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## **Polanyi's 'substantive approach' to the economy in action?**

### **Conceptualising social enterprise as a public health 'intervention'**

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#### **ABSTRACT**

For several decades now, critical public health researchers have highlighted the deleterious effects that pursuing neoliberal policies can have on the 'causes of the causes' of poor health and upon growing health inequalities. This paper argues that the conceptual tools of Karl Polanyi can help lend particular insight into this issue. The specific example that this paper focuses upon is the 'social enterprise': a form of organisation that combines both social and business objectives. The paper explores, conceptually, whether social enterprises may have the potential to act as one component in a neo-Polanyian countermovement: helping to re-embed the economy back into society, and offering greater recognition for a more comprehensive and socially-imbued concept of health. Importantly, this potential is critically examined in the context of neoliberal hegemony, where challenges to the status quo have regularly been met with assimilation, co-option and/or repression.

Keywords: Polanyi, public health, social enterprise, health inequality

## 1. INTRODUCTION

In the age of Industrial Capitalism, the prevailing liberal tenets – namely, self-regulation of markets, commodification of labour, land and money, and primacy of the market over other social institutions – were, according to Karl Polanyi (1944: 135), destructive to “the fabric of society”. The current pursuit of neoliberalism – “commonly understood as a political and economic approach which favours the expansion and intensification of markets, while at the same time minimizing government intervention” (Ayo, 2012: 101) – today carries a similar burden, and has been blamed for a number of social ills, not least widening health inequalities (Collins and McCartney, 2011; Mooney, 2012).

In this conceptual paper we argue that the theoretical perspective employed by Karl Polanyi provides an avenue for engaging with such health-related issues. Specifically, Polanyi’s conceptualisation of *laissez-faire* capitalism – as a system which disembeds<sup>1</sup> ‘the economic’ from ‘the social’ – allows us to dissect how various aspects of our society, including health, are compartmentalised and commodified to our detriment. Researchers such as Maureen Mackintosh (2003, 2006) and Andrew Fischer (2012: 14–15) have gained insight from Polanyi into the commodification of *healthcare* (that is, the *treatment* of poor health). This paper seeks, in a similar fashion, to employ a neo-Polanyian<sup>2</sup> perspective to

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<sup>1</sup> The concept of ‘embeddedness’ has been a central feature of the New Economic Sociology over the last 30 years, particularly since the seminal work by Granovetter (1985). However, the way in which Polanyi employs the term is not, strictly speaking, the same way that it was used by Granovetter and those who followed since him (for a full discussion see Krippner, 2002; Krippner et al., 2004; Krippner and Alvarez, 2007; Machado, 2011). To do justice to the history of the concept of embeddedness, which has undergone something of a ‘Great Transformation’ of its own, as Beckert (2011) aptly puts it, is well beyond the scope of this paper. For clarity, in this paper the terms ‘embed’ and ‘disembed’ are used in the Polanyian sense.

<sup>2</sup> The authors use the term neo-Polanyian to signify Polanyian ideas applied to modern day society (1970s-present).

understand the ‘causes of the causes’ of poor health and health inequalities, and hence, add to our understanding of how they might be *prevented*.

When Polanyi was writing in the middle of the last century, it looked hopeful (at least to him) that *laissez-faire* capitalism would inevitably be displaced by a broad social revolution or ‘countermovement’. In recent decades, however, we have experienced “deepening inequalities of income, health and life chances within and between countries, on a scale not seen since before the second world war” (Hall et al., 2015: 9). Inequalities, alongside insecurity, obesity, and austerity, have recently been described by Schrecker and Bambra (2015) as virulent forms of ‘neoliberal epidemic’, rapidly transmitted across international populations at the rate of biological contagions. It would appear that the large-scale structural change to the global capitalist system needed to prevent the spread of such ‘epidemics’ is unlikely to occur in the near future, not least due to the hegemonic nature of neoliberalism. We have seen that almost every country, from those that have emerged from the Soviet collapse, to those that might traditionally be labelled social democracies with strong welfare states, has embraced, either voluntarily or in response to ‘coercive pressures’ (Harvey, 2007), a version of neoliberalism, adjusting policies accordingly. There are, however, an increasing number of small-scale actors, on the fringes, who may arguably be enacting a Polanyian-like resistance to the economic status quo.

One such alternative actor in this arena is the ‘social enterprise’: namely, an organisation that challenges the neoclassical borders between the third sector and the market by combining social and business objectives or bottom-lines. It is the aim of this paper to critically explore the potential of social enterprise for contributing to the creation of a more socially-embedded economy, which, arguably, could positively affect health at a fundamental level. The current literature portrays social enterprise organisations as having

the potential to directly benefit 'health' through augmenting mainstream state or private healthcare provision, for example through providing services to underserved and/or vulnerable communities. In this paper, alternatively, we will focus on the potential for *all* social enterprises to impact upon health and well-being in an 'upstream' (McKinlay, 1979) systemic fashion, through 'operationalizing' Polanyi's (1944, 1957) substantive approach to the economy.

