May "For-Benefits" Businesses Help Sustainability in Future Healthcare Services?

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Abstract Demographic changes in western societies, namely progressive ageing of the population and the increased incidence of disabling chronic diseases, have put significant pressure on health systems and are demanding a new approach to health care. The so-called Health in All Policies concept and the systems theory can provide useful insights into a new health services model that addresses population's health needs without compromising the system future sustainability. Care integration provides a possibility to involve multiple agents from a variety of social domains, including social entrepreneurs. Their contribution to a more sustainable healthcare system is discussed here; the cases presented in this chapter are used to highlight the role they play, through their "for-benefits" businesses, in framing the future of health care.

Results indicate the relevance of different social partners, from the public and private domain, in these projects, which reveals a more integrative and inclusive approach to health problems and needs.

Keywords Fourth sector · Social entrepreneurs · Healthcare services · Sustainability

1 Introduction

Western society has undergone significant demographic changes, particularly the progressive ageing of the population and the increase in life expectancy, accompanied by the increased incidence of disabling chronic diseases, factors that together have put significant pressure on health systems. Therefore, if changes in healthcare models and/or design are not urgently implemented, this may result in excessive and unaffordable costs for societies, as well as in a decrease in the quality of health care or, to a limited extent, in the financial unsustainability of health systems as we know

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them. The World Health Organization (WHO), in a 2010 report, published by the European Observatory on Health Systems and Policies (Busse et al. 2010), already alerted and emphasized that chronic disease would be the leading cause of death and morbidity in Europe and that this was not exclusive to certain social strata and not confined to certain age groups of the population. Additionally, the physical and psychological consequences of chronic disease for individuals and the economic consequences are faced as quite relevant, namely: lower wages, lower labour participation and productivity, higher employment turnover, lower household consumption and the rise in early retirement as well as disability, which is expected to have a very significant negative impact on countries' GDP (Busse et al. 2010). Also, the lifestyle choices and the genetic predispositions can explain impacts of chronic disease within the working population, accounting for 62% of DALYs (Disability Adjusted Life Years lost) due to chronic disease in developed countries (WHO 2002), a trend that has not been reversed as at a global level, in 2017 more than 60% of the burden of disease results from non-communicable diseases (NCDs), with 28% from communicable, maternal, neonatal and nutritional diseases, and just over 10% from injuries (Roser and Ritchie 2016).

From the clinical point of view, the growing specialization of health knowledge also poses some difficulties in the management of chronic disease. And in a scenario of tightening public spending, what some countries have been trying to do is to improve the quality of care for chronically ill patients by trying to minimize costs by introducing changes in the architecture of their healthcare systems (Hofmarcher et al. 2007). Therefore, this new disease profile requires a more complex, long-term response, coordinated by different health professionals and involving sectors other than health. The world has changed, and continues to change, very rapidly, so that health systems need to generate new options in order to respond adequately to a demand with a profile that is not compatible with their current offer (Osterwalder and Pigneur 2010).

In this regard, it is important to recall the concept of Health in All Policies (Ståhl et al. 2006), which translates into the development of a horizontal health policy focused on identifying the factors that influence the health of populations, largely conditioned by sectorial policies that go far beyond the health sector. This approach assumes that population health is not only the result of health sector activity but is also determined by living conditions and other socioeconomic factors. The Health in All Policies concept has deep roots in public health and helps to strengthen the link between health policies and other policies in various sectors. The link between health and economics is evident: a healthy economy depends heavily on a healthy population, with clear consequences on labour productivity. And this is particularly relevant with population ageing, that is, the consequences of population ageing will also depend on the ability to keep populations healthy and active longer, a topic that brings us to the question of the importance of the integration of care.

Care integration has a broad scope, with possibilities for collaboration between different sectors and professionals, as well as with informal carers. It may include health care, social support as well as other services. Essentially, the goal of care integration is to ensure that clients have access to the services they need at the right

time and place a perspective in which the services available to people are able to provide a continuum of care that meets all their health needs, in an integrated and comprehensive manner, throughout their lives (WHO 2015).

Care integration appears to be necessary when services provided by institutions and/or individual professionals do not cover the comprehensive care needs of demand (Raak et al. 2003). Healthcare integration is part of a set of reforms deemed necessary to address current and future changes in healthcare demand conditions, and several reasons are given that justify its urgency in the current framework (Santana et al. 2010):

- The shift from an action centred on "treatment of the disease" to an approach focused on "overall patient well-being".
- The current fragmentation of the supply structure, with significant consequences for the various parties involved.
- In a global context of scarce resources, a high level of efficiency and effectiveness in health care is increasingly required.

The challenge is, thus, big, and complex. As discussed, addressing populations' healthcare needs is not a "one man's goal" and no fragmented solutions will be enough. Different sectors, actors and interests must come together, because health systems are, therefore, required to give an integrated response to chronic disease and to the new requirements of populations' healthcare needs. Integration is required to ensure that information is shared between care providers throughout the care continuum, also including the coordination of funding and prevention initiatives, as well as the incorporation of community resources. Expected outcomes with care integration are health gains, less waste, greater efficiency and more patient satisfaction (WHO 2002, 2015). However, for health systems to change direction to raise their performance standards, broader policies and a more integrated approach are required, as it is argued that change must be systemic. As one of the main goals of any health system is to improve the health of populations, it is argued that care should be increasingly user-centred, for which value should be created increasingly in delivery.

