Social enterprise in health organisation and management: hybridity or homogeneity?

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Abstract

Purpose – The purpose of this paper is to reflect on social enterprise as an organisational form in health organisation and management.

Design/methodology/approach – The paper presents a critique of the underlying assumptions associated with social enterprise in the context of English health and social care. Findings – The rise of social enterprise models of service provision reflects increasingly hybrid organisational forms and functions entering the health and social care market. Whilst at one level this hybridity increases the diversity of service providers promoting innovative and responsive services, the paper argues that further inspection of the assumptions associated with social enterprise reveal an organisational form that is symbolic of isomorphic processes pushing healthcare organisations toward greater levels of homogeneity, based on market-based standardisation and practices. Social enterprise forms part of isomorphic processes moving healthcare organisation and management towards market “norms”.

Originality/value – In line with the aim of the “New Perspectives section”, the paper aims to present a provocative perspective about developments in health and social care, as a spur to further debate and research in this area.

Keywords
Introduction

Over recent decades, policy developments in public sector reform have increasingly emphasised the decline and fragmentation of established welfare bureaucracies. This disaggregation and decentralisation of services has led some to suggest that service provision is becoming increasingly “hybrid” as established sectors and boundaries come together. Health and social care has been a key area for such changes. The promotion of competition and choice has led to an increasing emphasis on private and third sector providers entering the healthcare market. These providers have been encouraged on the grounds that they are capable of being more innovative and responsive than their public sector counterparts (Allen, 2009).

The English healthcare system has been particularly active in encouraging a diversity of providers. One such organisational model of provision has been social enterprise, which has been encouraged as a more innovative and responsive alternative for service users and healthcare staff. Social enterprises are broadly defined as “business[es] with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners” (Department of Trade and Industry, 2002).

In England, social enterprises are currently presented as organisational vehicles with the potential for dealing with complex social needs that create social as well as economic capital. This resonates with global trends that have seen governments invest significantly in social enterprise organisations to deliver public services (e.g. Defourny and Nyssens, 2008). In the following New Perspectives essay I want to argue that this increasing interest in social enterprise in health organisation and management reflects wider trends in welfare that draw attention to increasingly hybrid organisational forms and functions. Following this, I also want to challenge this notion of hybridity, arguing that whilst social enterprise increases diversity in our understanding of health organisation and management, its rise and increasing popularity is illustrative of isomorphic processes towards market “norms”. Social
enterprise is symbolic of isomorphic processes pushing healthcare organisations toward greater levels of homogeneity based on market based standardisation and practices.

**Background**

Policy makers are increasingly using social enterprise as a discursive vehicle to address a wide range of social problems (Teasdale, 2011). Nicholls (2010) explains that the organisational legitimacy of social enterprise has been as the result of a dynamic interplay between macro-level institutional structures and micro-level organisations. In the UK, network organisations like the Social Enterprise Coalition (SEC) represent “paradigm-building” actors that have been influential in establishing discourses and narratives to develop ideas about social entrepreneurship (Nicholls, 2010, p. 616). They draw attention to how social enterprises are an attractive proposition in providing “value-added” services better able to more effectively mobilise “pro social behaviour” than for-profit private enterprises (e.g. Allen, 2009).

In the English National Health Service, a variety of policy initiatives have encouraged social enterprises with the aim to create patient choice and give greater freedom to staff to be innovative, responsive and improve quality. For example, a Social Enterprise Investment Fund (SEIF) was established to support the development of new enterprises and encourage existing social enterprises to extend into delivery of health care (Millar et al., 2010). In the primary and community health sector, social enterprises were one of the organisational forms that could be considered under the Transforming Community Services programme (Department of Health, 2009). As part of a purchaser-provider split, primary care commissioning organisations (PCTs) were required to transfer their provider services to other organisations by 2012. This policy commitment was highly significant in that NHS employees were to be given a “Right to Request” (RtR) to set up social enterprise organisations to deliver community health services (Miller et al., 2012). The RtR programme has been followed in England by a Mutuals Programme to support 20 services to develop into “public sector mutuals”, and the Right to Provide programme encouraging staff within healthcare trusts to become social enterprises.
Existing research in this area has reported some notable benefits in becoming a social enterprise. This included greater innovation in clinical service delivery; the provision of a wider range of services; and efficiency savings from reduced staff absence (Miller et al., 2012; Hall et al. 2012; National Audit Office, 2011). These findings also support wider research about non-profit organisations in healthcare settings suggesting that they achieve better relations with those they serve; enhance quality and deliver more innovative service provision (e.g. Heins et al., 2010; Department of Health, 2009). That said, research also identifies challenges associated with social enterprise entry. Miller and Millar (2011) found only limited interest expressed by NHS staff to develop social enterprises due to a lack of staff support, leadership, organisational support and commissioning support. Commissioners have been highlighted as particularly problematic in often equating social enterprise organisations with being “not business-like enough” (Baines et al., 2010). Workforce concerns regarding job security, business skills and the potential loss of public sector branding have also been documented (Department of Health, 2010), as well as the difficulties in measuring anticipated benefits and securing funding from financial institutions and commissioners in a competitive market place.

