

Public, private or neither? Analysing the publicness of health care social enterprises

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PUBLIC, PRIVATE OR NEITHER? ANALYSING THE PUBLICNESS OF HEALTHCARE SOCIAL ENTERPRISES

Introduction

Debates regarding the ‘modernisation’ (Margetts and Hood, 2010) and ‘marketisation’ (Eikenberry and Kluvert, 2004) of public services continue to raise a number of important questions regarding the distinctiveness of the public and private sector. Various stereotypes often characterise these discussions, with the public sector seen as bureaucratic and wasteful, or reliable and dependable; whilst the private sector is seen as lean, innovative and customer centric or as self-serving and profit driven (Powell and Miller, 2013). Interestingly, what is often silent within these discussions is a lack of clear and convincing evidence about the realities behind these two polarities (Walker et al, 2013). Indeed, the traditional distinctions between public and private institutions are increasingly challenged based on the view that such polarities are misguided and fail to capture the diversity of organisational forms within and across the different sectors (Anderson, 2013; Yeung, 2005).

One such organisational form that challenges the polarity perspective is social enterprise. Often defined as ‘hybrid’ organisations (Battilana and Lee, 2014; Billis, 2010), these organisations are seen as blurring the boundaries between the private, public and third sectors (Dart, 2004); as businesses with primarily social objectives whose surpluses are reinvested to address a social or environmental need (DTI, 2002; Department of Health, 2008). Governments have actively encouraged social enterprises to deliver public services on the grounds that they represent a means to achieving more innovative, cost-efficient and responsive public services (Fazzi, 2012; Millar and Hall, 2013; Buckingham, 2012; Dickinson et al, 2012).

In England, successive governments have promoted the role of social enterprises within community health care and encouraged public sector commissioners to contract with social enterprises in relation to the delivery of NHS services. Policy initiatives to this end include the £100 million social enterprise investment fund, a pathfinder programme and various

guidance reports recommending the merits of social enterprise to NHS purchasers (Hall et al, 2012, Tribal, 2009, DH, 2005). Furthermore in 2008, the Transforming Community Services initiative gave English National Health Service (NHS) community healthcare services a 'Right to Request' to apply to their commissioners to form new organisations into which public services could be transferred (sometimes referred to as 'spin outs'). To support this process they were given financial and technical support and a guaranteed contract for between three and five years (Department of Health (DH), 2009; Miller et al, 2012a,b). The Coalition government commitment to NHS staff continued for one year under 'Right to Provide' (DH, 2011) and was then extended to other parts of the public sector workforce under the 'mutuals pathfinder programme' (Cabinet Office, 2011).

These policy initiatives have been underpinned by assumptions that combine various elements from public, private and third sector organisations. For example, the Right to Request guidance to staff described social enterprises as having similarities to the public sector in their 'common set of values and principles including a commitment to deliver high quality services, a desire to empower their staff and place the communities and people they serve at their core' (DH, 2009: 5). They also 'differed' from the public sector in that their 'business' focus would enable them to 'adopt flexible management structures, unique governance arrangements, and put into practice more innovative service models' (DH, 2009: 5). Where up to now research has principally documented the 'birth' of these new social enterprises as they grow and develop (Miller et al, 2012a, b; Hall et al, 2012; Millar et al, 2013), there is now an opportunity to explore the extent to which they can actually combine the perceived best of public, private and third sectors within established political, economic, and institutional environments.

This paper seeks to respond to these opportunities by drawing on a multi-dimensional framework of publicness (Anderson, 2012) to explore the views of the leaders of healthcare social enterprises that have spun out of the NHS regarding their sectorial identities, characteristics and behaviours. While 'publicness' has received some interest within healthcare contexts (Anderson, 2013), the concept remains relatively underexplored. This is particularly the case for organisations such as social enterprises that potentially combine public, private and third sector characteristics. Our paper provides much needed evidence

around the organisational characteristics and ethos of social enterprise spin outs which can be considered by policy makers, commissioners, researchers and social entrepreneurs. The recent history of these enterprises within the public sector arguably gives those leading them a unique insight into how their publicness has changed with a move into a new organizational form.

Publicness theory and social enterprise

Research comparing the performance of public and private organisations has a long established tradition (Walker et al, 2013). A key element of this has been the ‘publicness puzzle’ in terms of examining how the public or private context of an organisation affects its behavior (Bozeman, 1987; Moulton, 2009). This stream of analysis has evolved from the traditional ‘core’ definition of publicness which emphasised ownership and formal legal status (Perry and Rainey, 1988), to a ‘dimensional’ theory of publicness which emphasised control in terms of the political and economic authority held by an organisation as a way to distinguish between publicness and privateness (Bozeman, 1987). More recently, a values-based or ‘normative publicness’ has been introduced (Bozeman, 2007) defining publicness as the extent to which an organisation expresses attachment to and/or provides public values (Moulton, 2009), including due-process, accountability and welfare provision (Antonsen and Jorgensen, 1997).

