Title: Community business impacts on health and wellbeing: a systematic review of the evidence

Abstract

Purpose - This paper provides critical insight into the impact of locally embedded, community business-related approaches internationally to health and social care on users' outcomes, in particular exploring their effectiveness in delivering outcomes for users.

Methodology - The study used a robust systematic review methodology. It carefully identifies relevant studies that have been conducted on the impact of community business-related approaches, rigorously evaluates how well these studies have been carried out and combines the results from these studies to address that particular topic.

Findings - Health and social care related community businesses deliver on a range of health and wellbeing outcomes and impacts positively on local residents' satisfaction with their community/local area. Existing research into community businesses uses mostly qualitative methods, but a few studies have also used quantitative survey and mixed methods and demonstrate the challenges of conducting methodologically rigorous real-world research within local community settings.

Research limitations – The review was limited to papers published in English language and may have missed relevant studies published in other languages which could have influenced the overall findings. Only one reviewer screened the titles and abstracts of the identified papers. Having multiple reviewers would have strengthened the validity of the screening process.

Value - Community businesses offer a positive contribution to health and wellbeing, and highlight the significance of engaging local communities in promoting health, reducing health inequalities and addressing the wider determinants of health. This paper provides a baseline of evidence about community business' broad impacts on health and wellbeing to help inform new and emerging evidence.

Keywords systematic review; community business; social enterprise; health and wellbeing

1. Introduction

This paper provides a systematic review and critical analysis of the impact of community business approaches to health and social care, and in particular highlights their effectiveness in delivering outcomes for users. Community businesses, viewed as a spatially defined sub-set of social enterprise more generally (Kleinhans, Bailey and Lindbergh, 2019), is one of a number of terms used to specify social enterprise organisations that are located in a particular geographical location and community, that '…are accountable to their community and that the profits they generate deliver positive local impact.' (Power to Change, 2018). This paper contributes a timely perspective to an emerging body of knowledge about the evidence and significance of impact of local, geographically-defined social enterprises on health and wellbeing outcomes (Heins *et al.*, 2010; Roy *et al.*, 2014; Calo *et al.*, 2018; Suchowerska *et al*., 2019). Here, health and wellbeing outcomes were broadly defined to help encapsulate wider social determinants of health: including areas such as social engagement and participation, employment, community and resilience, quality of life and carer outcomes.

Recent research has provided key insights into the impact of social enterprise activities more generally on health and wellbeing, but our aim was to highlight the need to understand the importance of local settings and context, the ways in which community businesses are accountable and responsive to local

needs, how they encourage social participation and social connectedness, and work to empower local people (Roy 2017). Emphasising an assets-based approach to public health, locally-based social enterprise (defined here as 'community businesses') build on the strengths of individuals and communities and the localised resources they have at their disposal. As neighbourhood 'settings' for promoting health and wellbeing (Newman *et al.*, 2015), drawing upon assets and resources within the local community, they are a 'meaningful location' (Cresswell, 2004; Farmer *et al*., 2016; Kleinhans, Bailey and Lindbergh, 2019), and well positioned to address local social determinants of health and wellbeing (Milton *et al.*, 2012; Newman *et al*., 2015; South *et al.*, 2019).

Research into community businesses is growing (Farmer *et al*., 2016; de Beer, 2018), as are the attempts to provide clear definitions and nomenclature alongside robust investigative methodologies. Community businesses have been defined as, '…a trading organisation which is set up, owned and controlled by the local community and which aims to create ultimately self-supporting jobs for local people and to be a focus for local development. Any profits made from its business activities go either to create more employment or provide local services or to assist other schemes of community benefit' (Buchanan, 1984). In Scotland, local community redistribution of profits is seen as the norm for social enterprises (Murray, 2018), unlike in England where there are looser definitions (ibid) and more variation in both the understanding and delivery of the 'enterprise' model that underpins these entrepreneurial activities. In addition, community businesses differ in their governance structures (and by implication, their accountability – see Kleinhans, Bailey and Lindbergh, 2019) and pursue a variety of social purposes and aims, so challenges remain in bringing together evidence about their role in addressing complex health and social care needs.

In the UK there is also no consistent and legal definition of social enterprise, other than that provided by the Department of Trade and Industry (DTI) (2002), and in the academic literature. A key component of the DTI definition is that, unlike other voluntary organisations, social enterprises try to generate income from their trade which is then reinvested in the enterprising activities of the organisation; combined social and economic goals thus drive their activities (Blake, 2019; Finlayson and Roy, 2019) and is a characteristic of their 'hybridity' (drawing on diverse sources of income from private, public and non-profit sectors to achieve those goals) (Doherty *et al*., 2014; Kleinhans, Bailey and Lindbergh, 2019). Conceptualisation and operationalisation of both community business and social enterprise is thus problematic (Macaulay *et al*., 2018: 211), contested both in academia (Teasdale, 2011) and most likely in policy and practice.