The aim of this paper, then, is not to focus on case studies of new healthcare-focused social enterprises, but, instead, to conceptually and critically explore the potential for the social enterprise concept itself (and thus all social enterprises) to contribute to a neo-Polanyian countermovement, which may help alleviate social problems, such as ill health and health inequalities, which originate from (or are exacerbated by) neoliberal practices. The current health literature neglects Polanyian interpretations of the social causes of ill health, while focusing primarily on those social enterprises directly involved in healthcare. The majority of the social enterprise literature neglects, or is largely uncritical of, the potential for social enterprises to contribute to a neo-Polanyian countermovement, and has not focused on the specific case of health. This paper, then, offers a new conceptualisation of the social enterprise-health nexus, which can hopefully be applied to future studies in the field.

The paper will begin by exploring the increasing need for a more comprehensive approach to health, and the potential role that a neo-Polanyian perspective may have in understanding these concerns. It will follow this with an exploration of social enterprise as one potential means of addressing poor health and health inequalities, by viewing such facets as symptomatic of a broader neoliberal malaise. The paper will end, though, with an exploration of how many social enterprises, in operation, have been co-opted to a

neoliberal agenda. This creates a difficult environment for any who would attempt to contribute to a neo-Polanyian countermovement that could, potentially, address the health inequalities and other social issues that neoliberalism arguably helps propagate.

## **2. THE NEED TO ACT 'UPSTREAM'**

Since the end of the 1970s, health inequalities – the ‘preventable and unfair’ differences in health status between social groups, populations and individuals (Whitehead et al., 2001) – have been progressively widening in line with income inequality generally. Several high profile independent enquiries into the problem in the UK have gained international attention: from the ground-breaking Black Report (Department of Health and Social Security, 1980; Townsend and Davidson, 1982), to the Acheson Report at the end of the 1990s (Acheson, 1998) and then, more recently, the review chaired by Sir Michael Marmot (2010). At a global level, the final report of the World Health Organisation’s Commission on Social Determinants of Health (2008: 35), which was also chaired by Marmot, recognised that the social distribution of health is not a natural phenomenon, but rather the result of a “toxic combination of poor social policies and programmes, unfair economics, and bad politics”.

What these studies reveal is that health is inseparably connected to the underlying political, social and economic conditions. Consequently, public health interventions that work to address the ‘social determinants of health’ – the conditions in which people are born, grown, live, work and age – are acknowledged globally as an essential dimension in addressing health inequalities. In order to address health, therefore, this literature argues

that we need to address inequities more broadly, through action that takes account of the ‘upstream’ factors that influence social, economic, and environmental circumstances, such as those detailed in Figure 1.

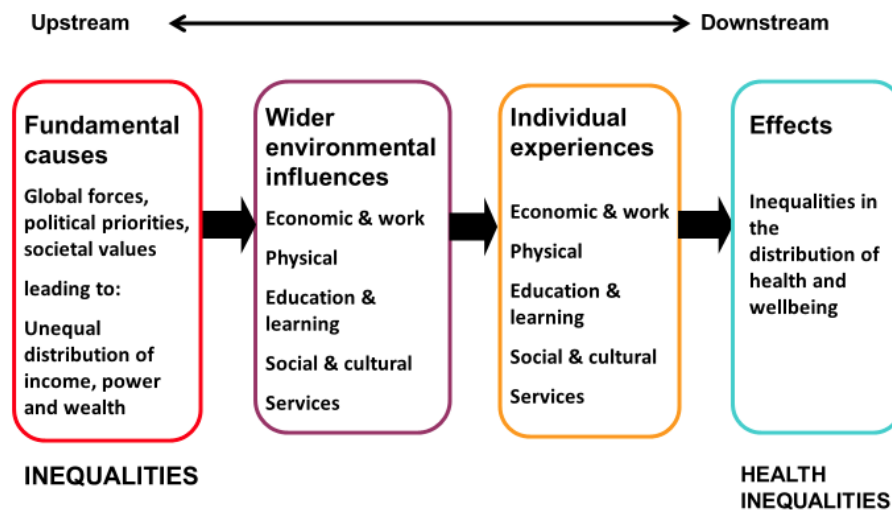


Figure 1: Theory of Causation of Health Inequalities (source: Scottish Government, 2014)

We know that factors such as unemployment, low income and poor education have a detrimental impact upon health (for example, see Bartley, 1994; McLeod et al., 2012; Park et al., 2007; Tseng and Petrie, 2014) and that people with higher socio-economic status may enjoy better health because they have the ability to invest in better nutrition, better housing and so on. But we also know that poor health can also significantly impact earning capacity. Cooper et al. (2015: 37) describe the effects of this as a “downward spiral, whereby declining socio-economic status and deteriorating health negatively reinforce each other”.

While this is significant, we also need to appreciate how low income is merely one facet of poverty, and how poor health is intertwined with disadvantage in various ways. Amartya Sen (1992), for example, calls for a wider acknowledgement of the non-material dimensions of poverty: he considers that a lack of opportunity (or *capability*) for some to

achieve good health, because of social vulnerability, is a particularly serious form of injustice. Richard Wilkinson (1996, 2005) has long argued that social cohesion is crucial to health: the better health outcomes seen in more egalitarian societies are a consequence of stronger community life and avoiding the worst of the 'corrosive effects' of inequality.

Such arguments suggest that policies targeting social and distributive justice are important steps in addressing the upstream causes of health inequalities. Indeed, various actors – including from academia and civil society – have argued that it is imperative that a full understanding of upstream factors requires us to look to the broader global *structures* that mould and direct everyday lives. Although critical of the upstream/downstream metaphor, arguing that it can often serve to obfuscate structural issues, Nancy Krieger (2008: 223) reminds us that our “understanding of the societal distributions of health...cannot be divorced from considerations of political economy and political ecology.” Specifically, some have argued that neoliberalism is intrinsically involved in engendering and propagating global health inequalities and is having “an enormous negative impact” upon the well-being, quality of life and health of populations in both developed and developing countries (Navarro, 2012: ix; see also Schrecker and Bambra, 2015).

