Entrepreneurial activity in community health promotion organisations: findings from an ethnographic study.

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Abstract

Purpose: This paper aims to examine the suitability of a social enterprise model for community health promotion organisations working in disadvantaged neighbourhoods. It focuses on organisational culture, social resources and capacity as pre-requisites for entrepreneurial activities.

Design/methodology/approach: This paper is based on ethnographic case studies in England including semi-structured interviews with the organisations’ staff, trustees and external stakeholders, participant observation, creative method workshops with staff and feedback meetings with staff and trustees.

Findings: The paper provides empirical insights into the potential for, and the consequences of, introducing entrepreneurial ways of working to community health promotion organisations. It suggests that pre-existing capacity, competencies and skills, as well as the ability to manage cultural hybridity are key factors.

Research limitations/implications: Studying three organisations allowed comparative analysis, however time constraints limited access to some stakeholders and meant that the researcher could not be continuously present. Fieldwork generated a series of “snapshots” of each organisation at several time points.

Practical implications: Community health promotion organisations should be mindful of the social and cultural implications of following the entrepreneurial route to income generation. Policymakers need to be more aware of the challenges community health promotion organisations face in taking on entrepreneurial ways of working.

Originality/value: This article contributes new empirical insights into the process of community health promotion organisations adopting entrepreneurial ways of working. This is underpinned by Bourdieu’s concept of habitus which provides a new theoretical lens for examining the social and cultural aspects of this transition.

Keywords: community organisations, social enterprise, hybrid organisations, organisational culture, habitus, health promotion.

Article classification: Research paper

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Community health promotion organisations in a changing environment

There has been previous academic interest in “hybridisation” in the third sector, i.e. organisations taking on ways of working characteristic of public sector organisations or businesses (e.g. Brandsen et al, 2005; Evers, 2005; Billis, 2010a; Buckingham, 2011). However, research to date has not considered community organisations’ ability to take on entrepreneurial activities in terms of their social and cultural resources. Hybridisation brings changes to organisational ways of working and culture - the common values, beliefs and meanings which are embedded in the way organisations work. Culture is the ‘organisational compass’ which gives direction and the ‘organisational glue’ which integrates individuals (Alvesson, 2002: 32). The scope of existing research relating to community organisations is limited, and focused primarily on what works, not what makes them work. Organisational beliefs and practices which underpin service delivery remain concealed in a “black box”, and it is argued, ‘you cannot know why something works unless you unpick all the factors and processes which underpin it.’ (Westall, 2009: 2). It has been recognised that more insight is needed into what allows these organisations to work successfully:

‘Third sector organisations are often valued by both the commissioners and the users of public services because of the distinctive approaches and values they bring to the provision of services. However, little research has been done to identify these approaches or to quantify these values.’ (Alcock, 2010: 44)

This article explores the ability of community health promotion organisations to engage in entrepreneurial activity and to successfully adopt a “hybrid” organisational identity. Informed by an ethnographic study of three English organisations carried out in 2011-2012, it focuses on the social resources, such as pre-existing capacity, competencies and personal predispositions and aspects of organisational culture which were found to be important in this transition. It aims to achieve this through applying the theoretical lens of Bourdieu’s (1977) concept of habitus and Hood’s (1998) application of Cultural Theory to the discipline of public management.

The three “sectors” of the economy: the public sector, the private sector and the voluntary and community sector are differentiated by features such as their purpose, ownership and finance mechanisms. Organisations simultaneously drawing on working principles from different sectors has been an influential idea in the design of public services in the recent years (Billis, 2010b). “Hybridisation” is the process of organisations taking on working practices typical of other sectors as they ‘learn to be efficient players in the services marketplace’ (Harris, 2010: 33). It is likely that in most cases organisations embark on such ventures out of necessity, not aspiration:

‘the present shifts in welfare mixes and hybridization processes are not the outcome of strategic choices but, rather, of coping strategies of actors and organizations under conditions of uncertainty.’ (Evers, 2005: 745)

Billis (2010c) suggests analysing hybrid third sector organisations through examining their proximity to the third sector “ideal type”- the association, which is owned by members, governed by private elections, committed to a distinctive mission, relies on members and volunteers as human resources and is funded by dues, donations and legacies. “Hybridisation” occurs when some of these principles are substituted by characteristics from other sectors, for example paid staff replacing volunteers and contracts becoming the main source of funding.
Small community organisations have been found to respond in a range of ways to the challenges posed by their commissioning environment. In her research Milbourne (2013) distinguished three different organisational types amongst small community providers of children and young people’s services: resisters, accommodators and entrepreneurs. They are not mutually exclusive categories, rather overlapping types lying on a continuum and do not indicate whether an organisation is better or worse equipped for surviving. “Entrepreneurs” are the organisations that use a business-like approach to diversify income. They see running a profit-generating arm (e.g. a café) as a way to fund their community activities and therefore as a means of improving the organisation’s sustainability and autonomy. Government policy has increased the popularity of entrepreneurial approaches through the introduction of markets to the organisation of public service provision (Cabinet Office, 2011) and by supporting the establishment of social enterprises and community interest companies (HM Treasury, 2007). There is, however, little consideration of how this would work in practice, and whether small, community-based organisations could integrate business activity into their work.

Equally, it has been suggested that third sector organisations, i.e. those in neither the public nor private sectors, are well placed to address some of the psycho-social causes of poor health and contribute to reducing health inequalities (Marmot, 2010). Community health promotion organisations aim to achieve this through supporting people to lead healthier lives. Their work is strongly rooted in the tradition of community development; individual growth and empowerment are realized through social integration, building social support networks, and providing opportunities for participation and collaboration in communities (Green and Tones, 2010). These organisations deliver services based on a “community-centred” approach to health and wellbeing, which means that they

- recognise and seek to mobilise assets within communities. These include the skills, knowledge and time of individuals, and the resources of community organisations and groups,
- focus on promoting health and wellbeing in community settings, rather than service settings using non-clinical methods,
- promote equity in health and healthcare by working in partnership with individuals and groups that face barriers to good health,
- seek to increase people’s control over their health and lives,
- use participatory methods to facilitate the active involvement of members of the public (South, 2015: 15).