1.1 Health and Social Care Related Community Business

There has been a steady growth in community-based and community-led social enterprises in the UK, and further afield (Diamond *et al*., 2017, Macaulay *et al*., 2018; Kleinhans, Bailey and Lindbergh, 2019), which form part of a wider third sector (or 'Third System', see Kay *et al*., 2016), alongside other voluntary, community and statutory sector activity (Hunter, 2009). Community-based social enterprises have a presence in other countries, such as the US, Australia, Canada, and across the EU, although their specific histories, conceptual definitions, policy landscapes, and local character may vary considerably. In the US, for example, the community-led sector is often referred to as 'not-for-profit' and exists to help foster market-based approaches to tackling social issues (Kerlin, 2006, cited in Teasdale, 2011). Thus, social enterprises are 'shaped by distinct historical, cultural and political processes' (Roy *et al*., 2015). Indeed, it is remarked that even in the UK it is almost impossible to offer a coherent overview of social enterprise and/or the Third sector due to the existence and continuation

of ‘policy divergences’ between England and Wales, Scotland and Northern Ireland, much of which is owed to the historical conditions that led to the formation of a Third sector and socially-derived and value-driven enterprise (Roy *et al*., 2015). What we can say is that, located within wider civil society, these community-based organisations engage in the market to address factors in local communities that may benefit or harm health and wellbeing (Roy *et al*., 2017). In the UK specifically there has been considerable investment (e.g. the Centre for Ageing Better charity) to support the growth of these organisations, as recent UK governments look to a range of options in addressing the complexities of the social determinants of health (Marmot and Wilkinson, 2006) and grand challenges like healthy ageing and obesity.

The reasons for the emergence and proliferation of community businesses, and social enterprises more generally in the health and social care sphere, vary between countries, but there are four notable shared themes: first, the nature of today’s grand public health challenges, the increase in chronic illness and long-term conditions – accounting for 70 per cent of the NHS budget (NHS England, 2014: 6) – and the consequences of an ageing society for health and wellbeing, as well as wider social consequences impacting on older people such as social isolation and loneliness (Wenger *et al*., 2017). Secondly, the decline in state-led services as well as a reform of the way services are delivered (Kay *et al*., 2016) along with changes to real terms growth in health funding (Kings Fund, 2018), due to the rise of austerity in government spending (Kleinhans, Bailey and Lindbergh, 2019), and the health costs associated with an ageing population. Third, the rise in consumer society, where individuals and communities are increasingly finding personalised solutions to a range of challenges (Fisher *et al*., 2011). And lastly, the rise in preventive health measures and innovative public health interventions (Hanlon *et al.*, 2011) to address these challenges, i.e. focus on wider social determinants and factors outside of individual control (Marmot and Wilkinson, 2006).

Communities coming together in a positive way and with shared vision to set up a business in order to address particular challenges in their community, through a sustainable model, is in essence a community business. As social enterprises, they explicitly promote a social purpose alongside financial sustainability (Jones, 2011; Mauksch *et al*., 2017), and principles of enterprise and entrepreneurship (Johnstone and Lionais, 2004; Addicott, 2011; Hayman, 2011). However, community businesses aim to create community benefits in their trade with and accountability to a defined local community (profits from the business are reinvested in a geographically-defined local area), and their broad community impact. With current funding and quality of care challenges in the health and social care system in England, and the contraction of local government services, it is likely that the community business sector will continue to grow (Diamond *et al*., 2017), as communities seek to address the deficit in statutory services positively and creatively. Current policy measures also encourage enterprising and entrepreneurial individuals to establish organisations that are owned by the community and service users (Cabinet Office, 2018).

1.2 Evidence on the impact of social/community enterprise on health and wellbeing

As social enterprises, the majority of community business are focused on delivering improved health and wellbeing – 25 per cent specifically identify health and wellbeing as the main social impact they aim to achieve, alongside reducing isolation or increasing employability (Diamond *et al*., 2017). Community businesses generate economic benefit alongside individual and community wellbeing (Hull *et al*., 2016). As well as directly providing health, social care and wellbeing services, they may also address the wider social determinants of health. This may include different aspects of health and

wellbeing: for example, physical and mental health, the social determinants that influence health and wellbeing (e.g. education, skills, and training), as well as social and employability skills, confidence and development of connectedness and social networks that may help individuals and communities to thrive. Therefore, community businesses may focus on:

- employment as an issue, e.g. in the example of men's sheds as a model (see Wilson and Cordier, 2013),
- developing social networks and relationships, through increasing community connectedness and the 'village' model (see Scharlach *et al*., 2011), or
- thinking about the social, economic, environmental aspects of the local community (Muñoz *et al*., 2015).

In recent years, a number of literature reviews have been published to capture the range of evidence surrounding the impact of social enterprise activities on health and wellbeing (Heins *et al.*, 2010; Roy *et al*., 2014; Calo *et al.*, 2018; Suchowerska *et al*., 2019). Each review has provided a different perspective on first, the extent to which social enterprises impact on health and wellbeing outcomes and the mechanisms and pathways through which social enterprises might improve outcomes (Roy *et al*., 2014), secondly, the organisational features of social enterprises that provide the vehicle for such impact (Suchowerska *et al.*, 2019), and thirdly, the added value of social enterprises and other third sector organisations for improving outcomes versus usual care (Calo *et al*., 2018) and/or delivery providers (Heins *et al.*, 2010).