A range of empirical research studies have employed publicness models that include aerospace (Bozeman, 1987), research and development organisations (Bozeman and Bretschneider, 1994), mortgage lending (Moulton, 2009) and substance abuse (Heinrich and Fournier, 2004). Studies have reported significant differences between public and private organisations in terms of: staff job satisfaction, motivation and commitment; clientele characteristics; organisational goals and performance; and levels of organisational red tape (Anderson, 2013; Bozeman and Moulton, 2011; Walker and Bozeman, 2011; Rainey and Bozeman, 2000). Generally, these findings suggest that public ownership leads to lower efficiency due to (often conflicting) bureaucratic demands (Ashworth, Boyne and Walker, 2002), lower staff performance due to a lack of financial incentives for staff (Clarkson, 1972)

and lower consumer satisfaction due to block contracting rather than individual payments (Niskanen, 1971). Andrews et al (2011) argue that as public organisations are disproportionately subject to political instead of market control, they lose the efficiency, consumer responsiveness and effectiveness associated with competitive pressures that exist in the private sector.

In healthcare, Allen et al (2011) argue that the boundaries between public and private providers of welfare services have become blurred. They looked at a range of healthcare providers in England and found that rather than belonging to categories of public, private or third sector, they are instead hybrids. They consider the role of mutuals and social enterprises in healthcare (although not explicitly Right to Request spin outs) and argue that they include elements of private (trading in markets), public (funding) and third sectors (embedded in civil society through collective action for common goals) (Allen et al. 2011:10). Anderson (2013) provides a study of publicness within the context of hospital pharmacies. This research identifies different categories of hospitals based on their degrees of economic and political authority. In doing so, he draws on a framework (Fig. 1) that integrates different elements of and maps relationships between publicness and public service outcomes (Anderson 2012). The framework brings together three distinct dimensions of organizational publicness; core, dimensional and normative.

First, *core publicness* refers to the ownership or formal legal status of an organisation i.e. public or private sector; government or industry owned (Anderson, 2012). Second, *dimensional publicness* refers to the extent to which an organisation is subject to political and economic authority. Here, political authority is defined by as “the extent to which the organisation is subject to central government control” (Anderson, 2012:316). It includes resource publicness in terms of the amount of funding and budget derived from the government e.g. contracts or grants, and communications publicness referring to transactions with external government actors e.g. telephone calls, mail and emails with government agencies (Anderson, 2012). Economic authority is defined as “the extent to which the organisation has freedom to make financial decisions” (Anderson, 2012:316). This is often grounded in property rights theory and is indicated by the inability to transfer the ownership of government organisations from one person/group to another. Other

indicators include the extent to which an organisation is motivated by profit, is able to raise capital, set borrowing limits, determine financial incentives for staff and retain financial surpluses (Anderson, 2012). Public organisations generally have high levels of government control (political authority) and low control over their financial decisions (economic authority). However, for social enterprises delivering public services, such levels of control and accountability are not so clear, and as Tenbensen et al (2014) argue, tensions can arise between government funders and third sector organisations due to the ‘overburden’ and inflexibility of reporting and contractual arrangements.

Third, *normative publicness* refers to the extent to which organisations adhere to and achieve public values (Moulton, 2009). Bozeman (2007:131) defines public values as those which provide “normative consensus about (a) the rights, benefits and prerogatives to which citizens should (and should not) be entitled; (b) the obligations of citizens to society, the state and one another; and (c) the principles on which government policies should be based”. Indicators of normative publicness include the extent to which services are of general public value, whether they are suited to private provision and whether they should be part of social welfare or if citizens should have to pay for it themselves. This might include for example the outcomes from a substance abuse treatment programme being decreased criminal activity or engagement in work (Heinrich and Fournier, 2004), although such indicators of public value can be nebulous, making them the most difficult aspect of publicness to evaluate empirically (Moulton, 2009; Antonsen and Jorgensen, 1997).

Insert Fig. 1

Current thinking regarding the notion of publicness raises a number of questions regarding the distinctiveness and relative weight given to particular sectors. That said, this understanding of publicness has often focused on a dichotomy between public and private sectors. The approach tends to assume that private and third sector organisations have more in common than third and public sector organisations. Furthermore, and (reflecting the views of Anderson highlighted earlier) it tends not to take into consideration the ‘loose and baggy’ organisations that make up this sector (Kendall and Knapp, 1995). Whilst social enterprise in particular has many definitions and is applied to organisations with very

different governance arrangements, business models and missions (Teasdale 2011), there is a general consensus that they make profit through business rather than donations, are driven by their values, and largely reinvest their profit to better achieve their social objectives. Social enterprises have also been conceptualized as 'hybrid' organisations that only combine elements of the private and not-for-profit sectors (Battilana and Lee, 2014), with no mention at all of the public sector. These key characteristics highlight that if we take a traditional view of what can be expected from different sectors, social enterprises are hard to place.