“Working with communities” became prevalent as an approach to tackling social problems in areas of disadvantage in the period when the New Labour government was in power. Its policies established “area-based initiatives”. The New Opportunities Fund (subsequently the Big Lottery Fund) launched its Healthy Living Centre programme in 1999, awarding grants predominantly to projects based in disadvantaged areas. The Healthy Living Centres were separate entities set up and managed in association with local government and the National Health Service (NHS) with staff often being seconded from the public sector, however were not directly accountable to public bodies. This funding programme came to an end in 2007. The New Deal for Communities was launched in 1998 as a government-sponsored programme of neighbourhood-based regeneration projects, with funding continuing until 2011 (DETR, 1999). Once these funding programmes came to an end, some projects were discontinued, whereas others, like the three studied organisations, have continued as independent third sector organisations funded predominantly from the public purse. In circumstances of austerity and marketisation, which were present at the time this study commenced in 2011,
community health promotion organisations had their budgets cut and were increasingly required to access funding distributed through competitive commissioning for specific services. Further uncertainty about future funding streams and collaborative relationships was triggered by NHS and public health reforms. The multiple changes in the organisations’ funding environment prompted them to consider finding other revenue streams that would make them less dependent on public sector commissioning. This article contributes new empirical insights into the process of community health promotion organisations taking on entrepreneurial ways of working, conceptualised as hybridisation. This is underpinned by Bourdieu’s concept of habitus which provides a new theoretical lens for examining the social and cultural aspects of this transition.

Cultural change in organisations: a theoretical framework

Previous work of Emirbayer and Johnson (2008) presented the considerable advantages of using Bourdieu’s concepts in organisational analysis and they have been suggested by Macmillan (2011) as a useful framework for theorising the “world” of voluntary and community action. In this article Bourdieu’s concept of “habitus” is used to facilitate understanding of the process of cultural change in community health promotion organisations. It denotes the perceptions, predispositions and competencies which people are equipped with and are referred to by Bourdieu as ‘cognitive and motivating structures’ (Bourdieu 1977: 78). Individuals become “socially competent” through subconsciously developing these dispositions in the process of socialisation – owing more to experience than purposeful learning (Jenkins, 1992: 76). Analytically “habitus” can also be attributed to a collective and is at the source of organisational culture. The lens of “habitus” allows tracing organisational ways of working to their positioning in the structure of the social world and the individual predispositions of the people involved. Habitus provides ‘consensus on the meaning (sens) of practices and the world, in other words the harmonization of agents’ experiences’ (Bourdieu, 1977: 80). It is self-perpetuating as organisations attract and recruit, deliberately, or unknowingly, people who “fit” their way of thinking and working as they will be naturally perceived as “one of us”. Likewise people choose to join organisations that “feel right” and are a comfortable environment where they can easily achieve common understanding:

‘And when habitus encounters a social world of which it is the product, it is like a “fish in water”: it does not feel the weight of the water, and it takes the world about itself for granted.’ (Bourdieu and Wacquant, 1992: 127)

Organisational habitus highlights the permanent and subconscious nature of the cultural preferences shaping organisational ways of working which may not be explicitly defined, but are enacted in everyday practices and interactions. Applying Bourdieu’s concept of habitus brings forth the more intangible social and cultural aspects of hybridisation in community organisations, ones which cannot be ignored if the suitability of the social enterprise model for these organisations is to be considered. It also draws attention to the propensity of organisations maintaining a continuity in ways of working typically associated with a given sector.

Cultural diversity in the organisation of public services was captured and conceptualised by Hood (1998) who introduced Cultural Theory to the discipline of public management. This theoretical framework describes four different “ways of life”. They designate distinct ways of perceiving and organising a social system according to two dimensions: the extent to which a culture imposes rules
and classifications on its people and the extent to which individuals are influenced by group norms. Each implies a different form of power-relations. Applying this to Billis’ (2010c) sector ‘ideal types’ allows us to see that each one has it’s ideal-type “way of working”: the “Hierarchist Way” (socially cohesive, rule-bound, managed by oversight) in the public sector, the “Individualist Way” (atomised approaches to organisations stressing negotiation and bargaining, managed by market competition) in the private sector and the “Egalitarian Way” (high-participation structures in which every decision is “up for grabs”, managed by mutuality) in the third sector. These “ways of life” are distinct types of habitus which shape practice in the three sectors.

Community health promotion organisations have a strong sense of purpose which is associated with their values, their beliefs about health and perceptions of social processes; how values are acted upon is considered to be the source of distinctiveness in how third sector organisations deliver welfare services (Blake et al., 2006; Jochum and Pratten, 2008). The egalitarian habitus is fundamental to the community development approach to health promotion. It is a way of delivering public services that is distinct from approaches typically taken by other sectors and that may lead to achieving broader social outcomes as well as helping people improve their health and wellbeing. The studied organisations were however working in an environment that was dominated by public sector actors and the externally set “rules of the game” were becoming increasingly close to market conditions. They were compelled to adopt practices associated with “ways of life” different than their own to remain sustainable. This entailed integrating new cultural elements and experiencing a hybridisation of their habitus to include cultural norms typical of the individualist and/or hierarchist habitus. The structure of an organisation and its values and beliefs must be in a mutually supportive relationship for the organisational model to be “viable”: ‘capable of cohering, attracting loyalty, and surviving over time’ (Thompson et al., 1990: 1-2 in: Hood 1998: 10). This suggests that community health promotion organisations may find it challenging to adapt their practices to become more entrepreneurial.