Across the studies, a range of findings related to health and wellbeing outcomes were highlighted, for example physical health (Roy *et al*., 2014; Calo *et al.*, 2018), mental health (Roy *et al*., 2014; Calo *et al.*, 2018; Suchowerska *et al.*, 2019) and social determinants of health (e.g., building social capital and improving employability) (Heins *et al.*, 2010; Roy *et al*., 2014; Calo *et al.*, 2018; Suchowerska *et al.*, 2019). These published reviews of the empirical evidence provide valuable insights into the benefits and limitations overall of social enterprise for health, wellbeing and social care. However, this paper focuses on reviewing the evidence for social enterprises that are specifically embedded in local, geographically-defined communities, and as such highlights both the importance of local settings and context, alongside an assets-based approach to public health, where communities themselves act as a key resource for addressing the social determinants of health reducing health inequalities (Morgan and Ziglio, 2007; Roy *et al.*, 2014).

For example, Suchowerska *et al*. (2019) refer to the study carried out by Macaulay *et al*. (2018), who talk about how community-led social enterprises that are cooperatives can improve health equities by placing community members in decision making roles, thereby improving 'collective efficacy'. As a result, this enables target beneficiaries to experience a sense of ownership and control, with wider implications for health and wellbeing, and which community businesses can help enhance. Moreover, Calo *et al.* (2018) suggest that a collaborative setting can enhance health outcomes, and it can be argued that locally-based social enterprises are more likely to collaborate closely with their local community beneficiaries, leading to greater connectedness within the community (Calo *et al.* 2018). Hence, it is important to draw out conclusions by conducting a systematic review of locally-based social enterprise on health and wellbeing. The wider purpose of our study and this paper in particular, is to provide a baseline of evidence about community business' broad impacts on health and wellbeing to help inform new and emerging evidence.

2. Methods

We endeavoured to answer a broad review question: What are the effects of community businesses on the health and wellbeing of their users – that is, stakeholder beneficiaries? We systematically identified and screened relevant papers; synthesised the findings from eligible studies; and critically assessed the methodological rigour of the finally included studies. Where we could, we followed optimal processes established by the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) framework (Liberati *et al*., 2009). Thus, due to the heterogenous nature of the topic, we analysed the extracted data from our included studies using a narrative synthesis approach rather than a meta-analysis. We also assessed the methodological rigour of our included studies rather than their risk of bias as we included studies with methodologies beyond quantitative techniques.

2.1 Eligibility criteria

Our eligibility criteria followed the Participant, Exposure, Outcome and Study design (PEOS) framework (Munn *et al.,* 2018).

Types of participants: Users of community business of any demographic (e.g. age, gender, ethnicity, occupation) or health (e.g. healthy, disabled, affected by mental illness) background.

Types of exposure: We were interested in community businesses and we defined community businesses as those businesses accountable to their local community with the local people having an influence in the running of the business; linked to a particular neighbourhood or place; whose profits are used to deliver positive social value in their community (however that community is defined); and trading in goods or services to become financially sustainable (Swersky and Plunkett, 2015, Hull *et al*., 2016). This means that we included studies that focused on businesses not necessarily labelled with the term, 'community business' (e.g. social enterprise); but described the nature of those enterprises or businesses in line with our conceptualisation of community business.

Types of outcomes: We focused on health and wellbeing outcomes that were broadly defined to include areas such as social engagement, employment, community and resilience, quality of life and carer outcomes. The nature of community businesses, as we have operationalised them in our review, lend themselves to directly impacting more on the wider social determinants of health and wellbeing. By health and wellbeing, we are referring to resources for everyday life rather the absence of illness and diseases. We were also interested in the social value of community businesses for stakeholder beneficiaries and not the economic benefits of these businesses. Hence, we excluded papers which had biomedically-defined disease-specific outcomes or focused on cost-specific outcomes and/or savings.

Types of studies: We excluded systematic reviews and other forms of evidence synthesis and included studies utilising any other methodology. Systematic reviews only provide an aggregated synthesis of the findings of various individual studies; however, we were interested in relevant detailed information from individual studies. Nevertheless, we looked through the references of similar systematic reviews to identify any relevant papers for our review. We included only papers written in English language. We limited the publication date from January 2008 to 2018 in all our information sources and carried out our last search in July 2018.

2.2 Information sources

We identified studies by searching electronic academic databases, grey literature sources and reference lists of included studies. We also consulted relevant organisations with an interest in

community businesses for eligible papers (e.g. Power to Change[1]). We applied our search to MEDLINE (Medical Literature Analysis and Retrieval System Online), AMED (Allied and Complementary Medicine); Social Policy and Practice; Web of Science; ASSIA (Applied Social Sciences Index & Abstracts); Power to Change website; The King's Funds, Economics Foundation, New Philanthropy Capital, Joseph Rowntree Foundation, Department of Health, Social Accounting and Audit (SAA) and Social Value UK.

2.3 Search

Table 1 shows the combined search terms we used in our electronic databases.

