Enterprise: A Global Comparison*, Lebanon, NH: University Press of New England, pp. xi–xviii.

Defourny, J. and Nyssens, M. (2010) 'Conceptions of social enterprise and social entrepreneurship in Europe and the United States: convergences and divergences', *Journal of Social Entrepreneurship*, 1, 1, 32–53.

Dobbie, L. and Gillespie, M. (2010) *The Health Benefits of Financial Inclusion: A Literature Review*, Glasgow: Scottish Poverty Information Unit.

Donaldson, C., Baker, R., Cheater, F., Gillespie, M., McHugh, N. and Sinclair, S. (2011) 'Social business, health and well-being', *Social Business*, 1, 1, 17–35.

Duflo, E., Banerjee, A., Glennerster, R. and Kinnan, C. (2013) 'The miracle of microfinance? Evidence from a randomized evaluation', NBER Working Paper Series WP 18950, National Bureau or Economic Research, Cambridge, MA, http://www.nber.org/papers/w18950.pdf (accessed 15 November 2013).

Duvendack, M., Palmer-Jones, R., Copestake, J. G., Hooper, L., Loke, Y. and Rao, N. (2011) *What Is the Evidence of the Impact of Microfinance on the Well-Being of Poor People?*, University of London: EPPI-Centre, Social Science Research Unit, Institute of Education, http://opus.bath.ac.uk/26940/1/Microfinance_2011Duvendack_report.pdf (accessed 15 November 2013].

Ferguson, K. M. (2012) 'Merging the fields of mental health and social enterprise: lessons from abroad and cumulative findings from research with homeless youths', *Community Mental Health Journal*, 48, 4, 490–502.

Ferguson, K. M. and Islam, N. (2008) 'Conceptualizing outcomes with street-living young adults: grounded theory approach to evaluating the social enterprise intervention', *Qualitative Social Work: Research and Practice*, 7, 2, 217–37.

Glasgow Caledonian University (2013) *£2m Study Will Examine Impact of Social Enterprise on Health in Scotland*, http://www.gcu.ac.uk/yunuscentre/newsevents/news/article.php?id=68021 (accessed 9 December 2013).

Goldstein, H. (1968) 'Longitudinal studies and the measurement of change', *Journal of the Royal Statistical Society, Series D (The Statistician)*, 18, 2, 93–117.

Grimm, R., Fox, C., Baines, S. and Albertson, K. (2013) 'Social innovation, an answer to contemporary societal challenges? Locating the concept in theory and practice', *Innovation: The European Journal of Social Science Research*, 26, 4, 436–55.

https://doi.org/10.1017/S1474746414000104 Published online by Cambridge University Press

Hanlon, P., Carlisle, S., Hannah, M., Reilly, D. and Lyon, A. (2011) 'Making the case for a "fifth wave" in public health', *Public Health*, 125, 1, 30–6.

Hawkins, R. L. and Maurer, K. (2010) 'Bonding, bridging and linking: how social capital operated in New Orleans following Hurricane Katrina', *British Journal of Social Work*, 40, 6, 1777–93.

Hill O'Connor, C. (2013) 'The role of Self Reliant Groups (SRGs) in improving individual health and wellbeing', *If Not for Profit, for What? And How?*, The 4th EMES International Research Conference on Social Enterprise, 1–4 July, University of Liege, http://www.iap-socent.be/sites/default/files/Hill%20O%27Connor%20ECSP-LG13-70.pdf (accessed 7 December 2013).

Ho, A. P. and Chan, K. (2010) 'The social impact of work-integration social enterprise in Hong Kong', *International Social Work*, 53, 1, 33–45.

Hulme, D. (2000) 'Impact assessment methodologies for microfinance: theory, experience and better practice', *World development*, 28, 1, 79–98.

Johnson, R. (2013) 'The work programme's only success is at "creaming and parking"', *The Guardian*, 20 February, http://www.theguardian.com/commentisfree/2013/feb/20/work-programme-success-creaming-parking (accessed 21 August 2013.

Karlan, D. and Zinman, J. (2010) 'Expanding credit access: using randomized supply decisions to estimate the impacts', *Review of Financial Studies*, 23, 1, 433–64.

Kerlin, J. A. (2010) 'A comparative analysis of the global emergence of social enterprise', *Voluntas*, 21, 2, 162–79.

Khatibi, F. and Indira, M. (2011) 'Empowerment of women through self help groups and environmental management: experiences of NGOsin Karnataka State, India', *Journal of Human Ecology*, 34, 1, 29–40.