Methodology
The research project was carried out as a multi-case study with each case following a similar course of fieldwork. Investigating several cases gave some insight into the diversity and significance of factors which could contribute to the organisations’ ability to adopt a hybrid organisational model. This study involved three English community health promotion organisations: Health Connections, Healthy Millborough and Overton Wellbeing Group1. The organisations were chosen on the basis that they aimed to improve health in a local area (without focus on any particular social group or specific health condition), applied a community-centred approach to health and wellbeing (South, 2015: 15) and worked in an area which included neighbourhoods classified as the 3% most deprived in England (Index of Multiple Deprivation score) according to 2010 Office for National Statistics data. The organisations also shared a background of starting off as local authority and/or NHS projects funded by grants: Health Connections and Healthy Millborough were set up with lottery money and Overton Wellbeing Group was financed from a New Deal for Communities grant. Each of these organisations decided to continue their work independently when their funding grants came to an end and their host bodies withdrew from the projects. Incidentally, all three have also been recognised through

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1 The case study organisations and individual participants were ascribed pseudonyms to maintain their anonymity, with names of locations and any other identifying characteristics removed or made more ambiguous.
sector awards or academic studies for the positive impact of their work, which indicates that there is good practice to be shared from their health promotion work. The organisations were chosen to be diverse in terms of their size, location and populations served – please see Table 1 for an overview.

Table 1: Case study organisations

<table>
<thead>
<tr>
<th></th>
<th>Health Connections</th>
<th>Healthy Millborough</th>
<th>Overton Wellbeing Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formal status</strong></td>
<td>Registered charity and company</td>
<td>Registered charity and company</td>
<td>Unregistered, formalised as a local residents committee</td>
</tr>
<tr>
<td><strong>Human resources</strong></td>
<td>24 part-time employees and some volunteers, trustees</td>
<td>8 part-time employees and some volunteers, trustees</td>
<td>8 volunteers (till March 2012 supported by council community development worker)</td>
</tr>
<tr>
<td><strong>Budget 2011/2012 (approx)</strong></td>
<td>£450,000</td>
<td>£450,000</td>
<td>£8,500</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td>Yorkshire</td>
<td>North West</td>
<td>South East</td>
</tr>
<tr>
<td><strong>Area served</strong></td>
<td>Suburban and semi rural ward</td>
<td>Urban local authority</td>
<td>Urban estate</td>
</tr>
<tr>
<td><strong>Population served</strong></td>
<td>Area of mixed affluence, some ethnic minorities, high number of refugees</td>
<td>2 white working class and one 90% South-Asian neighbourhood</td>
<td>White working class</td>
</tr>
</tbody>
</table>

The diversity of the participating organisations allowed for analysis within cases as well as cross-case analysis aimed at identifying key similarities and differences between them. This facilitated making more nuanced claims about the potential of entrepreneurial activity in community health promotion organisations and the factors that influence it.

Ethnography was chosen as the research methodology most suitable for “opening the black box”. Brewer characterises it as ‘experiencing, observing, describing, understanding and analysing of the features of social life in concrete situations as they occur independently of scientific manipulation’ (2000: 33). It includes ‘the analysis of people’s ‘meanings’ from their own standpoint: the feelings, perceptions, emotions, thoughts, moods, ideas, beliefs and interpretative processes of members of society as they themselves understand and articulate them’ (Brewer, 2000: 33). The nature of this methodology is that the researcher becomes inevitably part of the studied setting to enable ‘writing about the world from a standpoint of participant observation’ (Burawoy, 1998: 6) and hence also captures the more intangible aspects of their work. The positioning of the researcher as an “insider” or “outsider” is significant in ethnographic research (Merton, 1972; Zinn, 1979; Bulmer, 1982). In this research, the “outsider” status in organisations was assumed, however participant observation required the researcher to take on a ‘dual role a part insider and part outsider’ (Brewer, 2000: 60). The gradual process of becoming less of an outsider achieved through spending considerable time “hanging around” at the organisations’ offices and taking on small tasks to help out the team allowed
unique insights into organisational practices, working relationships and debated priorities. Engaging in this study meant the researcher simultaneously embarked on two journeys: one that led to learning about the ways of being, doing and thinking of the studied groups and individuals, and one that was directed inwards, towards discovering the researcher’s own identity, dispositions and, often misguided, preconceptions in contact with a new environment. This was very poignant learning, provoking a new, deeper understanding of how easily stereotypical judgements can be made about individuals and communities, resulting in social exclusion. It revealed how the organisations created social value and promoted wellbeing in communities: by reaching out over social barriers and approaching those who are socially disadvantaged with a positive and open-minded attitude, offering recognition, respect and an inclusive environment.

Fieldwork was carried out between October 2011 and November 2012 over the course of several visits to each location and involved:

- a total of 41 semi-structured interviews with staff, trustees, volunteers, service users and external stakeholders,
- participant observation of the organisations’ day-to-day work, both in the office and in the community,
- creative method workshops in two organisations where staff made collages reflecting their organisation’s identity (Gauntlett, 2007),
- feedback visits to two of the organisations and discussion of initial findings with staff and trustees.

The creative method workshops were a methodological innovation implemented during the last data-gathering visits at Health Connections and Healthy Millborough. Their aim was to give the community health workers a chance to jointly engage in an activity that would help explore the organisations’ identity and role in the local health system in an indirect way, offering ‘tools through which they can thoughtfully communicate their own meanings and understandings.’ (Gauntlett, 2007: 85). In Health Connections, five community staff members participated and four did so in Healthy Millborough. This method was not employed with Overton Wellbeing Group as, after previous contact with the volunteers, it was felt that due to personal circumstances, such as recovering after stroke or mental health problems, some of them would not have the confidence to express themselves in this group activity.