Social entrepreneurs, as individuals who consciously pursue social and/or economic objectives, create and sustain social value by pursuing new opportunities (Dees 1998), are well positioned, we believe, to be a part of the new healthcare system. They have been presented as enhancing well-being via focusing on social agency (Perrini 2006), "exhibiting heightened accountability" (Dees 1998) and prioritizing social impacts over other kind of results. The holistic understanding of health, required for the referred systemic change, can benefit from different ideas and approaches of a diversified set of actors, from health professionals to informal carers. These entrepreneurs, through their innovative, social value-creating activities, can address some of the gaps in the "health supply chain" and, therefore, contribute to its sustainability, as widely discussed, but extremely difficult to maintain in the current system.

Collaborations that enable organizations to assemble, mobilize and deploy resources necessary for social entrepreneurship have been reported in several

studies. Heinze et al. (2016) found that health community foundations in the USA make valuable contributions to improvements in children's literacy skills or adult dental health, helping also to draw attention to issues of holistic health. Authors state these social entrepreneurs are forcing changes in health and health care, therefore the impacts observed are worthy of further research.

This chapter intends to present and discuss the (potential) role of social entrepreneurs and their "for-benefits businesses" to a new healthcare system, more integrated, more sustainable and more capable of responding to people's needs. The recent developments of the so-called fourth sector, the combination of multiple logics and the convergence of organizational approaches and structures, bring the promise of a more equitable and sustainable society. We believe social entrepreneurs may be a key element in this process, therefore a chapter on this issue will give a valuable contribution.

2 A Systemic (and Place-Based?) Perspective on Healthcare and the Systems Sustainability

The concept of health system guides us around the idea that health care must be provided on a continuum basis and not constrained by time and/or structural boundaries, so it seems appropriate to work together with a set of organizations that may have an impact on the health and well-being of populations, which should not only improve the experience of patients and their families, but also of the professionals involved in care (Dias 2015). Such organizations can include, but not be limited to, social, mental health, public health, voluntary and community service groups as well as private organizations focused on well-being. Health and well-being must, therefore, be considered in the broader context, so, for example, the role of education, housing, employment and leisure should also be considered (Ståhl et al. 2006). And this collaborative work among these partners means the existence of a group workforce that can bring more flexibility to care provision, for example, but not only, which may also create new challenges to the professions, as well as more opportunities for numerous organizations. This is also a process of adjustment in which health planning assumes a commanding role in health system's design, and it is also expected that there will be an increasing focus on local needs since it is likely that, by concentrating efforts on populations with similar needs, with a concentration on local needs, a better comprehension of requirements is achieved and a more balanced relationship between demand and supply, with more value created for clients (Dias 2015).

The direction that drives this change is the significance of combining personalized interventions for clients within communities and this brings us to the discussion on the issue of integration of care, whose main goal is to ensure that the users have access to the care services they need, in the most appropriate time and place (WHO 2008). This approach is based on the idea that systems need to be re(organized) and

that they should be less fragmented and less arranged around the convenience of the structures and more around the real and global needs of the clients (Dias 2015).

Population ageing in the vast majority of countries with organized health systems, along with rising expectations of healthcare users, mostly chronically ill patients with complex disease profiles, combined with countries' financial constraints and with a decrease in its (less motivated) workforce, are aspects that compromise the sustainability of the systems. And it is reflected that the current response, still very focused on acute care, often results in care not provided in the most appropriate environment. And this can lead to negative results, both for the patient and for the health system itself, increasing the costs of care provision. Therefore, in order to meet new population needs and make the system sustainable, transformational change needs to be made, from a response that is characterized as fragmented and institution-based, to a more coordinated response, oriented around citizens and communities (Southern Derbyshire Clinical Commissioning Group-(SDCCG 2016)).

In this regard, it is imperative to remember the concept of Health in All Policies (Ståhl et al. 2006), which translates into the development of a horizontal health policy focused on identifying the factors that influence the health of populations, largely conditioned by sectoral policies that go far beyond the health sector. This approach assumes that population health is not only the result of health sector activity but is also determined by living conditions and other socioeconomic factors. Health in All Policies has deep roots in public health and helps to strengthen the link between health policies and other policies in various sectors. The link between health and economics is evident: a healthy economy is very much dependent on a healthy population, with clear consequences for labour productivity, as well as the link between health and the social sector, two complex systems that should be much closer to each other. And this is particularly important with population ageing, that is, the consequences of population ageing will also depend greatly on the country's ability to keep populations healthy and active longer, but this requires a more complete, more coordinated and less episodic response. Patients should have continuous care and should not be blocked by sectoral and/or organizational boundaries, hence the need to work closely with organizations that impact on health and well-being to "co-produce" and manage patients consistently and efficiently (SDCCG 2016).