Table 1 Search terms used in the electronic databases

For some of the grey literature sources (e.g. The King's Fund and The New Economics Foundation), we used the search terms 'community business' and 'social enterprises' separately. We used both 'community business' and 'social enterprise' as search terms because we suspected that there could be papers that may have used the term, 'social enterprise', to describe community businesses. Upon scrutiny of such papers, this was indeed the case.

We went through the list of available publications for others by hand (e.g. Joseph Rowntree Foundation).

We also went through the reference list of studies that met our inclusion criteria to ensure we did not miss any relevant literature. Full details of our search strategy are provided in the supplementary material.

2.4 Selection of studies

We selected papers to be included in our review through the process illustrated in Figure 1 – identification, screening, eligibility and inclusion. We exported the bibliography of papers identified using our search strategy to a reference manager software, where we removed exact duplicates. One reviewer (SUI) screened the titles and abstracts for relevant studies. All three reviewers (SUI, SM and EB) then independently assessed fifteen percent of the full text of the remaining studies against the eligibility criteria. Discrepancies were resolved following discussion before applying the agreed eligibility criteria to the remaining papers.

2.5 Data extraction and quality assessment

We concurrently extracted data and assessed the methodological quality of the final studies. We developed a bespoke data extraction form which we used to extract relevant information. The three reviewers independently pilot-tested the form on fifteen per cent of the included studies. All recommended changes were made before applying the form to the rest of the studies. We extracted information on: properties of the community business; context; country; mechanisms underpinning the function of the community business; study design; population of the study; types of outcomes and findings.

We used two types of established tools to assess the quality of studies in the review, based on the type of literature – academic or grey. We used the Critical Appraisal Skills Programmes tools (CASP, 2016) to appraise academic literature. These assess quality according to several components including study design, representativeness of participants, control of confounding factors, and reliability and

[1] Power to Change is an English charity set-up in 2015 to support community businesses through an endowment fund provided by the Big Lottery, and they commission small-scale studies into their impact locally (Power to Change, 2020).

validity of data collection methods. While there is a CASP tool for qualitative studies, there is not one for assessing cross-sectional studies or surveys; so, we adapted the CASP tool designed for cohort studies to use with these instead.

We rated the rigour of individual studies as 'strong', 'moderate' or 'weak'. A study was rated as strong if it was scored as adequate for all the criteria on the checklist used. This meant that it had no significant methodological and reporting flaws. A moderate study was one that was scored adequate on 50-90% of the quality assessment checklist; depicting some default in methodology and reporting. A weaker study was one with adequate scores for less than 50% of the items on the checklist and this showed that the study had significant limitations in its methodology and reporting. Thus, for qualitative studies where the highest possible quality score was 10: 0–5 was classified as weak, 6–9 as moderate and 10 as strong. For cross-sectional studies where the highest possible score was 9: 0–4 was weak, 5–8 moderate and 9 strong.

We used the Methodological Quality Checklist for Stakeholder Documents and Position Papers (MQC-SP) to assess the quality of the grey literature (JBI, 2018). This tool examines the quality of peer-reviewed position papers against six quality criteria - major stakeholder involved; well-defined aim; robust methodology; quality evaluation of analysed material; appropriate synthesis of analysed material; more than one stakeholder or co-authors involved. The total scores range from 0 to 6, categorising ratings into weak (0–3), moderate (4–5) and strong (6).

The three reviewers independently tested the appropriateness of the tools on three randomly sampled papers and produced unanimous results on their assessments.

2.6 Data synthesis

Our synthesis followed a narrative approach (Popay *et al.,* 2006). We undertook a descriptive and explanatory analysis of the extracted information to examine participant characteristics, features of community business, health and wellbeing effects of community businesses and methodological quality ratings of studies.

3. Findings

3.1 Study selection

Figure 1 illustrates the findings of the study selection process. Seventeen studies were finally included in the review. The search generated 8,092 records of which 450 were exact duplicates. Screening the titles and abstracts excluded 7,546 records, leaving 96 records that were examined in detail for eligibility. Of the potential eligible records, 79 did not meet the inclusion criteria and were discarded as a result.

Figure 1 Flow of information through the search process

3.2 Study characteristics

Table 2 summaries the characteristics and findings of the 17 papers included in the review for synthesis. Five individual studies examined more than one community business (Boswell *et al*., 2009; Macaulay *et al*., 2018; Teasdale, 2010; Vazquez Maguirre *et al*., 2018; Willis *et al*., 2017).

Table 1 Characteristics of included studies

Most (n=7) of the included studies were conducted in the United Kingdom; six in Australia; three in the United States of America; and, one explored community businesses in Peru and Mexico. More than half of the studies (n= 10) investigated community businesses that operated within a rural context. Few studies (n= 2) were focused on urban areas and for five of the studies, the context within which the community businesses operated was not reported.

The papers included in the review used a range of stakeholders as participants for their study. These participants were leaders of the community businesses; employees involved in the operation of the community business; managers of the community business; volunteers; public sector officials; community business customers and service users; local residents; staff of other organisations; and, other community and national stakeholders.