Specifically, it is the economic exploitation and social alienation that accompanies neoliberal processes that produce and reproduce health inequalities (Beckfield and Krieger, 2009; Coburn, 2000; Navarro and Shi, 2001). The physician Paul Farmer's (2001: 79) contributions, drawn from his work on the health of people with AIDS in Latin America, talks of the 'structural violence' that “is visited upon all those whose social status denies them access to the fruits of scientific and social progress”. In the public health literature, a number of researchers have looked to Marxist theory to critique neoliberalism's impact



upon health. Doyal and Pennell's (1979: 43) influential treatise, for example, draws attention to power relations in health, such as patients' unequal relationships with doctors, their lack of autonomy and power within the system as a whole, with the consequence that "the provision of medical care is an ideal mechanism for socialisation and social control". Similarly, the on-going work of the Politics of Health Group in the UK (see Bambra et al., 2003) draws attention to how political power, relations and ideology influence people's health.

In the public health literature, then, there has been a growing interest in how broader political-economic structures influence health at a fundamental level. Little-to-no analysis, however, has been undertaken using the conceptual tools of Karl Polanyi - one of the most influential critics of capitalism in the last century - to examine the connection between 'free market' capitalism and the causes of poor health and health inequalities. It is to his work, then, that we will now turn.

### **3. INTRODUCING POLANYI AND 'THE GREAT TRANSFORMATION'**

The principal legacy of Karl Polanyi is 'substantivism', an approach to economics which emphasizes the way in which humans interact with their natural and social environments in order to meet material (economic) wants and needs. His best known work, *The Great Transformation*, published in 1944, explores the rise of industrial capitalism and predicts its inevitable fall, due to its destructive 'disembedding' of the economy from society. The following overview of Polanyi's work will focus on the relevance of his ideas for understanding current global problems. This will, later, enable us to build a case for using a

neo-Polanyian perspective in creating upstream solutions to poor health and health inequalities, both globally and locally.

Polanyi observed that, at least up to the end of feudal times, all economic systems were organised either on the principle of reciprocity, redistribution or exchange, or, most often, on “some combination of the three” (Polanyi, 1944: 57). By conceptualising such an approach to the economy, Polanyi presents economic life as a *totality* of relations and institutions that goes beyond transactions of goods and services. Polanyi’s central argument is based on the premise that the rise of the ‘market economy’ disrupted this balance. Indeed, *The Great Transformation*, is, fundamentally, an analysis of the century-long ‘double movement’ struggle between those who advocated an unregulated *laissez-faire* market and those who sought to protect society from the social upheaval, instability and inequality that, Polanyi argues, a market economy inevitably causes. Cataclysmic events such as the First World War, the Great Depression of the 1930s, and the emergence of fascism in Europe were not, in Polanyi’s mind, wholly disconnected, but could be traced to the “utopian endeavour of economic liberalism to set up a self-regulating market system” (Polanyi, 1944: 31). They were manifestations of an underlying problem – the disruption of social unity by the rise of the market economy.

Production and distribution are entrusted to this self-regulating market system, with ‘self-regulation’ implying that all production is for sale on the market, and that all incomes derive from such sales. This effectively translates into the existence of markets for trading of all elements of society; that is, not only goods and services, but also other essential elements such as labour, land and money, a process that he describes as “fictitious commodification” (Polanyi, 1944: 72). To treat markets as if they are (or can be) somehow ‘disembedded’ – set apart and elevated above socio-political forces – as advocates of

*laissez-faire* insist, is simply to misunderstand how markets work, he argues: markets are part of society and cannot work without the legitimation and structures that states provide, nor the protection that states can offer from various crises and negative social impacts of market systems. When certain goods – public goods – are subjected to market principles, Polanyi argues that social life is threatened and major crises ensue. Polanyi never denied the utility of markets for the allocation of some goods and services. What he condemned was the “quasi-religious certainty expressed by contemporary advocates of market self-regulation” (Block and Somers, 2014: 3).

In Polanyi’s time, those on the side of ‘social protection’ won the day, and so we saw New Deal America, the rise of post-war social democracies, the development of new welfare states, and policies built upon Keynesian demand management. Since then, however, ‘free market’ capitalism has again become dominant, with neoliberal policies forged by Thatcher and Reagan. In contemporary times, there has been no coherent or meaningful structural transformation (Glynos et al., 2012), or ‘double movement’ as a countermeasure to the recent socio-economic crises precipitated by neoliberal capitalism. State leaders are turning more towards neoliberal ideals of smaller government and ‘free market’ liberalisation, dismantling welfare and labour protection policies built up over many decades (Sinfield, 2011), rather than protecting against these trends.

Polanyi can help us to understand the potential for society to mobilize in response to the dehumanizing effects of such ‘market fundamentalism’. It is within this context that the potential of alternatives to the mainstream market economy, “as a new model for restoring community and democratic participation” (Amin et al., 2003: 27), and thus, we argue, to health and well-being, is critically examined.