Regarding the trend of organizing care on a local basis, a 2015 study by the Kings Fund for the English National Health Service (NHS) (Ham and Alderwick 2015) addresses place-based care issues in great depth and takes it as a priority. The development of new care models designed to provide services that best fit the changing needs of the population is faced as urgent. The need for organizations to work together on site-based response systems has recently been recognized in the so-called "success regime" developed by NHS England, Monitor and the NHS Trust Development Authority, working with the Care Quality Commission. And this is described as a "complete systems intervention" in which national bodies work with commissioners and suppliers in areas of England that face deep challenges. Unlike

previous approaches focused on individual organizations, the scheme adopts a location-based approach in which all relevant NHS organizations are involved.

Even concerning clinical governance, a concept that was first introduced in the NHS Health White Paper in 1997 (NHS 1997), it has the explicit objective of stating that quality is everyone's responsibility and that it requires partnerships (health professionals/managers; individuals/organizations and NHS patients/public). The very concept of health system governance in its broadest sense presupposes the search for matching supply to demand needs, which may include dimensions such as safety, effectiveness, efficiency, equity, accessibility and continuity of care. Assuming, therefore, that the objectives intended by clinical governance depend on factors other than medical practice, the term "health governance" is proposed, as well as the shift from silenced governance to integrated governance, as it moves from the organizational level to the systemic level. And this results from the recognition that there is a very wide range of variables that have a major impact on the quality of care, and that each institution by itself does not control, namely: the characteristics of care organizations, partnerships, funding, human resources planning, regulation and patient characteristics. But this reorganization needs a firm commitment and cooperation between the various parties involved in the process and their willingness to assume greater levels of autonomy and responsibility in resource management. The response to the chronically ill cannot therefore be constrained by the traditional boundaries of health institutions, and it is crucial that it extends far beyond these limits, that is, by integrating services of other institutions in the community, which may even fill gaps in the provision of health services (WHO 2002).

Still related to the concepts of integration of care and organization of supply on a local basis, a conception appears in the literature as assuming a particular meaning and importance in this context, which is the concept of place and the place-based systems of care.

In environmental psychology, the meaning of "place" is discussed in terms of (Ham and Alderwick 2015): person (a sense of identity and socialization processes); location (physical and geographical aspects); and process (how the group and individuals relate). However, only recently there has been a growing interest in the importance of place in relation to social aspects, which reflects an understanding of the importance of place in economic and social development, particularly in relation to cities and regions.

Globalization has been accompanied by an equally global tendency to devolve authority and resources from nation states to regions and localities. Hall and McGarrol (2013) advocate a more positive "progressive localism", which sees places as active agents to reinvent the way care and society at large can be shaped through dynamic relationships within and outside their territory. According to these authors, "care" is understood as a broad set of practices and experiences in formal and informal spaces, and within a series of networks with families, friends and local organizations, as well as formal and individualized funding of care services, slowly building an "ethics of care". This localism has been the subject of criticism, that is, pointing out to the "setback" of the public sector, with an increasing role of private and voluntary organizations in providing "public" services, inequalities between

places that could be accentuated, with some communities having better resources and results. However, Hall and McGarrol (2013) present the places as hybrid, relational and dynamic, which encourages a more progressive interpretation of the devolution of responsibilities at the local scale. Instead of places being viewed as passive recipients of decision-making, their potential for innovation and creation is emphasized. Back to the concept of "ethics of care", a broader conceptualization of the meaning and practice of "care" is required and locates care in what may be called the "carescapes" of sets of relationships and local spaces. Also, in a period of budgetary constraints affecting both formal social support and health care and where demand for care continues to rise, other forms of assistance in the "public and private spheres" will become increasingly important for many; in circumstances of declining formal state support, it is often local communities as spaces and sets of relationships that can become the active subject of care, offering the possibility of an "ethics of the local".

Another concept that stands out in the context of location-based care is that of location-based leadership (Worrall and Leech 2018). More recently, policy seems to have moved away from its competition model, shifting emphasis to a more integrated and collaborative approach, which has led to the recent addition of "system leadership", encompassing social support and health care, challenging leaders and their organizations to collaborate, focusing on a common goal. Together they have the task of planning and providing health and social support services for a geographical area. Therefore, public service leadership plays a crucial role in harnessing resources by developing more collaborative and localized delivery structures and a greater focus on early intervention and prevention in care. Such approaches need to consider the particularities of the local population and the environment in which people live, work and spend their free time. This means understanding the differences between locations, rather than trying to impose a common process for identifying priorities and means of delivery for all areas and populations, by adopting a "location-based approach" to public service delivery. This involves shifting from a central model of social policy development and diffusion to one of social learning in diverse groups and through networks as a source of new ideas, policies and "innovation zones", which is not an easy path and involves leaders, collectively addressing areas of tension and conflict within themselves, with each other and with more organizations and places, to enable a collective approach to dealing with complex and multidimensional problems.

Now, contextualizing in real conditions and in concrete needs, it is important to discuss the challenges and opportunities that are posed to health systems, hence the narrative that follows, as an example, of specific needs and contexts of action, in particular: dementia, palliative care needs for vulnerable individuals and people with urgent care needs.