Ten studies used only qualitative research techniques such as interviews, focus group discussions, health impact assessment, mental mapping, geographical tracking, observations, document analyses, literature reviews and photography to examine the impact of community businesses on health and wellbeing outcomes. Six studies employed quantitative surveys and only one study used a mix of both qualitative (interviews and focus group discussions) and quantitative (survey) methods. We considered the methodological rigour of none of the studies as strong - five were judged weak (Boswell *et al*., 2009; Bertotti *et al*., 2011; Teasdale, 2010; Graham *et al*., 2016; Waling and Fildes, 2017) and the remaining twelve studies were assessed to be of moderate quality.

Three of the papers included in the review were grey literature (Boswell, 2009; Willis, 2017; and Pank, 2011); and the most common areas where studies were scored weak were the involvement of stakeholders in the evaluation process and the quality evaluation of the methods. Fourteen of the studies were peer-reviewed journal articles that employed a range of methodologies: cross-sectional (n= 4), qualitative (n= 9) and mixed methods (n= 1). The most common domains that had the lowest score among the four cross-sectional studies (Ang *et al.,* 2015; Graham *et al.,* 2014, Graham *et al.,* 2016 and Graham *et al.,* 2017) were the ability to generalise the results to the local population and the implications of the results for policy and practice. Eight out of the nine qualitative studies (Ballinger *et al.,* 2009; Bertotti *et al.,* 2011; Crabtree *et al.,* 2017; Farmer *et al.,* 2016; Macaulay *et al.,* 2018; Muñoz *et al.,* 2015; Teasdale, 2010 and Vazquez Maguirre *et al.,* 2018) failed to adequately consider the relationship between the researcher and the participants. The only qualitative study that addressed this domain adequately was Culph *et al.* (2015); however, we assessed the research design for this particular study not to be appropriate in addressing the aims of the research. Waling and Fildes (2017) was the only study that employed a mixed methods design – both cross-sectional and qualitative methodologies. The cross-sectional component of this study was only scored adequate on its focus on the issue and the accurateness of the measurement of the exposure variable (community business). Its qualitative component was weakest on the appropriateness of the research design to address the aims of the research; the appropriateness of the recruitment strategy; the adequacy of the data collection process to address the research issue; the consideration of the relationship between the researcher and the participants; and the sufficiency in rigour of the data analyses.

It is important to consider the findings of the studies within the context of the relative quality of the studies. This is discussed in the conclusion section.

3.3 Features of community businesses

We drew out various features of community businesses from the findings of the included studies in relation to structure, users and functions. These details have been summarised in Table 2.

We were able to categorise community businesses into four main groups. These categorisations are arbitrary and not based on any sound theoretical or empirical benchmark. We grouped community businesses by those that: were mainly social enterprise oriented (Bertotti *et al*., 2011; Farmer *et al.,* 2016; Macaulay *et al.,* 2016; Muñoz *et al.,* 2015; Teasdale, 2010; Vazquez Maguirre *et al.,* 2018); focused on men's shed (Ang *et al.,* 2015; Ballinger *et al.,* 2009; Crabtree *et al*., 2017; Culph *et al.,* 2015; Waling and Fildes, 2017); followed a 'village' model (Graham *et al*., 2014; Graham *et al*., 2016; Graham *et al*., 2017), where businesses organise access to services for older people to enable them to live independently within the community; and, those that did not clearly fit in any of our categories (Boswell *et al.,* 2009; Pank, 2011; Willis *et al.,* 2017).

The governance and operating models for community businesses varied, whether or not they traded: with examples of companies limited by guarantee, charities and community interest companies, amongst others. Some businesses relied on their local community's unique social milieu to operate (Graham *et al*., 2014; Graham *et al*., 2016; Graham *et al*., 2017); make collective decisions involving all members (Teasdale, 2010) or run as part of other services (e.g. community health service) (Ballinger *et al*., 2009). One of the community businesses in Macaulay *et al*. (2018) assumed a Work-Integration Social Enterprise (WISE) model, a model based on increasing the career prospects of users; and a few others operated as cooperatives (Boswell *et al*., 2009; Macaulay *et al*., 2018; Vazquez Maguirre *et al*., 2018). One community business (Farmer *et al*., 2016) was supported by community grants but had a mission to become financially sustainable.

A range of stakeholder beneficiaries were involved in the activities of the community businesses. These included men who were retired, made redundant at work, unemployed or on a disability pension, local residents, trainees, volunteers, employees, apprentices, families of community business users, community business clients (children, students and community groups, local business suppliers), health and social care professionals, refugees and asylum seekers.

The functions of community businesses were broad and variable, but specific to targeted cohorts. Studies described community businesses as spaces to engage users in practical activities such as woodwork, recycling, soap manufacturing, arts, leisure and recreation. Some community businesses employed local residents or people with physical and mental health conditions in retail, agriculture, mining or conservation.

Community businesses offered training for people with learning disabilities and provided volunteering opportunities to local people in outdoor community spaces through activities such as gardening and farming. Several community businesses focused on helping older people to live independently in their community by providing services such as transport, housing, leisure and health. Some community businesses provided affordable housing, children's outdoor activities and a community hub. Others focused on representing and exhibiting the traditions of people from minority ethnic groups, such as asylum seekers and Pakistani communities.