At the beginning of the workshop participants were given a selection of magazines and encouraged to think in a metaphorical and abstract fashion working collaboratively on a collage answering the questions “Who are we and what are our important qualities – for our partners, for individual service users and for the community as a whole?” They were on their own for about 30 minutes to carry out the task with a recording device left in the room. Afterwards they presented their piece. The created artefacts were used only to “mediate” abstract concepts expressed by the participants and only the recorded verbal data was analysed. Photographs were taken of the collages and retained to assist in the analysis of the workshop recording.

The research findings were generated through an inductive process of thematic analysis (Braun & Clarke, 2006). This was the point when the “story” of the organisations started taking shape and the process of interpretation began, i.e. bringing meaning and significance to the data and explaining the patterns, categories and relationships that exist between them. These initial findings and
interpretations of data were presented to staff and trustees of Health Connections and Healthy Millborough. It was not practicable to arrange such a meeting with Overton Wellbeing Group at the time. Burawoy (2003) describes these as “valedictory revisits” used to gauge the subjects’ reactions to the reported research results. At both meetings the response to initial research findings was positive. At Healthy Millborough the trustees and senior staff were unsurprised, however did not seem to engage more deeply with the presented issues, explaining that they are seeking workable solutions to the presented challenges. At Health Connections, there was a fervent response. The manager and staff in particular felt that the provided description and explanation of hybridisation and its challenges improved their understanding of the tensions they were experiencing and of some of the opportunities and threats for their organisation.

Findings: case outlines

Overton Wellbeing Group
Overton Wellbeing Group was a local resident group based in Overton, a majority ethnic white council estate on the periphery of a major, relatively prosperous city in South East England. It was developed as a volunteer-led support arm of neighbourhood project which was led by a council community development worker and funded through the New Deal for Communities programme. At the time of research, the volunteer group was funded through a small community grant which was due to finish in 2015 and the costs of running some activities (e.g. hire of community spaces, paying exercise instructors) were already wholly or partially covered by the modest charges placed on participants.

In March 2012, when the city council withdrew its remaining part-time community worker involved in the project, a committee of 8 volunteers took over the full administration of all the delivered activities. They organised exercise and social groups for the elderly and isolated, held regular health consultation drop-ins and provided healthy, homemade catering for a range of community events. These volunteers have all been involved in Overton Wellbeing Group for 6-10 years and over this period of time had undergone formal training which gave them the knowledge and skills to deliver these activities. It was considered quite remarkable that the volunteers managed to continue the organisation’s work with very little external support.

However, the committee members were not keen on performing administrative duties and searching for funding. They had consciously made the decision to not establish as a social enterprise, which was suggested to them by the council, and to uphold an informal and volunteer-led model which was very close to the associational “ideal type” (Billis, 2010c). The organisation, as far as was possible, was maintaining its status quo. Despite the prevailing optimism within the committee, the organisation’s sustainability was uncertain in light of their only funding stream coming to an end. It was difficult to see how they could, for example, develop their services or find new income streams after their current funding ran out, without significant external support.

Healthy Millborough
Healthy Millborough was a charity with eight part-time employees which worked in Millborough, a former mill town in the North West. It worked in three deprived neighbourhoods: one that adjoins the town centre and has a 90% South Asian population and two relatively remote council estates. It was successfully running two community gyms together with exercise groups which were self-sustaining (modest membership fee) and a local food cooperative coupled with cooking classes, had championed
successful cancer screening campaigns and ran community engagement projects which developed solutions to local health problems.

Healthy Millborough grew initially as an organisation after becoming independent, however it had lost nearly all its NHS and local authority funding in 2011 leaving it with only lottery funding to cover core costs. It therefore made several members of staff redundant and the remaining 8 reduced their working hours to save a post. They were uncertain about being able to maintain staffing levels in the next financial year. Morale was quite low and they questioned the organisation’s ability to rebuild its lost potential. As an organisation they were in “survival mode”, working hard to carry out essential tasks:

‘um, sometimes you get the impression that they are firefighting occasionally, that with the resources they are probably overstretching themselves, (...) so we have all sorts of discussions at the board that they manage their time effectively and don’t do too much else’ [Gerald, Trustee, Healthy Millborough]

The Healthy Millborough team therefore had insufficient capacity to be more proactive in promoting and developing the organisation to generate new income streams. Despite their enthusiasm to make their work known, no one had overall responsibility for a promotion strategy or could focus on communication activities.

Rashid became the organisation’s manager after many years of working as a local authority community development officer. He progressed from volunteering and political activism to a leadership role and was very driven and involved in front-line work. He came from a working class and minority ethnic background, which he perceived placed him at a disadvantage when working with organisational partners. He openly admitted to discomfort in the company of people he perceived as influential and described how he was making an effort to look like he fit his role:

‘no matter how many meetings I got to, I don’t always feel comfortable in those meetings because I don’t obviously want to make a fool of myself, but always end up um [pause] saying something, as I just want to be seen, to be heard at the meeting (...). So I want to be known, so I always kind of “suit up” for them’ [Rashid, Chief officer, Healthy Millborough]

Equally, he acknowledged that the strategic, business side of managing a small organisation was not an aspect of his role which he was keen to spend time on:

‘Things that really turn me off are doing reports, doing plans, doing strategic plans, doing action plans – that’s part of my job now, but it’s not something I would rush, I would run to do’ [Rashid, Chief officer, Healthy Millborough]

Healthy Millborough had some entrepreneurial success – the community gyms were self-sustaining (although managing them did take a significant amount of staff time) and the food-cooperative which was run by residents was trading very successfully thanks to the resourcefulness of one of its volunteers. Overall though, the organisation was not able to generate additional income through business-like activities. They tried hiring out their “health bus” to local organisations such as schools and businesses, however this was not deemed sustainable due to low uptake. Healthy Millborough
had some significant strengths as an established local organisation, however it lacked capability in terms of time and skills to establish commercial activity which would raise additional income.