According to McGovern (2016), there is growing evidence to support the importance of adopting a person approach in the environment in care provision. In the particular case of dementia dealt with in this study, extending beyond traditional approaches which tend to focus more on people than on places, this approach may provide pathways for new care practices for higher quality of life and ageing at

home. Home here is defined as the home in which one lives continuously. Significantly, perceived quality of life correlates with better outcomes for people with dementia and their informal providers, including fewer concurrent illnesses and injuries, reduced rates of depression and longer life expectancy. In addition, ageing at home or in the community is related to greater well-being in adulthood. According to this author, while care partnerships are beginning to be considered in dementia practice and research, attention to the site is still low. When the place is approached, it tends to explore the impact of ageing on the place, defined as institutionalized life rather than home in which one lives continuously. Growing old in a residential setting, in a long-term home or in a community where the pitfalls of everyday life are familiar, routines are ingrained and contact with friends and family is regular, facilitates continuous connection and increases the sense of belonging, which are correlated to well-being.

Another study, in this case on the use of emergency departments (Hudgins and Rising 2016), places health seeking behaviour in the context of a man's social history and clinical condition. This review aims to inform policy interventions that can create entry points for patients to access a first point of contact with the system to access the care they need in environments that are best suited to their condition, and move researchers away from the blaming approach of "appropriate" and "inappropriate" services users. These authors suggest that institutions should develop structural competencies to deal with the administrative inattentiveness that creates barriers to care, specifically by promulgating care at a community level, based on employing community health workers. It is reasoned that health-related habits are not isolated and distinct but are very much connected to social networks and practices rooted in history and identity.

People-based approaches, on the other hand, focus on individuals' health problems when they arise without the actual inclusion of patients' circumstances in preventing, diagnosing and treating an injury or illness. Hudgins and Rising (2016)'s proposal recognizes that social ecologies shape the health of individuals and that the local context, networks and social relationships are important for health and health care.

Giesbrecht et al. (2018) also critically explored how the "places" of formal healthcare settings shape experiences and access to, in this specific case, palliative care for the structurally vulnerable (e.g. homeless). End-of-life care occurs in a variety of settings, from hospitals, clinics, doctor's offices to informal spaces such as the home. The word "occurs" implies the occurrence of care activities, but also the literal ways in which a person occupies a place in a specific environment, social hierarchy or system. Conceived in this way, place plays a significant role in shaping experiences and accessing end-of-life care, resulting in diverse populations experiencing various care contexts in different ways. The findings of this analysis disclose how those who suffer structural end-of-life vulnerability simply do not fit into public/formal health settings but also have no other place to access needed care. While it is acknowledged that this "homelessness" is increasingly experienced by the homeless in many urban landscapes, it is also emphasized as this denied "place-in-the-world" becomes increasingly pronounced as you move further along becoming

increasingly vulnerable and nearing the end of its life. This spatial exclusion has been found to produce symbolic, political, cultural, physical, emotional and social adverse outcomes that were not conducive to quality palliative care. Many participants lived their entire lives outside the main health system and making them live their last days of life in that system only increased their suffering. Thus, these treatment sites were found to increase discomfort, fear, anxiety and harm, resulting in disproportionate and undue hardship. The location-based experiential knowledge offered in these findings has the potential to inform decision-makers on ways to directly impact policies, practices and system-level changes, particularly on ways to improve access and quality of palliative care of vulnerable populations. Given participants' generally negative experiences in public/formal health settings and echoing promising practices raised elsewhere, these findings suggest that palliative care should become more flexible and mobile. This suggests that palliative care should be provided in a variety of contexts, considered acceptable and safe by structurally vulnerable populations. Palliative care services need to be delivered in environments that go beyond formal healthcare settings and serve clients "where they are". In addition, what may be needed is also a new view of what "home" means in the context of home care. Expecting those who are dying and facing structural vulnerability to seek and coordinate their own palliative care, often with limited support and social resources, is unrealistic and, as the authors' findings mention, is often not possible. As such, creating flexible services that employ harm reduction strategies outside the formal health environment are promising steps to ensure that everyone has equitable access to palliative care and the opportunity to alleviate suffering and obtain a dignified death.

3 The Emergence of Fourth Sector and the Role of Social Entrepreneurs

For-benefits are a new class of organizations, rapidly growing, that are giving rise to the fourth sector of the economy. These organizations are defined by two main characteristics, which distinguish for-benefits from other organizational models: a primary commitment to social purpose, together with a predominantly earned-income business model (Sabeti 2011). For-benefits companies represent a new paradigm in organizational theory and design because they link two concepts which are held as a false dichotomy in other models, the private interest and the public benefit (Collander 2012). In addition, most for-benefits present some other secondary characteristics like transparency, fair compensations, inclusive ownership or social or environmental responsibility, which contribute to maximize benefit to all stakeholders. For-benefits organizations are referred to by many different names, such as public benefit corporations, social enterprises, social businesses, sustainable enterprises, cooperatives, to name just a few (Sabeti 2011).

Traditional entrepreneurs, as referred to in the literature, are presented as individuals who are motivated by self-interest, driven almost exclusively by the desire to maximize profit (Miller et al. 2012). However, more recently, a new kind of entrepreneurs are being identified, the social entrepreneurs who are (also) motivated by social objectives. Although there is no agreement on one single definition, it is accepted that social entrepreneurship is "an innovative social value-creating activity, that can occur within or across the non-profit, business or government sector" (Austin et al. 2006, p.2). Social entrepreneurs comprise a variety of individuals with different backgrounds, different motivations and goals, but present the common desire to achieve social objectives (Mottiar et al. 2018). Research on social entrepreneurs has gained significative impulse among a variety of business fields. In tourism, Mottiar et al. (2018) identified three key roles played by social entrepreneurs in rural destinations. They found that these entrepreneurs are individuals who often identify tourism opportunity in the first instance, enhance local networks and develop common goals and visions among the local community. Social entrepreneurs in this study are a significant force in catalysing a collective vision, acting as leaders and involving local communities in projects that will enhance local development. They also create and maintain networks that benefit projects and communities. As network architects, they develop collaboration at various scales, providing access to information, people, support and ideas, and strengthening social capital where they operate.