3.4 Effectiveness of community businesses in delivering health and wellbeing outcomes for users

We categorised the health and wellbeing outcomes examined in the studies into five main domains as they emerged from the findings of the included studies in the review: social connectedness (e.g. social capital, security, integration, social bonding, social contact, social interaction), self-esteem (e.g. self-efficacy, capability, achievement, confidence, motivation), physical health (e.g. fitness, activities of daily living, physical activity), mental wellbeing (e.g. depression, anxiety, psychological wellbeing, happiness) and quality of life (e.g. sense of purpose, meaning in life, ageing in place, satisfaction with

local area). These outcome categories are, however, not mutually exclusive of each other and neither did we seek to explore the links between the various outcomes.

Table 1 presents details of the findings of individual studies on the health and wellbeing impact of community business related approaches for users.

Community businesses foster social connectedness

A key health and wellbeing outcome of community businesses is increasing social connectedness. Findings from majority of the included studies (n = 11) showed that community businesses developed and bolstered social connectedness among their users, as they serve as a socialising space where people meet and build social networks, which engenders community cohesion (see Ballinger *et al*., 2009; Teasdale, 2010; Bertotti *et al*., 2011; Pank, 2011; Graham *et al*., 2014; Muñoz *et al*., 2015; Graham *et al*., 2016; Crabtree *et al*., 2017; Graham *et al*., 2017; Waling and Fildes, 2017; Willis *et al*., 2017). In Graham *et al*. (2017) for example, more than half (56%) of 'village' members felt their involvement in community business activities had increased their sense of connection to others.

In Muñoz *et al*. (2015), community businesses provided an avenue for intergenerational integration, bringing about feelings of inclusion and sense of belonging. People made new social contacts through community businesses and felt less lonely after participating in activities (Waling and Fildes, 2017). By using community businesses, individuals who previously felt marginalised were able to relate better with others with whom they shared similar health or socioeconomic conditions (Muñoz *et al*., 2015).

The effect of the use of community businesses on social connectedness was influenced by a number of factors. Social impact was influenced by frequency of volunteering, engagement in social activities and more use of companionship services. Social engagement was higher among those: younger members (75 years and under); with low educational attainment; who used community business over a longer period of time; who volunteered more frequently; reporting at least good health; and with no functional disabilities (Graham *et al*., 2014; Graham *et al*., 2017).

The positive impact of community businesses in generating social cohesion seems to be predicted more by direct use of the community businesses, rather than spatial proximity to potential users. Willis *et al*. (2017) found in one (out of six) of the community businesses they studied that residents who lived close to the premises of the established community business expressed less favourable feelings of community cohesion. Moreover, some people who lived nearer to the premises of community businesses were less involved in community development activities than those living farther away.

There were some negative effects of activities of community businesses on social connectedness related outcomes for some users. In some cases, there were signs of homophily, where ethnic homogeneity in developing social bonds naturally excluded individuals who were not socially compatible with others (Bertotti *et al*., 2011).

Community businesses boost positive feelings about the self

Approximately half (n=8) of the included studies suggested that community business models increased feelings of self-esteem. Positive feelings about one's self were expressed in various ways. Completion of tasks such as woodwork, farming and gardening as part of community business activities provided a sense of accomplishment and pride for users (see Ballinger *et al*., 2009; Boswell *et al*., 2009; Bertotti *et al*., 2011; Pank, 2011). Older, retired and unemployed men engaged in men's shed activities reported a rejuvenation of their working skills, imbuing a sense of self-confidence and heightened motivations to recover from the negative self-esteem consequences of switched socioeconomic roles (Ballinger *et al*., 2009; Crabtree *et al*., 2017; Waling and Fildes, 2017). Nevertheless, older users who

were more satisfied with their past were more inclined to report higher feelings of self-efficacy due to their engagement with community business activities (Culph *et al*., 2015).

'Village' model related community businesses provided support services such as transport, sports, leisure and housing for older adult users, to enable them to take control of their lives and live independently in their community (Graham *et al*., 2014; Graham *et al*., 2016). However, one paper (Macaulay *et al*., 2018) reported that, while users of community businesses expressed increased feelings of self-efficacy to take responsibility for undertaking certain tasks, this eventually led to feelings of stress in managing such responsibilities.

Community businesses promote physical health

Some community business users were involved in activities such as production of goods and services, gardening and farming, transportation, sports and leisure (mentioned in just under half of the included studies). These activities involved some form of physical activity, leading to perceived improved physical health (see Boswell *et al*., 2009; Pank, 2011; Muñoz *et al*., 2015; Macaulay *et al*., 2018). However, in Graham *et al*. (2017) only eight percent of 'village' members claimed that community business membership had improved their physical health, while reporting that improved physical health was more likely among members with lower educational background (no college degree) or those having functional disabilities.

Community businesses enhance mental wellbeing

Community businesses act as catalysts for promoting mental health and wellbeing. In eight of the included studies, community business users reported feeling happy, supported and hopeful towards the thriving of their local community (see Ballinger *et al*., 2009; Boswell *et al*., 2009; Pank, 2011; Culph *et al*., 2015; Crabtree *et al*., 2017; Waling and Fildes, 2017; Willis *et al*., 2017; Macaulay *et al*., 2018). Paying users (staff) for their contribution to a social enterprise had a positive impact on their mental wellbeing. Paradoxically, the perceived lack of sustainability of this income, as they were based on winning grants or contracts, had a detrimental effect of user's mental wellbeing (Macaulay *et al*., 2018).