**Health Connections**

Health Connections was a charity with about twenty part-time employees working in a suburban and semi-rural ward in Yorkshire. Their key areas were outreach work with underserved groups, promoting access to NHS services such as screening or ante-natal consultations, building social support networks, nutrition support and exercise classes. It had been expanding since it became independent, maintaining core funding from the NHS, but also employed support staff in fundraising and communications/marketing roles who have successfully contributed to gaining new sources of income. At the time of fieldwork Health Connections was slowly building their capacity for generating income; according to their annual report, in the 2013/2014 financial year they had raised 8% of their income through business activity. Health Connections, incidentally, also had a bus that it used for its outreach work. They hired it out commercially with some success. The organisation was also running a project which got young people to make things which they sold to raise money for youth work projects. Since the time of research, the organisation established several entrepreneurial initiatives: a shop, community café and an upcycling workshop space.

Health Connections was the largest of the studied organisations and was deemed ‘big enough to count’ by local stakeholders. Health Connections had a strong focus on marketing and communication with stakeholders and potential partners. They employed a part-time staff member who was responsible for communication and promoting the organisation through multiple channels, amongst others, a frequently updated website, Twitter, quarterly newsletters for service users, commissioners and other local stakeholders. It was believed that this was worth the organisational resources dedicated to it:

‘because we are very good at being able to demonstrate that we are delivering and reaching need and we respond to need, and that in that sense it is sustainable, there is lots to do with marketing, there are lots of organisations that don’t bother (...) and I think if you’re not out there, you don’t get your reputation, you don’t maintain your image, and it’s awful that so much effort has to go into it, but it is about communicating what you do’

[Patricia, Manager, Health Connections]

Patricia, the manager’s, personal skills and experience facilitated building the organisations’ strategic relationships. Patricia was a strong-minded leader who came across as very articulate and persuasive. She demonstrated a high level of self-confidence in dealings with external stakeholders which reflected her broad experience in the voluntary sector and a higher education background. Her collaborators held her in great esteem and commented on her ability to lead the organisation in a challenging environment, as described by one of Health Connections’ trustees:

‘I think she’s [Patricia] great at her job actually; I like what I call her entrepreneurial spirit and her confidence in taking risks. If she was what I call “old world voluntary sector” I don’t think I’d be sitting here. She’s what I call “new world” in voluntary not-for-profit sector.’

[Steve, Trustee, Health Connections]

Staff were overall very engaged and enthusiastic about new initiatives and ways of working, although this was perceived to have caused a demand for more “efficient” work which left little time for service development and value-added work:
‘suddenly it’s all got so busy that it’s quantity not quality (...) suddenly there is no extra, two years ago there was time, there was lull, there was time to do the creativity bit, but we no longer have the time to develop new resources or whatever it might be’ [Clare, Community nutrition worker, Health Connections]

The organisation was taking on more work to gain much needed income, but these contracts did not budget for time spent by staff creating the extra value in communities which they saw as the core of their work. Health Connections were deemed financially sustainable, however there was growing concern that the organisation was sacrificing the quality of their work to deliver more “outputs” with the same staff capacity.

**Entrepreneurial activity: key themes**

*On the social enterprise route*

Views about working like a social enterprise were ambiguous in the organisations. Health Connections and Healthy Millborough were set up with the intention of engaging in business activity. Both chose to register as companies when establishing as independent organisations, even though at the time they were still well supported by statutory funding. The organisations however guarded their core third sector identity, fearing that an entrepreneurial image would suggest profit-making to service users and members of the public. In both organisations the term “charity” was most commonly used in reference to their organisation:

‘We’re a charity first and foremost, we describe ourselves as a charity in most of our communications because we are generally applying for grant funding or we’re looking for service users. Where we use the term social enterprise is for example, if we’re talking to an NHS body that is keen on social enterprise’ [Kate, Trustee, Health Connections]

When specifically asked about it, both organisations acknowledged that their way of working was becoming increasingly like a social enterprise, however the term was not otherwise used in their publicity materials or in conversations. It was, in fact, perceived to be quite contentious:

‘My board are very cautious and don’t really like the notion of social enterprise so although I present it as a social enterprise (...), I play it low, because people don’t necessarily understand and we’re not doing that much business at the moment, but I can see that we might well have to, that might be another way that we can get more money in’ [Patricia, Manager, Health Connections]

On the other hand, “amateurism” is a common criticism of third sector organisations (Salamon, 1987) and staff at Health Connections and Healthy Millborough were clear that this is an image they needed to distance themselves from:

‘people think of charities as little corner shops that just take money and sell second-hand things. Whereas this is a professional organisation of professional people and some of the work is certainly on the par with what you would get in the private, commercial sector.’ [Pete, Finance manager, Health Connections]
They had an intuitive sense of the hybrid nature of their organisations and tried, as best as they could, to use it to their advantage. What became clear when discussing initial research findings with Health Connections, was that the management was less aware of the drawbacks which are discussed below.