Kivimäki, M., Feldt, T., Vahtera, J. and Nurmi, J.-E. (2000) 'Sense of coherence and health: evidence from two cross-lagged longitudinal samples', *Social Science and Medicine*, 50, 4, 583–97.

Krupa, T., Lagarde, M. and Carmichael, K. (2003) 'Transforming sheltered workshops into affirmative businesses: an outcome evaluation', *Psychiatric Rehabilitation Journal*, 26, 4, 359–67.

Leatherman, S. and Dunford, C. (2010) 'Linking health to microfinance to reduce poverty', *Bulletin of the World Health Organization*, 88, 6, 470–1.

Lenton, P. and Mosley, P. (2012) *Financial Exclusion and the Poverty Trap: Overcoming Deprivation in the Inner City*, London: Routledge.

Lomas, J. (1998) 'Social capital and health: implications for public health and epidemiology', *Social Science and Medicine*, 47, 9, 1181–8.

MacCallum, D, Moulaert, F., Hillier, J. and Haddock, S. V. (2009) 'Introduction', in D. MacCallum, F. Moulaert, J. Hillier and S. V. Haddock (eds.), *Social Innovation and Territorial Development*, Farnham: Ashgate, pp. 1–10.

Marmot, M. G. (1999) 'Job insecurity in a broader social and health context', in J. E. Ferrie, J. Griffiths, M. G. Marmot and E. Ziglio (eds.), *Labour Market Changes and Job Insecurity: A Challenge for Social Welfare and Health Promotion*, Copenhagen: World Health Organisation Regional Office for Europe.

Marmot, M. G. (2010) *Fair Society, Healthy Lives: The Marmot Review – Strategic Review of Health Inequalities in England Post-2010*, London: The Marmot Review.

Marmot, M. G. and Wilkinson, R. G. (2006) *Social Determinants of Health*, Oxford: Oxford University Press.

McHugh, N., Gillespie, M., Loew, J., and Donaldson, C. (forthcoming) 'First steps towards self employment – microcredit for enterprise in Scotland', *Scottish Affairs*.

McHugh, N., Sinclair, S., Roy, M. J., Huckfield, L. and Donaldson, C. (2013) 'Social impact bonds: a wolf in sheep's clothing?', *Journal of Poverty and Social Justice*, 21, 3, 247–57.

McKinlay, J. (1974) 'A case for refocusing upstream: the political economy of illness', Proceedings of American Heart Association Conference on Applying Behavioural Science to Cardiovascular Risk, American Heart Association, Seattle, WA.

McLean, J. and McNeice, V. (2012) *Assets in Action: Illustrating Asset Based Approaches for Health Improvement*, Glasgow: Glasgow Centre for Population Health.

https://doi.org/10.1017/S1474746414000104 Published online by Cambridge University Press

Mohindra, K. S., Haddad, S. and Narayana, D. (2008) 'Can microcredit help improve the health of poor women? Some findings from a cross-sectional study in Kerala, India', *International Journal for Equity in Health*, 7, 1, 2.

Moulaert, F., MacCallum, D., Mehmood, A. and Hamdouch, A. (eds.) (2013) *The International Handbook on Social Innovation: Collective Action, Social Learning and Transdisciplinary Research*, Cheltenham: Edward Elgar.

Mulgan, G., Tucker, S., Ali, R. and Sanders, B. (2007) *Social Innovation What It Is, Why It Matters and How It Can Be Accelerated*, Oxford: Saïd Business School/The Young Foundation/Skoll Centre for Social Entrepreneurship.

Mumford, M. D. (2002) 'Social innovation: ten cases from Benjamin Franklin', *Creativity Research Journal*, 14, 2, 253–66.

New Economics Foundation (2012) *Everyday Insecurity: Life at the End of the Welfare State*, London: New Economics Foundation, http://www.neweconomics.org/publications/entry/everyday-insecurity (accessed 11 December 2012).

Nicholls, A. and Murdock, A. (2012) 'The nature of social innovation', in A. Nicholls and A. Murdock (eds.), *Social Innovation: Blurring Boundaries to Reconfigure Markets*, Houndmills: Palgrave Macmillan, pp. 1–32.

Odell, K. (2010) *Measuring the Impact of Microfinance: Taking Another Look*, Washington, DC: Grameen Foundation, http://business.dom.edu/sites/default/files/documents/Measuring-the-Impact.pdf (accessed 15 November 2013).