Some community businesses employed people with mental and physical disabilities. Carers for those with disabilities sometimes felt anxious of the way their family members would cope with community business activities; but also acknowledged the respite such employment brought to them, and how it impacted positively on their mental wellbeing (Macaulay *et al*., 2018).

Community businesses provided users with a safe haven from negative influences such as drug and alcohol misuse, especially for those who experience violence in their home settings (Ballinger *et al*., 2009; Muñoz *et al*., 2015). In some cases, the use of community businesses as a safety refuge from these damaging behaviours reportedly led to recovery from depression, drug addiction, aggression and violent behaviour (Pank, 2011; Culph *et al*., 2015).

Users of community businesses who had mental health issues reported feeling less stigmatised as they integrated with other people in the community. For example, Pank (2011) described how community business volunteers with disability who were acknowledged as 'gardeners' during gardening activities, felt that the labels of their disability were taken off from their identity and made them feel more included in community life.

Community businesses improve quality of life

There were different dimensions of user quality of life linked to community businesses. Apart from those studies that reported improved general quality of life of users of community business (Graham *et al*., 2014; Graham *et al*., 2017; Vazquez Maguirre *et al*., 2018), there were also reports of perceived higher sense of purpose of user engagement with community business activities through assisting colleagues in tasks and activities (Ballinger *et al*., 2009; Waling and Fildes, 2017).

Community businesses served as an active ingredient for healthy ageing, enabling users to live independently in the community by providing support services in housing, transport, sports and leisure. The impact of community businesses on quality of life was sometimes distinctive to some users. For instance, in one study (Graham *et al*., 2017) nearly half of the 'village' members reported higher quality of life (n=1742), notably among those users: with lower levels of education (no university/college degree); with functional disabilities; who had been involved in the community business for a longer period; and who volunteered more frequently in community business activities.

In two developing countries (Mexico and Peru), establishing community businesses led to community developments such as improvements in education, housing, fuel supply for cooking; electricity provision, roads and potable water. Such enhanced social amenities translated into better quality of life for residents in such communities when compared with their neighbours (Vazquez Maguirre *et al*., 2018).

Willis *et al*. (2017) reported mixed results on the effects of living near a community business on residents' satisfaction with their local area. Residents who lived in closer proximity to some community businesses expressed more satisfaction with their local area than those living farther away. Meanwhile, for other community businesses, this was the opposite.

4. Discussion

This paper provides a baseline of evidence about community businesses broad impacts on health and wellbeing to add to and help inform new evidence, such as that provided by recent reviews of the literature (Heins *et al.*, 2010; Roy *et al*., 2014; Calo *et al.*, 2018; Suchowerska *et al*., 2019). These published reviews of the empirical evidence have provided valuable insights into the benefits and limitations overall of social enterprise for health, wellbeing and social care. However, this paper's specific contribution to the burgeoning literature is on reviewing the evidence for social enterprises that are specifically embedded in local, geographically-defined communities. As such, it highlights both the importance of local settings and context ('community businesses'), alongside an assets-based approach to public health, that builds on the strengths of individuals and communities, alongside their physical and social capital/resources, in addressing the social determinants of health and reducing health inequalities (Roy *et al.*, 2014).

Social enterprises embedded in local communities have the potential to 'create and sustain health' (Morgan and Ziglio, 2007: 18), to respond to local needs, and to empower people (Roy, 2017), they present an asset focused model that considers how to raise the capabilities and capacities of individuals and communities, leading to less dependency on problem-focused ('deficit-based') solutions of statutory health and social care services. Here, assets refer to the 'resources that individuals and communities have at their disposal, which protect against negative health outcomes and/or promote health status' (ibid: 18). Although not without its critics (Roy, 2017) it can be argued that asset-based approaches foster a salutogenic approach to health and wellbeing (Antonovsky, 1996), given that community-based social enterprises work to create the foundations of positive health.

Our study highlights the evidence that shows that community businesses offer a positive contribution to health and wellbeing (Scharlach *et al*., 2011; Wilson and Cordier, 2013; Muñoz *et al*., 2015; Farmer *et al*., 2016; Macaulay *et al*., 2018; Hull *et al*., 2016; Diamond *et al*., 2017). A major theme in the research on health and social care related community businesses is their impact on improving social participation and alleviating social isolation in specific community-related activities, and the broader impact this has on social connectedness (social capital), feelings of belonging (social integration), decline in feelings of loneliness and engagement in meaningful social activity. Such impacts have been highlighted in the other published reviews to date as an indication of addressing social determinants of health (see Roy *et al.,* 2014; Calo *et al.,* 2018; Suchowerska *et al.,* 2019). This review suggests that improving social connectedness is a core feature of community businesses related approaches to health and social care, from which other positive health and social care outcomes often derive (Ballinger *et al*., 2009, Teasdale, 2010, Bertotti *et al*., 2011, Pank, 2011, Graham *et al*., 2014, Muñoz *et al*., 2015, Graham *et al*., 2016, Crabtree *et al*., 2017, Graham *et al*., 2017, Waling and Fildes, 2017 Willis *et al*., 2017). We also see how community businesses can be important and illustrative examples of the expansive role of local communities themselves.