Establishing entrepreneurial practices was seen as a route to sustainability. Firstly, to replace income that had already been lost with the decreasing resources available from public sources and avoiding the risk of closing down:

‘But the reality is that they are losing their ground so they are having to do that [be entrepreneurial]. Whereas on the whole, a big NHS organisation isn’t losing its ground, or it’s having a cut, but it’s not having to actually go out of business. It focuses a manager’s mind quite considerably.’ [James, Commissioner, Health Connections]

Secondly, to build future resilience to mitigate the risks associated with future funding shortages:

‘So essentially it’s critical to our sustainability to look at diversifying our funding base, (...) anything we can to actually bring in more income so that we are less reliant on one source of income. It’s absolutely critical to our future. [Kate, Trustee, Health Connections]

Equally, less dependence on statutory funding enabled the organisations to have more autonomy in pursuing their mission. Data gathered at Healthy Millborough’s creative workshop indicated that community workers felt disempowered by their financial dependency on statutory funders. Increasing the organisations’ unrestricted funds improved their ability to respond to diverse needs, including those that are not seen as a funding priority by statutory bodies:

‘but it comes down to money, what we can apportion funds to is restrained, and sometimes we see a need, we really want to address that need, but it’s slightly out of our post-code area or we can’t quite align it to one of our, you know it’s a constant process of trying to fit what we can spend the money on.’ [Kate, Trustee, Health Connections]

The two managers, Patricia and Rashid, had business ambitions, although neither of them had any previous experience of working in or running a business. They were aware that some aspects of their organisations’ work had to be business-like and recognised that being market savvy was an essential part of their role. Their entrepreneurial mind-set was demonstrated by the language they used and how they pictured their organisations as ones that have to take risks, prove their innovative capacity and gain influence in the “market” of local community services:

‘Three letters – USP – unique selling point: what is going to make you different to what is out there already, why do we need you?’ [Rashid, Chief officer, Healthy Millborough]

They wanted to be seen as capable partners who bring value to their relationships, not just organisations who “spend other people’s money”. The managers were acutely aware of the fact that in a very competitive environment where finances are tightly controlled their services have to be innovative and cost effective:

‘when we’re looking at trying to meet a need we need to come up with a really good idea that is cost effective, value for money and that is going to meet that need, and it’s also based on what people said they want, so you have to really think hard about how you,
rather than – got an idea, here’s £50k, go and see if it works’ [Rashid, Chief officer, Healthy Millborough]

The staff at Health Connections and Healthy Millborough were recognised by their collaborators for their responsiveness to local needs and ability to adapt to changing circumstances. It was seen as an inherent characteristic of the community development approach to health promotion:

‘as a community development charity you’re constantly: opportunity – is it working – yes, is it working – no – do something else, next opportunity... It is very, it’s controlled chaos, in a good way. You are constantly responding to things in the community, trying new things, learning from them.’ [Kate, Trustee, Health Connections]

This predisposition to constantly reflect on their ways of working and willingness to change was likened to the approach common in small businesses which had to respond to a dynamic market. It was particularly valued by those who purchased their services:

‘going to an organisation that’s got a little bit more scope, whose got that in-built flexibility, to tailor things to what we need rather than tell us what we can have, that is hugely helpful.’ [Janet, Housing association community projects manager, Healthy Millborough]

However despite these similarities in views and approaches to entrepreneurial activity, Health Connections and Healthy Millborough differed considerably in the extent to which this aspect of their work was embedded throughout the organisations. In Health Connections the organisational strategy was clearly driven by the management team, however senior community workers also held responsibility for finding new income opportunities. This was emphasized in team meetings and away days, one of which got all staff involved in discussions relating to organisational strategy and promotion:

‘I think everybody has to realise that they have the responsibility for marketing Health Connections and doing elevator pitches around areas that nobody’s comfortable in. So if you’ve never done anything around teeth you have to do it around teeth, or sexual health so that you start talking about aspects that you really aren’t comfortable with.’ [Patricia, Manager, Health Connections]

Staff were very conscious of the challenges the organisation faced in terms of sustainability and of the fact that ‘we’re now in an age where we do have to be making money’ [Emily, Community health worker]. They were encouraged to share responsibility for the financial and managerial aspects of Health Connections’ work. This came surprisingly naturally to several of them who, as part of their work, established new relationships with public sector bodies, other third sector organisations and local businesses and found new ways of delivering services which would prove financially beneficial to the organisation. The “entrepreneurial spirit” permeated through Health Connections and was something the staff actively identified with. In Healthy Millborough the community workers were acutely aware of the tight finances and the need to save money and generate new income, however they were not involved in developing the organisation’s business potential. It was primarily the three managers (chief officer, community development manager and finance manager) who searched for new opportunities and dealt with stakeholders. The rhetoric employed by some of the organisation’s
leaders indicated that they wanted Healthy Millborough to be more entrepreneurial, however they were not clear on how they would achieve this.

Overton Wellbeing Group differed significantly in that it was run entirely by volunteers who did not want to change the ways of working that they were accustomed to, preferring to maintain a lay, non-professionalised image in the community. The committee also considered the time and effort members could commit to running the group. The volunteers were all in the 60+ age group and, coincidentally, each of them had personal experiences of serious health problems. They were therefore more inclined to reduce their commitment rather than increasing it:

‘the thing is what people say, that voluntary work takes your life over, and you sort of get roped into events and before long, I think some days – oh, just can’t be bothered.’ [Pam, Deputy chair, Overton Wellbeing Group]

Emma, who had been supporting them since the beginning of the project, made the following comment on their transition to independence from the city council:

‘they did look at things like becoming a social enterprise and there is all sorts of schemes available, they could have looked at bidding for other work, there is certainly other work that the organisation could do, (...) but that really needs to happen from the organisation itself, you can’t impose that on them, but that was explored with them, but they reached the level of commitment [that they were comfortable with].’ [Emma, Local authority voluntary sector liaison officer, Overton Wellbeing Group]

The existing paperwork and formal arrangements were perceived as a burden. Particularly Jill, who took on the role of Overton Wellbeing Group’s chair, mentioned several times that it feels ‘like a job’ in terms of time and level of obligation. Other members of the committee were not disposed to take on any administrative duties beyond coordinating the weekly activity groups. Consequently, becoming more entrepreneurial was not seen as a viable option for the organisation.