#### 4. A NEO-POLANYIAN APPROACH TO ADDRESSING HEALTH INEQUALITIES

A neo-Polanyian perspective of the world contends that neoliberal forces are deleterious to the proper functioning of society: by disembedding the economy, neoliberalism disrupts the core social processes essential for a cohesive society. We can extend this rationale to health. Other critical public health researchers, as noted above, have argued that the widening *wealth* inequalities, which seem to be a consequence of pursuing neoliberal policies, have been a primary factor in global *health* inequalities. A neo-Polanyian perspective allows us to imagine solutions to health inequalities and poor health that go to what we have argued is the heart of the problem; that is, addressing health by addressing the destructive disembedding of the economy from society which neoliberalism promotes.

The medical model of health – that health is simply the absence of disease or disability, and the responsibility of individuals is to minimise exposure to ‘risk factors’ – remains by far the dominant discourse (Link and Phelan, 1995; Watt and Sheiham, 2012). This approach focuses on the habits of individuals – on how to stop people from smoking and eating unhealthily, for example – without understanding and dealing with the complex reasons behind health inequalities: for example, the structural social and political reasons why people living in lower socio-economic areas are statistically more likely to live what could be termed ‘unhealthy lifestyles’. Various actors, especially over the last couple of decades, have been increasingly promoting the need to put the ‘social’ dimension back into health: producing a broader, more complex, multi-dimensional understanding of health and recognising that political, economic, social, cultural, environmental, behavioural and biological factors can all favour or harm health. Such a view was presented in the Ottawa

Charter on Health Promotion (WHO, 1986) which also re-emphasised the need for governments to play a key role in tackling upstream determinants including unemployment, poverty and lack of resources.

It could be argued, however, that the five key tenets of neoliberal rationality - of minimal government intervention, market fundamentalism, risk management, individual responsibility, and inevitable inequality as a consequence of choice (Ericson et al., 2000) - have worked to subvert the enactment of key messages in the Ottawa Charter, away from a focus on provision of income, shelter and food, and back on to a track of framing the problem of poor health as the consequence of freely choosing individuals making poor lifestyle choices (Ayo, 2012). That is not to say that agential factors such as lifestyles and behaviours do not matter – in fact, they play a critical role – but more theoretically satisfactory accounts of the inter-relationships between social structure, context and agency and their impact upon health and well-being are required (Williams, 2003).

The ideas contained within the Ottawa Charter, and key documents published since, have significant parallels with the broader Polanyian concept that we need to re-embed the economy back into society. Indeed these are not only two similar ideas, they are integrally related. It is largely *because* of our current economic structures – the capitalist ‘marketisation’ ideology which encourages us to increasingly view society through a material lens – that health has become conceptualised in such a narrow and individualized fashion. Fischer (2012: 14) argues that treating health as a Polanyian fictitious commodity – given it is not ‘produced’ for buying and selling on the market, unlike real commodities - is a “perversity”, similar to the argument that *healthcare* has also become fictitiously commodified (see, for example, Mackintosh, 2003, 2006).

One way to re-embed the 'social' in health, then, is by more broadly promoting the re-embedding of the economy back into a holistic concept of society. If we look to significant 'causes of the causes' of poor health and health inequalities, we can, theoretically, find some answers and solutions by adopting a neo-Polanyian prescription for the 'malaise' in society: that is, addressing health by implementing changes to the 'free market' capitalist processes. The push, by various actors, to put the 'social' back into health could, then, be seen as one component of a neo-Polanyian countermovement. The corollary, then, is that non-health-related activities which contribute to a neo-Polanyian countermovement (but are not necessarily directed at the health system), still have the potential to indirectly positively affect health and reduce health inequalities, as they target the structural 'causes of the causes' of many modern health issues. In this paper, we critically examine a particularly interesting example of a possible contributor to a neo-Polanyian countermovement, one that may have the potential to address health both directly and indirectly: namely, the social enterprise.

## **5. SOCIAL ENTERPRISE AS A NEO-POLANYIAN HEALTH 'INTERVENTION'**

### **5.1 Social enterprise in a neo-Polanyian countermovement?**

Ridley-Duff and Bull (2011: 100) argue that "social enterprises offer either a partial or a complete rejection of established rules of international capitalism"; while Tsai and Kao (2008) enquire as to whether social enterprise can actually be framed as an attempt to contribute to a Polanyian-like countermovement against the contemporary neoliberal hegemony. The argument that social enterprise can be interpreted through a Polanyian lens

is a compelling one. There are strong parallels between the arguments put forward by Polanyi in the mid-1900s and key scholars of the social economy in modern times: most prominently that ‘free market’ capitalism promotes a separation between the economy and society which is unnatural and hence detrimental to society.

In the EMES approach (*EMergence des Entreprises Sociale en Europe*), social enterprise is a *de facto* ‘operationalisation’ of Polanyi’s thinking: “By following Polanyi and his ‘substantive approach’ to the economy, we argue that social enterprises combine the economic principles of market, redistribution and reciprocity and hybridize these three types of economic exchange so that they work together rather than in isolation from each other” (Defourny and Nyssens, 2006: 10–11). Social enterprises within this conceptualisation are located in the ‘intermediate space’ (Defourny et al., 2014; Evers and Laville, 2004) ‘at the crossroads of market, public policies and civil society’ (Nyssens, 2006) .