In the health domain, arguments have been presented that sustain social entrepreneurs create and implement locally situated innovative approaches to promote health and wellness. They define the social problem, generate social capital in the community and educate potential partners (Heinze et al. 2016). Social entrepreneurship is growing as influential individuals and organizations work to fill the gaps left by government and business in addressing social needs (Dacin et al. 2011). Social entrepreneurs aim for value in the form of social benefit, by developing innovative solutions to social problems. Most research on social entrepreneurship has centred on individual entrepreneurship (Bielefeld 2008), but less is known about how local social entrepreneurs develop innovative solutions (Heinze et al. 2016), namely how collaborations enable organizations to assemble, mobilize and deploy resources necessary for social entrepreneurship. These resources include financial assistance, expertise, cultural and institutional resources. Building networks and bonding across sectors, social entrepreneurs can collectively expand capabilities and reach advanced solutions to social problems (Drayton 2010). However, establishing and maintaining collaborations is not easy and depends on partners' engagement, resources, scope, complexity and strategic value (Bielefeld 2008).

Heinze et al. (2016) found that entrepreneurs follow four steps in the social entrepreneurship process: (1) define the social problem, (2) build the social capital, (3) educate the potential partners and (4) call partners with complementary competences. It is suggested, as in the case of social entrepreneurs in tourism (Mottiar et al. 2018), that these actors serve as knowledge brokers—strategically aligning interests and capacities to establish community collaborative norms that are often more stable than contractual norms. Ambiguity is reduced with problem definition and focusing

effort and energy on issues of more relevance to the local community. Authors also found that local social entrepreneurs inspire and legitimate more innovative collaborations by addressing social problems and educating partners. The most appropriate partners are convened and strong relationships within community are developed. This way synergies are accomplished, and strengths capitalized. Therefore, social entrepreneurs are giving a contribution to develop local solutions to the social problems of population health. Trust is a key precursor of innovative collaboration in this context as in others (Mishra 1996). Trust is important for non-profits engaging in local social entrepreneurship, and social entrepreneurs can build trust in the community, through listening to, learning from and participating in the activities of community organizations. Involving citizens in the process and providing feedback and guidance for communities and organizations also help to strengthen this trust (Heinze et al. 2016). This is better accomplished because local entrepreneurs understand particularities of the local population and the environment in which people live, work and spend their free time. Therefore, they have good conditions to integrate systems that can provide for peoples’ healthcare needs.

4 Methodology

A qualitative, essentially inductive approach was selected for this chapter, considering the limited empirical scientific research on the topic. A case study, of an exploratory nature, was chosen for gaining rich information (Mitchell and Fisher 2010) that may help to understand social entrepreneurship in health care and the emergence of for-benefits businesses in this industry.

A literature review was performed about healthcare systems based on a systemic local-based approach, social entrepreneurship and for-benefits businesses. The case study approach was considered as it is viewed as relevant to theory development (de Jong et al. 2015) and enables to gain a holistic understanding of how dynamics unfold in real-life settings (Yin 2014).

This chapter analyses the case of Portuguese social entrepreneurs whose businesses are reported in the online platform (https://inovacaosocial.portugal2020.pt/sobre/portugal-inovacao-social/), and critically discuss their role and contribution to the healthcare system, within a sustainable, integrated approach. For this analysis, 36 projects were considered, identified as “health” activities, and the data available were organized and systematized around the following data categories: (1) problem, (2) region, (3) social investors and (4) implementing entities. This process was made sequentially by the two researchers, and the data collected were compared and crossed. Content analysis here performed attempts to find evidence that might support the idea that social entrepreneurs are, through their actions, contributing to a more integrated and sustainable healthcare system. It is expected this critical discussion will bring some additional insights into the subject.

5 Results

5.1 *The Case:* "Portugal Inovação Social"[1]

The choice for the presentation and analysis of the case presented here is due, first of all, to the potential it presents towards promoting "for-benefits" businesses, as well as to the possibilities it offers in order to integrate different areas and sectors in the design and organization of the health system, with a view to improving not only the quality of life of populations, but also the financial sustainability of the health (and social) system itself.