Capacity and social resources
Capacity in terms of availability of human resources and having the skills required for a more business-like approach were identified by participants as prerequisites to entrepreneurial activity. Despite size differences, varying organisational workloads and ways of working, the studied organisations all struggled to cope with increased demands on their time. “Staying alive” was the prime focus and not having enough people to effectively manage workloads was a difficulty experienced by all three organisations. The smaller the organisation, the harder it was for them to go beyond delivering existing services. The socio-economic characteristics of their broader locations were also significant for the organisations. Even though all three case study organisations delivered services in neighbourhoods with high levels of social need, they had a different pool of social resources available to them. Health Connections benefited from working in an area of mixed affluence and proximity to a metropolitan centre – this meant that they were able to recruit “high quality” trustees, staff and volunteers with appropriate skills and confidence to, for example, engage with local businesses. They benefited from highly-skilled and experienced individuals joining the board of trustees and offering their time to help the organisation develop an effective strategy which could give them more independence from public sector funders. There were also people locally who have the time and abilities to help run some services:
‘I suppose because we are so linked into the wealthier end, like you’ve got [village], we’re able to capture a whole load of volunteers (...), so you’ve got a social pool.’ [Patricia, Manager, Health Connections]

Millborough, on the other hand, was located in an area of post-industrial towns where the social pool was much more limited – there were fewer organisations which would employ professionals and a much less dynamic civil society. It was therefore much more difficult for Healthy Millborough to recruit volunteers and trustees with a broad range of skills and build a network of supporters who would bring not only professional experience, but also their own valuable social connections. Similarly Overton, although on the edge of a city, formed a relatively isolated community where not many relationships were built with people and organisations from outside the estate. It was also observed that because the area was perceived as undesirable to live in, the population was quite transient and it was hard for the volunteers to build a stable support network amongst people of working age. It can be concluded that the organisations’ ability to take on new, entrepreneurial ways of working was dependent on local availability of people with influential social networks, skills and time.

Managing cultural hybridity
As argued by Hood (1998), organisations delivering public services generally follow one of the distinct “ways of life”: the hierarchist way, the individualist way and the egalitarian way. It was found however, that hybridisation brought with it what will be referred to here as “cultural hybridity” – a hybrid organisational habitus which includes cultural norms typical of more than one way of life. The three organisations’ health promotion work was strongly rooted in a community development approach which promotes an ethos of being attentive to and reacting to the needs of service users and requires an egalitarian “way of life”, with little “rules” about how they work but high importance of social cohesiveness and being inclusive in decision-making processes (Hood, 1998). This approach was fully present in Overton Wellbeing Group which did not divert from its associational roots. Healthy Millborough and Health Connections presented a dynamic, responsive and “made to measure” approach to health promotion where the community development and entrepreneurial aspects of the organisation’s identity were strongly associated with one another, with some benefits, such as recognition from external partners, but not without its problems.

Equally, perpetual adjustment and trying to meet contradictory expectations from different stakeholders was a source of tensions and disruption for organisations. They had to become more “self-interested”, compromises were made to meet external expectations, negotiate costs and remain competitive. The pressure on staff to deliver “more for less” was an aspect of entrepreneurial culture which not only potentially impacted on the quality of their services, but also significantly decreased employee work satisfaction. There were several areas of tension related to “cultural hybridity” which were most evident in Health Connections and well evidenced by the conversations held in their creative workshop.

The first area of tension was between the need to be “professional” and effective and continuing to deliver high quality and distinctive services which correspond with the organisations’ ethos. All three of the studied organisations had a clear sense of mission and it was noticeable that the “feel good” aims commonly took priority over the more tangible outcomes and targets. This conflicted with the need to be business-like. A staff member at Health Connections articulated this when discussing organisational identity:
'it’s not about money-making, not a business, it’s about community spirit and working together, and putting things together and supporting each other.’ [Emily, Community health worker, Health Connections]

Some concern was also expressed about “mission drift”; this was associated with the organisations taking on work that was outside their remit and beyond their immediate scope of practice because they needed the extra funding. David, a trustee at Healthy Millborough and director at a local housing association explained that the organisation has responded to radically shrinking local resources for health promotion by seeking new sources of income:

‘I think they have moved from very much, or are starting to move from projects that clearly had a health label to it, so smoking cessation, to even something like taking on the trainees last year from the future jobs fund.’ [David, Trustee, Healthy Millborough]

Likewise concerns were raised about Health Connections taking on numerous and diverse projects to safeguard financial stability and whether this would damage the quality of their work:

‘I do wonder sometimes whether our strengths may become our weaknesses if we’re not careful, in that we are very flexible, we do an awful lot of things, we’ve already got to the point where our enthusiasm went before us, (...) we’re too successful for our own good’ [Clare, Community nutrition worker, Health Connections]

There were also tensions between the organisations’ business orientation and employee work satisfaction. The general working culture in the organisations was relaxed and the staff members valued maintaining good professional and personal relationships with each other. They attached importance to eating lunch together, having spontaneous work-related or personal conversations during the day and building a strong team spirit:

‘gosh [pause] if I could change one thing [pause] I would have more, I would have more social time with my colleagues. Cause we all work part-time and a lot of us are in on different days, when we are in, we’re all so busy, we don’t have enough time when we just sit down at a desk and have a giggle, even for 5 minutes, I don’t tend to do that and I haven’t worked in that environment before.’ [Nicky, Community health worker, Health Connections]

This kind of sociable atmosphere was still observable in Healthy Millborough’s office despite the staff’s perception of increased workload and “being very busy”.

Discussion
Despite facing similar circumstances of withdrawal of support from public agencies and an increasingly competitive funding environment, the three studied organisations were in very different positions. In Health Connections well-managed hybridity became perceived as a necessity, but also as a way of fulfilling their organisational potential and their mission of responding to local need. A business-like approach to generating income was embraced, but caused tensions within the organisation. Healthy Millborough was keen to generate additional income through business activity, but was not well equipped to do so. In the case of Overton Wellbeing Group, hybridisation was not considered a viable option from the onset and, at the time of research, they were maintaining services by relying solely
on a grant and participant contributions. The differences between the three organisations were largely a reflection of the variation in their access to social resources.