To assist in this explanation, Polanyi’s three principles of reciprocity, redistribution and exchange are represented in Figure 2 by community, state and market respectively. In this conceptualisation, social enterprises are generally understood to use trading in the market as the means to their end (fulfilment of an explicit social mission to help the community) rather than for the accumulation of wealth for shareholders or investors.<sup>3</sup> The EMES conception also envisions social enterprises as able to adopt a participatory governance model, which extends the process of democracy beyond the political realm into that of the economic. In this way, the traded goods or services are, theoretically, imbued

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<sup>3</sup> That is: while a conventional for-profit business may reinvest its profits into capital assets as a means of extracting higher profits down the line for owners or shareholders, the (EMES conception of) social enterprise would presumably reinvest into capital assets as a means of enhancing their social impact, either immediately (allowing them to employ more disadvantaged people for example) and/or down the line through, for example, achieving greater efficiencies and thus a greater amount of reinvestment into the community/social enterprise in the future.

with a social value that goes beyond the monetary value, effectively altering the process of commercialisation and commodification that accompanies 'normal' business practices.

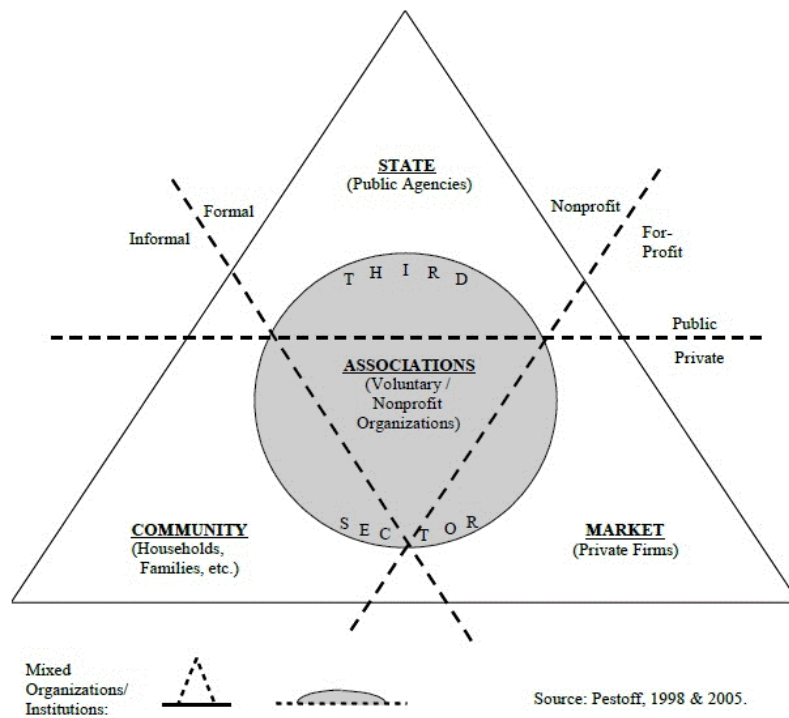


Figure 2: Social Enterprise at the crossroads of community, state and market

The EMES approach to social enterprise is firmly rooted within the traditions of the 'social economy' (Amin, 2009; Laville, 2014; Mendell, 2009). Such types of organisations include co-operatives, mutuels, credit unions, and many companies limited by guarantee, with no share capital. Within the EMES school "there is an implicit assumption" argues Ridley-Duff (2008: 293) "that profits are desirable so long as they can be channelled towards the collective needs of socially excluded groups. This view of social enterprise, therefore, is *redistributive* with strong ideological commitments against individual appropriation of wealth and an emphasis on the 'common good'."



## **5.2 Social enterprise helping to build an alternative road to better health?**

From this perspective, all social enterprises (as defined by EMES), indirectly, have the capacity to help society to conceptualise a different form of economy, one that breaks the conventional capitalist mould of thinking, and helps us to see all processes (including health) through a lens which views the economy and society as a whole. Through their social mission, social enterprises aim to address one or more aspects of social vulnerability. We will consider the likelihood that even those social enterprises that do not work in the health sector or aim to tackle health problems explicitly can nevertheless be contributing to a broader neo-Polanyian countermovement which aims to create a more socially embedded and equitable economy, and thus positively influence the health inequalities that neoliberal capitalism has precipitated.

Social enterprises can potentially work to build social capital, and improve health behaviours (Roy et al., 2014) all of which can contribute to overall health and well-being. A range of impacts can be hypothesised in the model presented in Figure 3, in which it is posited that a chain of causality exists from the trading activity of a social enterprise through to health and well-being of individuals and communities (see also Mason et al., 2015; Muñoz et al., 2015). For example, a social enterprise which supports people distanced from, or disadvantaged from, the mainstream labour market through enhancing their skills and employability, can then lead to increased self-reliance and esteem and reduce stigmatization, particularly of marginalized groups (Ferguson and Islam, 2008). An example of an organisation that operates along such lines is presented in Box 1.