"*Portugal Inovação Social*" ("Portugal Social Innovation", SPI-Project) is a public initiative that aims to promote social innovation and boost the social investment market in Portugal. It mobilizes around 150 million euros from the European Social Fund, under the Portugal 2020 Partnership Agreement, and channels this money into the market through four financing instruments designed to finance projects that propose alternative and innovative approaches to respond to social problems. This initiative is a pioneering experience in Europe, as Portugal is the only Member State that has reserved part of the Community funds until 2020 to try new financing instruments that aim to foster innovation and social investment. The execution of the Portugal Social Innovation Initiative is coordinated by the Portugal Social Innovation Mission Structure (EMPIS), whose main purposes are:

- Promoting Innovation and Social Entrepreneurship in Portugal as a way of generating new solutions to social problems, in a complementary way to traditional responses, for the resolution of important social problems
- Streamlining the social investment market, creating financing instruments that are better suited to the specific needs of the social economy sector and social innovation and entrepreneurship projects
- Training the actors of the innovation and social entrepreneurship system in Portugal, improving the response levels of social economy entities and contributing to their economic and financial sustainability

These projects are always guided towards and by a social problem. There are many social problems that affect our collective life, and which vary according to geographical, historical or socioeconomic contexts. At the PSI-Project, the social problem is understood as the risk of inhibiting or effectively constraining the quality of life or the prospects for the development of one or more social groups, current or future.

The financing instruments of PSI-Project are used to finance IIES (Innovation and Social Entrepreneurship Initiative). Social innovation occurs when the social entrepreneurship process is successful, that is, when a new response to a social problem is generated, differentiated from conventional ones, which promotes autonomy and generates positive social impact, with efficient use of resources. Regarding social

[1] https://inovacaosocial.portugal2020.pt/sobre/portugal-inovacao-social/

entrepreneurship, it is the process of implementing and developing innovative ideas to respond to community problems, aiming at a social and often also economic end.

Within the scope of PSI-Project, an IIES is a project that aims to implement or develop an innovative solution to one or more social problems, that is, it is a project that aims to intervene in an innovative and efficient way on one or more social problems with the objective to generate a positive social impact. In other words, an IIES, as a social innovation project, must always constitute itself as an attempt to solve or mitigate a social problem, promoting the transformation of conditions, ways or life perspectives, with the potential for universal reach.

Concerning the financing instruments, this initiative manages four financing instruments aimed at supporting the development of social innovation projects and each of the four instruments is oriented towards a specific phase of the life cycle of social innovation projects. In all, alongside the financing of the PSI-Project, there is the participation of one or more Social Investors (public or private entities that accompany or co-finance projects). The financing of each project is approved upon submission of applications by the organizations within the scope of open calls periodically.

The different financing instruments are: "Training for Social Investment", "Partnerships for Impact", "Social Impact Titles" and "Social Innovation Fund". A characterization of these instruments is examined in Table 1.

The instrument "Training for Social Investment" finances the development of organizational and management skills that enable Social Economy organizations to successfully implement a social innovation project, the Social Entrepreneurship Initiatives (IIES). To respond to the specific training needs of Social Economy entities, a fixed non-refundable amount, up to a maximum of 50,000 €, is allocated to finance a Training Plan, including a Training Needs Diagnosis that must be carried out prior to the application by an independent entity. Any Social Economy entity (Associations, Foundations, Cooperatives, IPSS, etc.) that has an IIES in progress can apply or that has already carried out a pilot experiment to test the concept can apply for this support.

"Partnerships for Impact" is another financing instrument that finances social innovation projects, in partnership with social investors, to achieve greater scale and impact. This instrument aims to finance the creation, development or growth of social innovation projects, in the form of co-financing with social investors, stimulating impact philanthropy and contributing to a more stable, effective and lasting financing model. Private sector, Social Economy or public sector organizations can apply for this instrument, subject to the restrictions provided for in each competition. National or international organizations from the private sector, the Social Economy or the public sector, who are committed to allocating financial resources to support the IIES Development Plan, may take on the role of social investors, provided they have no control relationship with the entity candidate who will develop this IIES.

Regarding "Social Impact Titles", it finances innovative projects in priority areas of public policy, through the achievement of measurable social results previously contracted. This financing instrument aims to finance, by contracting payment for results, innovative projects aimed at obtaining social results and efficiency gains in

Table 1 Financing instruments

Instrument	Scope	Who can apply	Financing amount per project (euros)
Training for Social Investment	Development of organizational and management skills, through the implementation of a Training Plan	Social economy entities (Associations, Foundations, Cooperatives, IPSS, among others)	Up to 50,000
Partnerships for Impact	Creation, development or growth of social innovation projects, in the form of co-financing with social investors, stimulating impact philanthropy and contributing to a more stable, effective and lasting financing model	Private sector, social economy or public sector organizations	More than 50,000
Social Impact Titles	Innovative projects in priority areas of public policy, such as Social Protection, Employment, Health, Justice and Education	A partnership of one or more private entities (to implement) and one or more social investors (to finance)	More than 50,000
Social Innovation Fund	Facilitates access to credit and co-invests in organizations that implement social innovation projects with sustainable business models	Social Economy entities and SMEs and investors such as Business Angels, Venture Capital Funds, SMEs, Foundations, among others	NA

Source: PSI-Project website (adapted)
Notes: NA, not applicable

priority areas of public policy, such as Social Protection, Employment, Health, Justice and Education. The project must be implemented by one or more private entities and financed by one or more social investors, proposing to achieve certain measurable social results, whose indicators and goals must be previously validated by the public entity responsible for the sectorial policy. The social results to be achieved, as well as their indicators and respective goals, are previously defined and contracted in the application area. If these results have been achieved, social investors are fully reimbursed for the amount invested to achieve them. The application must be made in partnership by the entities involved: the implementing entities (who carry out the project), social investors (who finance the project) and public entities (who validate the project's alignment with public policy and the relevance of the expected results).

