Social Innovation & Health and Well-being

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One of the largest areas of expenditure of modern states remains health and social care. However we are consistently seeing diminishing returns from investment in these areas: demographic changes and spiralling costs of new technologies have placed budgets under ever-increasing strain (Donaldson, 2012). Furthermore, the long-term deleterious impact of austerity policies on a variety of factors relating to health is only now starting to emerge (Reeves et al., 2013; Stuckler and Basu, 2013) and health inequalities remain stubbornly persistent.

Across successive governments, the UK’s Department of Health has promoted the role of social enterprise as an alternative provider of health and social care (Hall et al., 2015; Millar, 2012; Roy et al., 2013). However, like many other areas of policy involving social enterprise, much of the policy rhetoric in this space seems to be based upon flimsy or even non-existent evidence. Debates as to whether social enterprises are intrinsically ‘better’ (howsoever defined) at delivering health and care services than the private or public sectors remain ongoing, and empirical work in this area is just emerging (although see Calò et al., 2017).

An altogether different idea has also emerged recently which approaches the social innovation/health debate from an alternative angle: considering the potential of social innovations such as social enterprises or microfinance institutions to address ‘upstream’ social determinants of health (Dahlgren and Whitehead, 1991; Whitehead and Popay, 2010) – the factors in the social environment that determine the conditions in which we are born, live, work and age. While this work has begun to identify plausible pathways from engagement with a social enterprise (for example Macaulay et al., 2017; Roy et al., 2017, 2014) or with microfinance initiatives (McHugh et al., 2017) to health and well-being, the role of social innovation(s) more broadly in addressing issues such as health equity (Mason et al., 2015) is still very much in its infancy.

We, therefore, welcome papers exploring the role of social innovation (broadly defined) on the health and well-being of citizens and communities. Such innovations could operate at the level of individuals, communities or systems, ranging from the social impact of new technologies focused on a particular health issue, to ‘co-produced’ community-led interventions focusing on addressing the sorts of vulnerabilities (Farmer et al., 2018) that we know impact upon health and health equity.
References


Guidelines:

**Paper abstracts** must be maximum 300 words, excluding references. They should articulate: the research objectives or questions being addressed; the conceptual or theoretical perspectives informing the work; where appropriate, the methodology utilised; and the contribution of the paper to knowledge in light of the conference themes.

Optional full paper submission for consideration in best paper awards is due no later than 31st July 2019.

A maximum of two abstracts may be submitted per presenter (joint papers to be presented by coauthors will also be considered).

All paper abstracts must be submitted to isirc2019@gcu.ac.uk. On abstract submission please ensure you advise the conference stream.

**Panel proposals** must be maximum 400 words, excluding references. They should include: the panel purpose and its relationship to the nominated conference stream; details of (minimum) three and (maximum) four papers and paper presenters to be included in the panel; and the expected contribution to the panel.

All panel proposals must be submitted to isirc2019@gcu.ac.uk.

Abstract and panel proposals submission: Closes 28th February 2019
Decision on submissions: Notification by 31st March 2019
Full papers submitted for consideration in best paper awards due: 31st July 2019

Enquiries about conference administration and technical issues related to online submission should be directed to the conference administration team at isirc2019@gcu.ac.uk