For some users of community businesses, improved social connectedness often led to feelings of increased self-esteem as users engaged in activities that allowed them to develop new skills, create or accomplish activities that provided a sense of achievement, thereby improving users' sense of self-confidence and self-efficacy (noted also in Roy *et al*., 2014; Calo *et al.* 2018; Suchowerska *et al*. 2019. Many users reported improvements to physical health, sometimes brought about by strenuous physical activity, or engaging in more healthy lifestyles. There were notable improvements for mental health and wellbeing, as users of community businesses highlighted how striving for personal achievements raised their sense of personal wellbeing as it gave them an increased sense of hope and happiness in those moments.

Having a shared sense of purpose with other users of community businesses, and the shared experiences that come with that, provided greater reported quality of life (Ballinger *et al*., 2009; Graham *et al*., 2014; Graham *et al*., 2017; Waling and Fildes, 2017; Vazquez Maguirre *et al*., 2018), a sense of healing others as well as contributing to improvements in the local community. Increasing social networks may generate improved health and wellbeing, particularly for older people. The review findings also suggest that benefits are generated through a number of mechanisms including supporting healthy lifestyles, providing emotional support and offering payment for involvement in community business activities.

The presence of community businesses could also impact positively on local residents' satisfaction with their community and local area (an issue under-explored in the social enterprise literature), though there were notable differences amongst community businesses in terms of how well local communities engaged with their activities. An excess of social 'bonding' capital (intra-group relationships), such as in the examples of 'male shed'-related community businesses, could be made at the expense of social 'bridging' capital (across social groups), and clearly indicates the value of exploring the dynamics of both social and cultural capital in neighbourhoods where community businesses work (Carpiano, 2006). More research is therefore needed to explore the specific characteristics of both local communities as well as community business demographics to further understand how each of these factors may contribute to the success, or limitations, of community businesses for health and wellbeing outcomes.

5. Conclusions

This paper contributes an international perspective to an emerging body of knowledge about the evidence and significance of impact of community businesses and community-based social enterprises on health and wellbeing outcomes for users. In particular we focused on health and wellbeing outcomes, but these were broadly defined to help encapsulate wider social determinants of health: including areas such as social engagement, employment, community and resilience, quality of life and carer outcomes. Community businesses are defined as those businesses accountable to their local community with the local community having an influence in the business operation, they are closely associated with a particular place, and any profits should be used to deliver positive value in the local community (Swersky and Plunkett, 2015; Hull *et al*., 2016).

5.1 Limitations

As we limited our review to papers published in the English language, we may have missed relevant studies published in other languages which could have influenced our overall findings. Only one reviewer screened the titles and abstracts of the identified papers. Having multiple reviewers would have strengthened the validity of our screening process. One of the challenges or our research study, and for this paper, was working with the numerous definitions of community businesses in both the academic and grey literature. In addition, the term is not necessarily transferable between local, regional, national and international settings. We therefore included a range of similar models to community businesses in the systematic review, to ensure a broad enough reach.

5.2. Implications for research, practice and society

Our study, in line with other systematic reviews (Heins *et al.*, 2010; Roy *et al*., 2014) identified limited high-quality evidence on community businesses for health and social care. Although the evidence was mixed in terms of overall methodological quality, a clear message is that community businesses deliver benefits for users, but that more research is needed to provide robust and evidence-based comparisons, and studies are needed on the diverse range of stakeholders, such as users, employers, staff and volunteers, commissioners in health and social care, national stakeholders and the local community representatives (see also Suchowerska *et al.* 2019).

There is a need for longitudinal studies that use objective measures of health and wellbeing to further assess the impact of community businesses on physical and mental wellbeing. Where there is collaboration and partnership between different providers of health and social care, more research is needed into the benefits of collaboration, to better understand the unique impact of social enterprises, as Calo *et al.* (2018) suggests.

We also suggest research that provides more in-depth, ethnographic insights into the intra-community politics and governance that lead some community businesses to be more successful than others. Lastly, to improve the quality of evidence, it will be important for community businesses to develop the way they evaluate their work and provide evidence for the effectiveness of their health and wellbeing activities. For example, Roy *et al.* (2014) argue for more research into the causal mechanisms that underpin how social enterprises (as public health interventions) impact on health and wellbeing outcomes.

In terms of practice and societal implications, we noted that community businesses may have to manage the tension between ensuring the sustainability of its diverse income sources and addressing

local needs and keeping to the values that make it attractive to the local community. One of findings was that the presence of local community businesses frequently impacts positively on residents' satisfaction with an area, but we do not know how this influences community businesses engagement with localities and the extent to which different stakeholders can benefit from this community-entrepreneurship nexus. We need a more comprehensive picture of the ways in which specific geographical, political and socio-environmental contexts influence the vitality of social enterprise activities. Moreover, we need to better understand the wider civil society and community empowerment implications of transferring knowledge and expertise and how this may impact on the health and wellbeing of communities in the longer term.

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