Office for National Stastics (2013) *Statistical Bulletin: Labour Market Statistics, July 2013*, London: Office for National Statistics, http://www.ons.gov.uk/ons/rel/lms/labour-market-statistics/july-2013/statistical-bulletin.html (accessed 21 August 2013).

Ray, K., Hoggart, L., Vegeris, S. and Taylor, R. (2010) *Better Off Working? Work, Poverty and Benefit Cycling*, London: Joseph Rowntree Foundation, http://www.jrf.org.uk/publications/better-off-working (accessed 15 November 2013).

Rees, J., Taylor, R. and Damm, C. (2013) *Does Sector Matter? Understanding the Experiences of Providers in the Work Programme*, TSRC Working Paper 92, Birmingham: Third Sector Research Centre.

Roy, M. J., Donaldson, C., Baker, R. and Kay, A. (2013) 'Social enterprise: new pathways to health and well-being?', *Journal of Public Health Policy*, 34, 1, 55–68.

Roy, M. J., Donaldson, C., Baker, R. and Kerr, S. (2012) 'The impacts of social enterprise-led activity on health and well-being: an integrative review', Prospero – International Prospective Register of Systematic Reviews.

Schreiner, M. and Woller, G. (2003) 'Microenterprise development programs in the United States and in the Developing World', *World Development*, 31, 9, 1567–80.

Shaw, M., Dorling, D. and Davey Smith, G. (2005) 'Poverty, social exclusion and minorities', in M. Marmot and R. Wilkinson (eds.), *Social Determinants of Health*, Oxford: Oxford University Press.

Sibbald, B. and Roland, M. (1998) 'Understanding controlled trials: why are randomised controlled trials important?', *British Medical Journal*, 316, 7126, 201.

Sinfield, A. (2011) 'Credit crunch, inequality and social policy', in K. Farnsworth and Z. Irving (eds.), *Social Policy in Challenging Times: Economic Crisis and Welfare Systems*, Bristol: The Policy Press, pp. 65–80.

Spear, R. and Bidet, E. (2005) 'Social enterprise for work integration in 12 European countries: a descriptive analysis', *Annales de L'économie Publique, Sociale et Coopérative*, 76, 2, 195–231.

Szreter, S. and Woolcock, M. (2004) 'Health by association? Social capital, social theory, and the political economy of public health', *International Journal of Epidemiology*, 33, 4, 650–67.

Teasdale, S. (2010) 'How can social enterprise address disadvantage? Evidence from an inner city community', *Journal of Nonprofit and Public Sector Marketing*, 22, 2, 89–107.

Teasdale, S. (2012) 'Negotiating tensions: how do social enterprises in the homelessness field balance social and commercial considerations?', *Housing Studies*, 27, 4, 514–32.

https://doi.org/10.1017/S1474746414000104 Published online by Cambridge University Press

Teasdale, S., Lyon, F. and Baldock, R. (2013) 'Playing with numbers: a methodological critique of the social enterprise growth myth', *Journal of Social Entrepreneurship*, 4, 2, 113–31.

Tesoriero, F. (2006) 'Strengthening communities through women's self help groups in south India', *Community Development Journal*, 41, 3, 321–33.

USFD (2013) *US Financial Diaries*, http://www.usfinancialdiaries.org/ (accessed 15 November 2013).

Vidal, I. (2005) 'Social enterprise and social inclusion: social enterprises in the sphere of work integration', *International Journal of Public Administration*, 28, 9–10, 807–25.

Warner, R. and Mandiberg, J. (2006) 'An update on affirmative businesses or social firms for people with mental illness', *Psychiatric Services*, 57, 10, 1488–92.

Weber, H. (2004) 'The "new economy" and social risk: banking on the poor?', *Review of International Political Economy*, 11, 2, 356–86.

Whitehead, M., Dahlgren, G. and Gilson, L. (2001) 'Developing the policy response to inequities in health: a global perspective', in T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya and M. Wirth (eds.), *Challenging Inequities in Health: From Ethics to Action*, Oxford: Oxford University Press, pp. 309–23.

Williams, A., Fossey, E. and Harvey, C. (2010) 'Sustaining employment in a social firm: use of the work environment impact scale V2.0 to explore views of employees with psychiatric disabilities', *The British Journal of Occupational Therapy*, 73, 11, 531–9.

World Health Organisation (2013) *What Are Social Determinants of Health?*, http://www.who.int/social_determinants/sdh_definition/en/index.html (accessed 6 August 2013).

https://doi.org/10.1017/S1474746414000104 Published online by Cambridge University Press