The financing needs of the projects must be greater than 50,000 €. Any private sector or Social Economy organization (Associations, Foundations, Cooperatives, IPSS, among others) can be social investors or implementing entities; however, there can be no control relationship between the social investor and the implementing entity.

Concerning the "Social Innovation Fund", it facilitates access to credit and co-invests in organizations that implement social innovation projects with

sustainable business models. This is an impact investment fund designed to support Innovation and Social Entrepreneurship Initiatives in the process of consolidation or expansion, which require significant investments and which present conditions of financial sustainability that allow reimbursement investments. In addition to being a pioneering experience within the scope of the European Social Fund, it is the first public financial instrument to foster the social impact business market that allows the direct intervention of credit institutions and capital investors (for example, Venture Capital and Business Angels) in innovation and social entrepreneurship projects. This fund was created as an autonomous fund by Decree-Law No. 28/2018 of 3 May 2002 and is dedicated to financing/investing in impact businesses, which are recognized as IIES by the "Portugal Innovation Mission Social Structure". Social Economy entities and small and medium enterprises (SMEs) can apply and investors, such as Business Angels, Venture Capital Funds, SMEs, Foundations, among others, can also apply. In this case, SMEs are the entities eligible for investment.

Within the scope of this public initiative PSI Project, the number of projects on this date totalizes 465, with the social investment corresponding to 21,024,871 euros and the investment of Portugal 2020 to 59,061,972 euros.

Although practically all other areas covered by this initiative can be considered as relevant to health, as all of them, in some way, determine the health of populations, the following brief analysis considered only the projects that were classified as "health" with respect to the intervention area. Therefore, these "health" projects correspond to about 19% of all projects (88 "health" projects), which corresponds to 14% of all investments already made under the SPI-Project. Table 2 shows a general overview of this reality.

The information collected regarding these projects was grouped into the following four categories/dimensions of analysis:

Table 2 General overview of the SPI-Project investment (up to this date)

Instrument	Total projects	Social investment	Public investment (Portugal 2020)	Total Health projects	Health projects social investment	Health projects public investment
Training for Social Investment	201	0	7,441,804 euros	48	0	1,828,084
Partnerships for Impact	252	17,734,843	48,330,139	39	2,598,868	6,810,502
Social Impact Titles	12	3,290,029	3,290,029	1	239,660	239,660
Social Innovation Fund	INA	INA	INA	NA	NA	NA
Total	465	21,024,871	59,061,972	88	2,838,528	8,878,246

Source: PSI-Project website (adapted)
Notes: values in euros; INA: Information not available; NA: not applicable

Table 3 PSI Health projects in the different Portuguese regions, by typology of investment instrument

Instrument/ regions	Training for social investment	Partnerships for impact	Social impact titles	Total
North	19	16	1	36
Centre	27	15	0	42
Alentejo	2	2	0	4
Algarve	0	4	0	4
Multiregion	0	2	0	2
Total	48	39	1	88

Source: PSI-Project website (adapted)

1. Problem
2. Region
3. Social Investors
4. Implementing Entities

In this analysis, the projects are divided into two large groups, according to the financing instrument that, in the case of the health projects under exploration, are mainly divided into two types: "Partnerships for Impact" and "Training for Social Investment", while "Social Impact Titles" accounts for one project only.

Of the 88 projects under study, 39 have the "Partnerships for Impact" as a financing instrument and 48 projects in "Training for Social Investment" typology. Table 3 shows the projects in the different Portuguese regions, by typology of investment instrument.

Regarding the problem that these projects propose to tackle, they are very diverse, from illness to social problems in particular fragile groups, like children and senior isolated population. Table 4 gives an overview of the main problems addressed by the financing instrument.

Concerning social investors, foreseen in projects with the financing instruments here documented, it is possible to see that companies, municipalities and social organizations are all represented. Public investment accounts for approximately 70% of all the investment done in health projects analysed. However, the growing interest and participation of social organizations and companies in this kind of investment should be recognized.

Regarding the entities implementing the projects, in the three financing instruments, the majority relate to Social Economy Entities. Among these, Associations are clearly the main organizational type here represented, accounting for almost 50% of all project's implementation. It was possible to verify that partners involved are very diverse. Multiple activities, sizes and organizational types can be found among the implementing entities. Municipalities, foundations, universities, computer companies, food industry, dentists, restaurants and tourism enterprises are among them.

Table 4 Problems addressed in PSI Health projects, by typology of investment instrument

Instrument/problem	Training for social investment	Partnerships for impact	Social impact titles
Dementia	6	10	
Social exclusion	1	3	
Lack of access to medicines and treatments	1	1	
Social isolation in senior population	6	5	
Childhood obesity, quality of life and lifestyle	8	5	
Reduce risks related to habits and lifestyles	2	3	
Young people emotional and behavioural disorders	3	4	
Stress problems	4	2	
Overload of informal caregivers	6	1	1
Oral health promotion	1	4	
Organizational capacity, management and learning in new technologies	10	–	
Others	–	1	

Source: PSI-Project website (adapted)

6 Discussion and Conclusions

Reporting specifically on the results of the case under analysis and looking at this public initiative as a whole, the "health" projects correspond to about 19% of all projects, with a social investment of around 13.5% of the total social investment and about 15% of the total public investment. Of the 88 projects under study (the "health" projects), these were distributed by three financing instruments: "Partnerships for Impact", "Training for Social Investment" and "Social Impact Titles". "Partnerships for Impact" finance 39 projects, "Training for Social Investment", 48 projects and "Social Impact Titles", 1 project (Figs. 1 and 2).