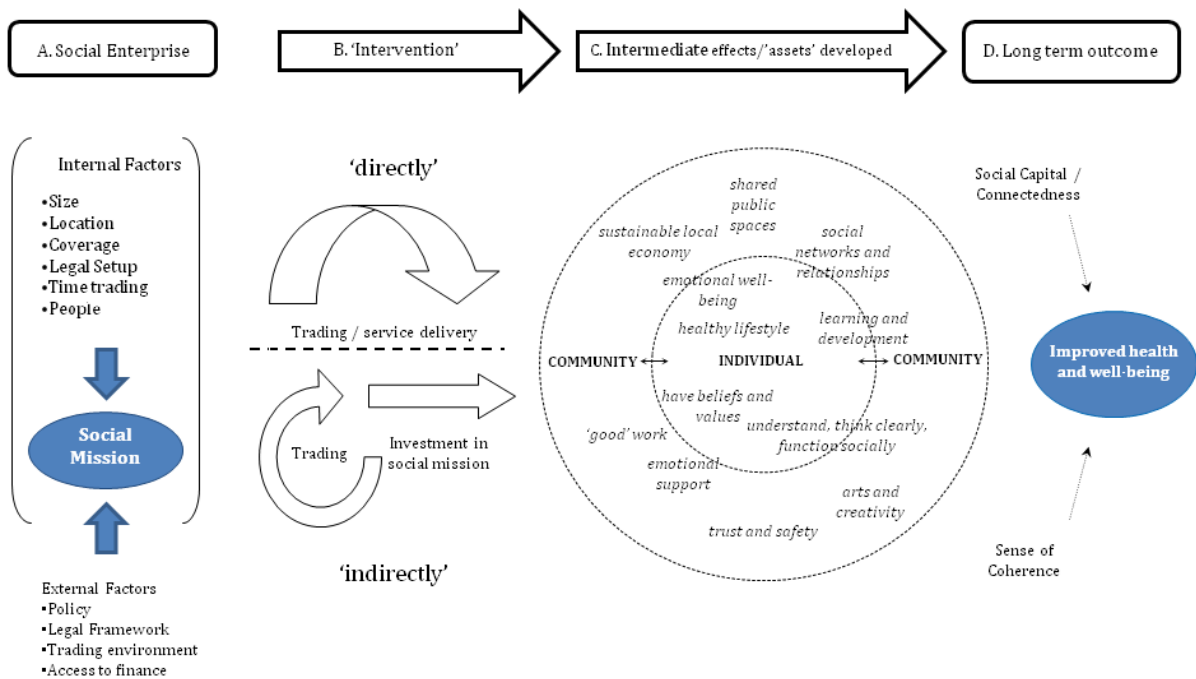


Figure 3: Hypothetical Model of Social Enterprise as a Health and Well-being 'Intervention' (Source: Roy et, 2014)

### Box 1: Theatre Nemo

Theatre Nemo (theatrenemo.org) is based in the centre of Glasgow, Scotland, and aims to improve mental health and well-being through the medium of the creative arts and specialises in supporting vulnerable people who have left, or near to leaving, long-term institutional care. Theatre Nemo was founded in 1998 as a company limited by guarantee with charitable status, and includes ex-offenders and other beneficiary groups in the governance arrangements. The organisation was established out of frustration of a perceived lack of proper mental health services and care for those in prison: the founders' son had committed suicide while on remand.

The Scottish Government presents Scotland as having "the most supportive environment in the world for social enterprise" (see Roy et al., 2015), not least because of a complex array of policy instruments encouraging social enterprise activity. One of their key initiatives is the

‘Enterprise Ready Fund’ and an independent evaluation of the support that Theatre Nemo received from this Fund, commissioned by the Government (Logie, 2015), found that the skills and learning programmes and ‘creative therapy’ provided by the organisation decreases the likelihood of reoffending. Ex-offenders are supported to re-integrate into society, find new forms of responsibility and purpose, and improve their confidence and self-esteem. While Theatre Nemo regularly has to bid for grants and contracts, their case is most often framed around impacting upon recidivism. However such impacts could also reasonably be presented as having clear benefits for public health.

Figure 3 models how the EMES concept of social enterprise may positively affect the upstream causes of social ills such as poor health. Translation of this potential into reality, however, is dependent upon a range of internal and extraneous factors. Furthermore, the EMES definition is not necessarily the most adopted or promoted concept of social enterprise in operation today. As we will now explore, the potential for social enterprise to contribute to a neo-Polanyian countermovement is highly dependent on how the concept is interpreted, and by whom.

### **5.3 Differing conceptualisations of social enterprise**

Despite, or perhaps because of, the significant increase in focus upon social enterprise and the terms ‘social entrepreneur’ and ‘social entrepreneurship’ across the world in recent years, these are (or have become) “fluid and contested” concepts, with meanings that are “politically, culturally, historically and geographically variable” (Teasdale, 2012: 100). Peattie and Morley (2008: 95) describe the social enterprise field as a “definitional minefield”, comprised of a plethora of organisational types that vary “in their size, activities, legal

structure and ownership, geographic scope, funding, motivations, degree of profit orientation, relationship with communities and culture”.

In an attempt to bring about some semblance of conceptual clarity and understanding to what is still a nascent field, Defourny and Nyssens (2010) have identified three broad ‘schools of thought’ of social enterprise: the *earned income* school and the *social innovation* school, both of which originally came from the US (and Anglo-American business schools in particular); and the *EMES approach* from Europe. While this is not the only typography of social enterprise (for example, see Alter, 2004), these categorizations will later help us to identify the underlying political tensions involved and the ability of powerful interests to influence emerging arenas of socio-economic resistance.