Employing the notion of a “hybrid habitus” brings recognition that, as a result of hybridisation, organisations have to manage conflicting principles and ways of working. In Heath Connections and Healthy Millborough there was a clear conflict along the lines of the grid and group dimensions of Hood’s (1998) conceptualisation of the ways of working in different sectors. Following the “Egalitarian Way”, they were not rule-bound whilst promoting group cohesiveness i.e. prioritising relationship building and wide participation in decision-making. This put them at odds with the business model where social relationships are disregarded according to the “Individualist Way”.

Bourdieu (1977) argues that social groups develop a shared habitus which is reproduced and reinforced through practice. Individuals involved in third sector organisations, either as volunteers or as employees, have certain expectations regarding the “rules of the game” in particular sectors: ‘although sector realities may become hybridized, ideas about sector continue to carry important meanings’ (Lewis, 2010: 223). The staff and volunteers in the three organisations were drawn to working in a community organisation (as opposed to public or private sector organisations) believing that this would allow them to prioritise creating social value over contractual obligations and team relationships over generating additional income. Equally, not all the organisational leaders were naturally inclined to take on a management role that would include running business activities and their social background and competencies were significant in this. Patricia, Rashid and Jill had varying life and career trajectories and they inadvertently brought different predispositions to their work. As maintained by Bourdieu (1986), habitus cannot be changed or attained voluntarily in a short period of time, it is ingrained in individuals as a manifestation of social origin which has accumulated over time, through the process of socialization in the family, interacting with people of a particular social background and through formal education. Consequently the leaders’ habitus, which in all three cases facilitated working in the community could have been a disadvantage, for example in presenting a business-like image to potential clients. The predispositions of the organisations’ leaders appeared to have influenced the positioning of the organisations and had bearing on the organisational culture.

This study indicates that not all community health promotion organisations are equally willing and able to manage cultural hybridity. Overton Wellbeing Group chose to avoid hybridisation, both on principle and based on an assessment of their capacity to change their ways of working. Healthy Millborough and Health Connections had the ambition to transform to a social enterprise model of work, however they differed in their ability to adapt to this way of working. The case of Health Connections demonstrated that some community health promotion organisations have a habitus that can facilitate a more entrepreneurial way of working (although as demonstrated previously, was not without its challenges). Following Bourdieu and Wacquant’s (1992) metaphor, it can be inferred that this organisation was already rooted in an environment which supported cultural hybridity and had sufficient capacity and social resources to be like “a fish in water” in the new circumstances it faced. However Healthy Millborough’s trustees and staff found it more difficult to adjust to the implementation of the more individualistic aspects of a hybrid organisational culture and a change in circumstances left them to be more like “a fish out of water”. This resonates with Cox and Schmuecker’s argument that
‘many aspire to social enterprise, which is welcome. But it also seems to indicate some organisations trying to fit into a narrative that is not, in reality, suited to them.’ (2013: 12)

Applying the Bourdieusian lens of habitus and identifying the tensions between different “ways of life” in the three sectors of the economy provides a new, critical perspective on hybridisation as a resilience strategy for community health promotion organisations. Organisational culture and social resources were found to be critical to transforming from being predominantly state-funded to a social enterprise model.

Conclusions
This article examines the ability of community health promotion organisations to hybridise in the context of changing economic and political circumstances. The research findings suggest that community health promotion organisations can become more entrepreneurial, but their willingness and ability to do so depends on the social and cultural resources, such as pre-existing capacity, competencies and personal predispositions, available in the organisations themselves and in their environment. Those which lack these resources may struggle to adopt ways of working that are alien to their egalitarian “way of life” and are therefore less likely to attempt or maintain an entrepreneurial approach to funding their work.

Therefore, in terms of policy, it should not be expected that all community health promotion organisations can successfully become social enterprises which generate income independently of state sources. In an economic and political context where public resources are stretched and entrepreneurial activity is portrayed as a panacea for third sector organisations, these research findings question the universal desirability and feasibility of social enterprise for community health promotion organisations working in disadvantaged areas where financial and social resources are scarce. Policymakers need to be more aware of the challenges community health promotion organisations can face in adapting their “ways of life” to a more entrepreneurial way of working.

The research findings provide new valuable insights for practice within the sector, indicating that community health promotion organisations should be mindful of the social and cultural aspects of hybridisation when choosing to follow the entrepreneurial route to income generation. This article particularly raises two issues: firstly, the need to assess whether the organisation has the predispositions and capacity to be entrepreneurial, secondly, recognising the risk of tensions within organisational culture, which may lead to distortions of organisational identity and the unsettling of staff, when entrepreneurial ways of working are introduced. Organisational leaders should acknowledge and reflect on these challenges when embarking on entrepreneurial activity.

Methodologically, the ethnographic approach and the specific methods used in this study have proven to be appropriate for examining the organisational “black box” (Westall, 2009). They revealed some of the more intangible factors which underpin hybridisation in community health promotion organisations. The limitations of this study are inevitably associated with the small number of studied cases. There is limited scope for generalising the specific findings of this study, however the applied theoretical approach could be successfully used in future studies to assess the prerequisites and impact of hybridisation in other areas. On the other hand, the researcher was not able to be continuously present in three organisations, therefore the findings are based on a series of “snapshots” at several time points from each. Time constraints also meant that it was not possible to access all the
stakeholders. The service user perspective on hybridisation of community health promotion organisations was not explored in this study – it would be beneficial to address this gap through future research. Furthermore, gaining deeper understanding of the “hybrid habitus” through a more focused study of how other organisations “make sense” of hybridisation and negotiate the inherent cultural tensions would be of value.

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