Regarding the problem that these projects propose to tackle, they are very diverse, from illness to social problems in particular fragile groups, like children and senior isolated population. Mental health is also assuming a growing interest. Concerning social investors, it is possible to observe that most of the projects comprise partnerships: companies, municipalities and other types of social organizations. Some of the entities (even though, details are scarce in the platform) can be included in the for-benefits label since they have a social goal and a profit orientation as well.

It is also clear, given the results, the relevance of social issues and social partners in these projects, which reveals an integrative and more inclusive approach to health matters. Another aspect that deserves to be highlighted is the greater preponderance of the North and Centre regions in these initiatives.

Considering the projects classified as "health", although it may seem insufficient that they correspond to around 19% of the total of the projects, it remains unclear if

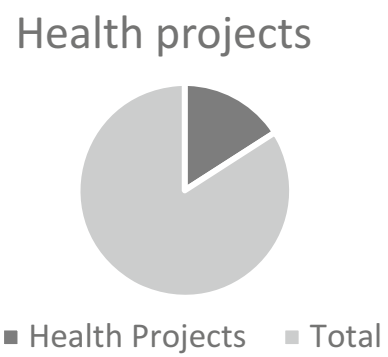

Fig. 1 Health projects (number). Source: PSI-Project website (adapted)

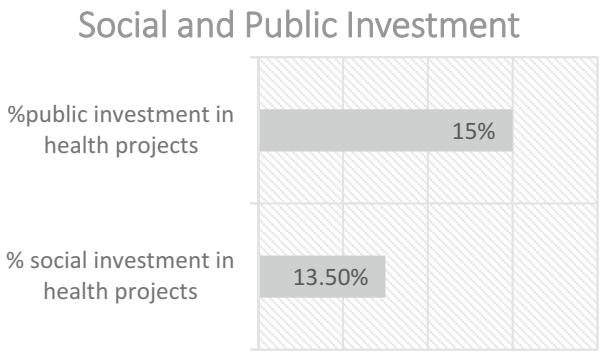

Fig. 2 Percentage of social and public investment in health projects of the total social and public investment. Source: PSI-Project website (adapted)

the projects classified in other areas will not have an important role and contribution for the health and quality of life of populations, therefore a deeper analysis would help to clarify if the perspective of Health in All Policies (Ståhl et al. 2006) can already be found in the PSI-Project.

Demographic changes in western societies, particularly related to the progressive ageing of the population and the increase in life expectancy, brought new disease profiles that require a more complex and challenging response, coordinated by different professionals and involving sectors other than health. The world is changing, quickly and with many unforeseen events, so the systems must be capable of anticipation and (re)organization, committing actors that traditionally would not be involved. Complex problems require multidisciplinary approaches, which means that more innovation is required in the design and implementation of response, where the systemic perspective and the integration of care seem to play a central role. In fact, consequences of population ageing will also differ in the ability to keep populations healthy and active longer, which is highly dependent on the system's ability to influence the health of communities, largely conditioned by sectorial policies that go far beyond the health sector.

Care integration brings opportunities for collaboration between different sectors and professionals, public and private, as well as with informal carers and it may include health care, social support as well as other services. The role that the so-called social entrepreneurs can play in this new healthcare system model is also emphasized and the holistic approach to health is assumed to benefit from inputs of a diversified set of actors, from health professionals to informal carers. In this perspective, the case presented in this chapter, the PSI-Project, is perceived as revealing the potential of value creation in order to mitigate the discontinuities and failures of current systems, with particular emphasis on the social and health systems, both in terms of the continuity of the response to the needs of populations and in relation to the system's financial sustainability.

The possibilities offered by this public initiative are understood as enormous, as it is feasible to bring different areas and sectors into the projects, including social economy entities, municipalities and private companies. However, the still modest involvement of private companies, mainly as implementing entities, must be recognized, and their participation promoted.

Also concepts such as the place-based approach or the people-based approach are realized as being present in the design and implementation of this initiative, in the first case because of the regional approach and the creation of local networks and in the second, the projects' orientation to specific problems of certain groups and/or particular contexts.

Although practically all other areas covered by this initiative can be considered as relevant to health, as all of them, in some way, determine the health of populations, only the projects that were classified as "health" with respect to the intervention area were considered in this study. Therefore, it is important to emphasize that this is work in progress, limited to the available information of PSI-Project platform, which can be considered scarce. The identification and analysis of projects that, either because of the nature of the problem, the target audience and/or the nature of the entities involved, can be coordinated with health and other sectors with a relevant potential impact, could be a future line of research. Thus, this work should be considered as a first step in the development of a more comprehensive research on this subject including the assessment of the specific ongoing initiative here presented, the characterization of entities involved, their business and social goals, and other relevant information that would enable the understanding of their for-benefits orientation.

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