In the late 1990s, a definition of social enterprise was put forward by the US-based Social Enterprise Alliance as ‘any earned-income business or strategy undertaken by a non-profit in support of its charitable mission’. This ‘earned income’ school is thus concerned with strategies such as starting or diversifying a business, to earn income in order to support an organisation’s social mission and diversify its funding base (Dart, 2004; Dees et al., 2002). With its focus on the ability of non-profit organisations to become more commercial, this conception of social enterprise has become the model of choice for many western welfare-based governments, such as in the UK and Australia (an important point that we will return to shortly).

The second ‘school of thought’ is termed the ‘social innovation’ school and emphasises the innovative use and combination of resources (Mair et al., 2006; Mair and Martí, 2006) in the Schumpeterian sense of innovation and entrepreneurship, i.e. that of disruptive ‘creative destruction’. The term ‘entrepreneurship’ is thus associated with opportunity identification, innovation and risk (Dey and Steyaert, 2010; Luke and Chu, 2013)

and the introduction of something new to the market. As such, social entrepreneurship involves seizing opportunity for the market-changing innovation of a social purpose. In this school, social entrepreneurs are often presented as 'heroic' agents (Ruebottom, 2013; Spear, 2006) of large-scale sustainable social change. Early pioneers of this movement include Bill Drayton, the founder of the Ashoka movement in the early 1980s, who describes social entrepreneurs as 'change makers' who aim to make "significant and diverse contributions to their communities and societies, adopting business models to offer creative solutions to complex and persistent social problems" (Zahra et al., 2009: 519). Personal profit-making is not considered incompatible with social enterprise's objectives, in this conception of the field, though it is still deemed a secondary objective. It is this model that is most influential upon US foundations such as Ashoka, and universities such as Duke University's Fuqua School of Business (Hackett 2012: 28-29).

In contrast to the EMES conception of social enterprise, the social innovation school in particular affords primacy to the individual entrepreneur - and thus individual agency - to make change, rather than focus on collective action. This is arguably a reflection of the historical roots of this concept, with the EMES tradition drawing from the Italian collectivist movement in Bologna for example (Restakis, 2010). Significantly, though, the result of this focus on individualism in Anglo-American conceptions of social enterprise – among other elements – also reflects the ability of neoliberal norms and actors to influence the trajectory of the field.

#### **5.4 Social enterprise: neo-Polanyian countermovement, or co-opted by neoliberalism?**

Ridley-Duff and Bull (2011: 103) differentiate between two types of social enterprise actors operating throughout the world: (a) those who appear to "accept [free market capitalist]

globalisation and use it to advance social entrepreneurial enterprises”; and (b) those who “seek to subvert the logic of the free market, and change relationships between money, land and people”. Both positions reflect ideological positions on the nature of business and the way that profits can be used and distributed. The difference could be seen as those who see social enterprise as an efficient solution to a temporary market failure within the current capitalist system, and those who describe social enterprise as a permanent solution that will challenge the status quo (Hackett, 2010, 2012). While a categorisation of social enterprise actors, such as this, inherently generalises what is a complex range of motivations, it can nevertheless help us to develop important ‘political economy’-based questions about the potential for social enterprises to act as part of a neo-Polanyian countermovement. Specifically, how have these two agendas been encouraged and promoted, and by whom?

Teasdale (2012: 107), for instance, shows that social enterprise has been presented as one element of a “neo-liberal grand narrative” of social entrepreneurship, where “‘doing good’ (the social) and ‘doing well’ (the economic) are combined under the seemingly unproblematic notion of the ‘double bottom line’” (Dey and Steyaert, 2010: 91). The potential for social enterprise to act as a public health ‘intervention’ must, we argue therefore, be critically examined in the context of neoliberal hegemony, where challenges to the status quo have regularly been met with assimilation, co-option and/or repression. Too firm a market-based focus, as is arguably the case in many business school conceptualisations, runs the risk of social enterprise contributing to the commodification of social processes (Hjorth, 2013) - and thus, potentially, perverse outcomes, particularly at the so-called ‘bottom of the pyramid’ (Prahalad, 2006) - rather than acting as a form of neo-Polanyian countermovement.

The potential for social enterprise to be used by governments to further neoliberal aims has arguably already been enacted somewhat, most notably in countries such as the UK and Australia. Both governments appear to have adopted a conceptualisation of social enterprise that most closely follows the ‘earned income’ school of thought.<sup>4</sup> Various authors have critically examined the choice of these governments to promote social enterprise practices in organisations that provide social goods: effectively, using the concept to further liberalise the third sector and diminish government responsibility for public social services (see Grenier, 2009 in a discussion of the UK; and Hackett, 2012: 37–38 regarding Australia). Furthermore, the UK Government’s promotion of social enterprise in the National Health Service (NHS) has led to some criticisms that the UK government’s goal is the privatisation of the health sector ‘by stealth’ (Butler, 2011; Roy et al., 2013) and a prominent example of this is discussed in Box 2.

#### **Box 2: Circle Healthcare**

Circle Health ([www.circlepartnership.co.uk](http://www.circlepartnership.co.uk)) became the only private company to run a National Health Service (NHS) hospital in the UK when it won a contract to take over the running of Hinchingsbrooke NHS Trust in Cambridgeshire, England, in early 2012. The organisation was founded as a part-employee owned business in 2004 by a former NHS surgeon and a former investment banker and was promoted in the media, variously, as a ‘John Lewis-style mutual’, a ‘third-sector provider’, and a ‘social enterprise majority owned

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<sup>4</sup> Or, more accurately, when promoting social enterprise to third sector actors, the UK government appears to promote the ‘earned income’ school’s focus on the ability of non-profit organisations to generate revenue while serving a social purpose; but the official definition of social enterprise provided by the UK government (2006: 10) – ‘A social enterprise is a *business* with *primarily* social objectives whose surpluses are *principally* reinvested for that purpose in the business or in the community, rather than being driven by the need to maximize profit for shareholders and owners’ [italics added] – provides space for profit-oriented pseudo-‘social enterprises’ to enter the field. See Box 2 for an example of this.

by employees' (McKee, 2011; The Guardian, 2011).