**Social enterprise: hybridity or homogeneity?**

Social enterprise has been discussed and researched in the health and social care context but as yet the debates surrounding their entry have not been extended to analyse how social enterprises interact with other public and private sectors. It has been documented elsewhere of a “tension field” as different sectors and boundaries interact and become increasingly porous and overlapping (Evers and Laville, 2004). Billis (2010), for example, suggests that this hybridity represents an expanding aspect of the complex and overlapping relations between the state, the market and the third sector that is challenging and supplanting the core features, and values, of established welfare institutions. As a result of contracting out, privatisation and performance measurement, the traditional boundaries between market, state and third sector have been breaking down, leading to the emergence of a class of organisational hybrids: complex organisations with opaque accountability structures. Here, Billis (2010) argues that a prominent example of welfare hybridity is social enterprises that fuse third, public and private sector values. Such organisations are indicative of existing third sector organisations in health and social care that are now introducing social enterprise “trading arms” as
part of their organisation. They are also indicative of changes to health care organisations currently operating within the public sector. For example in England we have seen the introduction of hospital Foundation Trusts that aim to combine public sector with private and third sector approaches (Allen et al., 2012).

Social enterprises represent the arrival of new hybrid organisational forms in health organisation and management. Whilst these organisations are associated with greater innovation and responsiveness, they also represent a response to the current pressures faced by healthcare organisations to reform and adopt managerial principles grouped under the umbrella of new public management (NPM). As Brown et al. (2003) suggest, these managerial principles are aimed at changing the public sector in three areas, summarised by Maor (1999) as first, a change from hierarchical to economically based structures, second from regulative to economically based processes and third, from legally based to economically based values. In seeking to achieve these goals, the existing healthcare sector is being required to downsize, devolve managerial responsibility and introduce managerialist methods and practices from the private sector.

Social enterprises represent a hybrid organisational form that is symptomatic of this convergence towards NPM ideas and practices. When we start to reflect on debates about the nature and implications of this hybridity, current thinking about hybridity as a concept tends not to extend beyond the “tension field” as depicted by Evers and Laville (2004). A critical reflection on these developments in healthcare suggest that social enterprise is indeed symptomatic of this hybridity but perhaps the organisational form is also symptomatic of increasing homogeneity: a convergence and blurring of sectoral boundaries that represents a market based isomorphism currently taking place in health organisation and management. It was DiMaggio and Powell (1983) who most famously described the three processes of isomorphic behaviour. These are coercive isomorphism that stems from political influence and the need for legitimacy, mimetic isomorphism resulting from standard responses to uncertainty, and normative isomorphism associated with professionalisation. DiMaggio and Powell (1983) suggest that the product of coercive, mimetic, and normative isomorphism reflected an increasing homogenisation and convergence of organisational forms fuelling standardisation and professionalisation.
It has been documented elsewhere how the appeal of the third sector is based on its ability to bridge government and civil society yet problems remain for these organisations in becoming social enterprises. The dangers of the increasing influence of adjacent sectors, the loss of independence and possible mission creep in which these organisations gain resources, possible influence and the opportunity to deliver more services come at the cost of those fundamental attributes which made it an attractive proposition in the first place – its mission, values and voluntary contribution (Haugh and Kitson, 2007). Kelly (2007) suggests this blurring of sectoral boundaries has usually been regarded either as a cause or as the effect of a process of structural isomorphism in which non-profit organisations have become increasingly bureaucratised and commercial. Mimetic isomorphic forces are also at play as the organisation becomes increasingly professionalised as it is continuously required to adopt business methods that are likely to impact on the rationale and culture of the organisations.

The rise of social enterprise in the context of market-based isomorphism also reflects how existing public sector healthcare institutions are susceptible to mimetic, normative, and coercive pressures as much as business and non-profit sectors. Research has tended to view public sector agencies more as playing the role of catalyst to institutionalisation in other organisations, as forces pushing non-profits and business firms toward greater levels of homogeneity. As Frumkin and Galaskiewicz (2004) suggest, these same organisations are also being subject to the same kinds of pressures. This vulnerability of public sector organisations to isomorphic pressures is particularly significant as governments tend to be the principal funder of non-profit service delivery. With increasing amounts of non-profit agency finance flowing from public sector agencies (such as the Social Enterprise Investment Fund in England), the vulnerability of government agencies to institutional pressure may have effects on the scope and character of contracting relations. One effect might well be a narrowing of the range of innovations that government agencies are willing to consider under conditions of uncertainty (Frumkin and Galaskiewicz, 2004). This could in the long run have serious implications for the diversity of non-profit initiatives such as social enterprise and might well be in tension with the drive for social innovation that is commonly associated with these organisational forms.
Concluding remarks

In DiMaggio and Powell’s (1983) classic article, the “norm” was the bureaucratic organisation of Max Weber. What we are seeing now is the norms changing towards market forms of organisation. In this New Perspectives essay I have argued that the rise of social enterprise is indicative of increasingly hybrid forms of organisation in healthcare delivery. What I have also argued is that within these hybrid arrangements we are seeing increasing diversity in service provision but we are also seeing an increasing convergence and homogeneity of organisational forms. Social enterprise organisations are symptomatic of the requirement to converge around a market based isomorphic process that is requiring the third sector and the public sector to converge around managerialist methods and practices fuelling standardisation and professionalisation.

References


Further reading