It is useful to consider the political context in which such rhetoric was employed. The (then) UK Health Minister had said that he wanted to “liberate” the NHS and create “the largest social enterprise sector in the world by increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises” (Department of Health, 2010: 5). However, awarding the contract to Circle Health, which was majority-owned by a private hedge fund, to take over a significant part of NHS operations for private profit, led to claims that the UK Government was deliberately stretching the concept of social enterprise, essentially for use as a ‘smokescreen’ to disguise the highly controversial step of privatising of part of the NHS (Roy et al., 2013).

In September 2014 the UK’s Care Quality Commission inspected Hinchingsbrooke Hospital and found poor hygiene standards, patients being neglected and staffing problems (Campbell, 2014). It was then reported in January 2015 that the organisation was in talks with the Government to end the contract to run the hospital early, citing funding cuts and increased demand for Accident and Emergency services as making the contract unprofitable (Watt et al., 2015).

It appears, then, that these concepts of social enterprise are, ironically, readily adaptable to the purposes of pro-neoliberal institutions. While much of the original literature from social entrepreneurs themselves concerning the role of social enterprise, called for changes to the capitalism system in order to create a more a socially-responsible, socially-conscious and socially-sustainable economy (see, for example, Yunus 2007), current government leanings and underlying neoliberal norms (for example, concerning a focus on



the individual, innovation and self-help) have arguably shaped the field's current direction in countries such as the UK, USA and Australia. The pressures of global economic competition have also, in many cases, compromised the ability of EMES-like cooperative social enterprise ventures to benefit their members beyond "bare subsistence in the informal sector or facilitating a precarious integration into the global economy at the bottom end of long corporate-dominated commodity chains in a few sectors" (Reed and Reed, 2009: 243). However, it would be premature to dismiss or disregard all attempts at social enterprise as simply extending or even 'embodying', the neoliberal project. Gibson-Graham (2008: 618) argue that experimental forays into building new economies, such as upon social enterprise, are often dismissed as capitalism in another guise, already co-opted and/or judged to be inadequate, before they are explored "in all their complexity and incoherence". Even for social enterprises that do attempt to challenge the status quo, pressure from above often requires covert means or pragmatic measures (Dey and Teasdale, 2015; Hackett, 2012) that may at first glance appear to compromise rather than help establish a neo-Polanyian-like countermovement.

Social enterprise has the potential to support the re-embedding process; it can challenge the dominant business discourse and provide tangible, incremental contributions to addressing the upstream causes of poor health and health inequalities. Social enterprise could even be presented as a means of supporting action guided by the principle of 'proportionate universalism' which Marmot (2015) insists is required to address such issues. However, social enterprise practitioners need to become more aware of their own national political context. For many in the field, politics is the 'elephant in the room' (Curtis, 2015), meaning the potential for co-option is high. The sector also needs, we argue, to become more self-reflective in defining itself, articulating value, and establishing research alliances.

Importantly, while some conceptions of social enterprise, such as EMES, may arguably be more suitable for a Polanyian-like challenge to the status quo, all definitions are susceptible to co-option, and it is essential for researchers to uncover the various ways that neoliberalism attempts to steer the direction of social enterprise, in discourse and practice.

## **6. CONCLUSION**

Tackling health inequalities is a complex problem, and any solution will likely involve working at various waypoints within the public health 'stream'. We know that social and economic policies impact upon the quality of life and living conditions in homes and communities. We also know that economic resources available to the household can affect health (Williams et al., 2008). Social enterprises often work at the local level to try and ameliorate or mitigate against the immediate social problems with which people – often the most vulnerable in society – face in their day to day lives.

In order to fulfil their potential in this regard, social enterprise, we have argued, must also aim to impact upon more upstream 'fundamental causes' of problems. A dynamic and engaged social enterprise sector may enhance the relevance and acceptability of actions aimed at addressing the social determinants of health, and work as key agents in the development and maintenance of community assets and in the encouragement of self-help in ways that provide promise for further enhancing well-being. While, perhaps, social enterprises have little chance of impacting upon global-scale events and powerful elites, Mendell (2007: 81) recognises that "even if their larger impact remains incremental, they are contributing to a process of institutional reconfiguration". In order for social enterprises to do so in a way which challenges the neoliberal status quo, perhaps as part of a broader neo-Polanyian countermovement, however, requires more awareness in the field of the potential for co-option.

Further work in this area, and indeed operationalizing Polanyi's ideas more generally, will likely involve adopting a research approach which resonates with Polanyi's realist (Block and Somers, 2014; Rotstein, 1990) view of the world – which Mendell (2007) describes as 'conceptualizing lived realities' – through developing empirically informed conceptual frameworks. Such an approach may help us to better understand the processes at work within social enterprises and – perhaps more crucially – within the communities they serve.

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