This paper therefore develops these ideas by bringing together publicness theory and empirical interview data collected from social enterprises that have 'spun out' of the NHS. By focusing on NHS spin outs, we are looking at what happens to an organisation's publicness when it leaves the public sector yet continues to deliver publically funded services. Most studies on publicness to date are theoretically driven or have employed a quantitative approach; however we use qualitative data to allow a deeper understanding of publicness and the values and ethos within organisations that make them public or private. We also look at the third sector, a sector that has to date been largely ignored from publicness debates. We therefore use Anderson's publicness framework to explore the 'publicness' of social enterprise spin outs. We focus on the three key publicness dimensions in relation to social enterprises by asking the following research questions:

1. What sector(s) do social enterprise spin-outs in health care see themselves as belonging to (core publicness)?
2. To what extent are social enterprise spin outs in health care subject to economic and political authority by the public sector (dimensional publicness)?
3. To what extent do the values and objectives of social enterprise spin outs in health care reflect those of the public, private or third sector (normative publicness)?

Methods

Building on previous work in this area (Miller et al, 2012a,b; Hall et al, 2012; Millar et al, 2013), our research employed a case study approach to understand the nature of publicness within a range of healthcare social enterprises. Where many of the existing studies in the area of publicness have focused on quantitative comparisons, our interest in publicness was interpretive in understanding the experiences and perceptions of those individuals involved in the transition from public sector to social enterprise. From what we know about social enterprises already, by paying attention to these sense making and sense giving processes, research can illuminate important dimensions of organisational life (Millar et al, 2013).

Drawing on previous work and subsequent Department of Health publications (DH, 2012) we undertook a mapping exercise of all social enterprises that had spun out of the NHS (Miller et al, 2012a) leading to the creation of a database of 39 social enterprises. A purposive sample (Patton, 1990) was selected from the database to represent a diversity of organisational forms (including the forms of CIC, Community Benefit Company and Charitable Company Limited by Guarantee), size (ranging from 50 to 1300), services (including whole community service and more specialist services), user groups (including general public and excluded/vulnerable users) and geographical locations (urban and rural). In total, 11 social enterprises agreed to take part and an interview took place with the Chief Executive (or equivalent) in each case. Whilst interviewing the Chief Executive presents limitations as the views of other staff and stakeholders were not included, the purpose of the research was to understand the organizational structures, governance and objectives of the social enterprises, and the Chief Executive was in the best position to be able to provide such information. Interviews were undertaken over the phone, recorded (with permission from participants) and transcribed verbatim.

All social enterprises were based in England but covered a diverse range of locations, including cities and rural areas. Most (10 out of 11) were established under Right to Request in 2010 or 2011 and all took the legal form of a Community Interest Company (CIC). The social enterprises involved in the research represent a diversity of services, including GPs, wellbeing, primary care for excluded groups and community services. Over half (7 out of 11) are community services which is representative given that community services were the

most common type of service to establish under Right to Request. The organisations ranged in size from 40 to 1300 members of staff.

Insert Table 1

The interviews aimed to cover the various aspects of publicness as identified in Anderson's (2012) publicness framework (see Fig. 1). The questions represented key indicators under each of the dimensions of publicness: core, dimensional and normative. Data analysis then coded the material within these dimensions. The qualitative data analysis employed a thematic approach that looked to identify commonalities and differences within the data. Fereday and Muir-Cochrane (2006) describe how thematic analysis represents a search for themes that emerge as being important to the description of the phenomenon. The process involves the identification of themes through "careful reading and re-reading of the data" (Rice and Ezzy, 1999: 258), where the emerging themes become the categories for analysis. Here, our analysis was most closely aligned the deductive a priori template of codes approach outlined by Crabtree and Miller (1999). This involved using the dimensions of publicness put forward by Anderson as a template (or 'code book'). The analysis read the data and associated particular passages of text with the publicness dimensions being used to form various codes which were applied as a means of organizing text for subsequent interpretation.

The research was conducted under the ethical guidance of the host University. All interview data collected from participants was treated with confidence and reported anonymously. All participants were fully informed of the research content and purpose and offered the right to withdraw.

Findings

The results of our interviews identified a variety of perspectives concerning the nature of publicness within healthcare social enterprise spin outs. The following section presents

these findings organised around the three elements of Anderson's (2012) publicness framework: core, dimensional and normative.

Core Publicness

To answer the first research question, we asked each of the social enterprises about their core publicness i.e. their organisational form and sector. All of the participants defined their organisation form as being a 'social enterprise' and their ownership or legal status as a Community Interest Company (CIC). However, when asked about which sector they were located within (public, private or third sector), they communicated considerable ambiguity and in many ways confusion:

It's a combination, isn't it? It's a combination of probably all three... To see it with the NHS, and now as a social enterprise, it's... I don't know. I don't know how to answer that one, actually. (SE1)

As is common within third sector studies in particular (Macmillan 2013), one means of responding to this lack of clarity was to define their sector as not being either private or public (and therefore the one that was left):

It is a third sector organisation, I mean, it's not an NHS body, it's not a for-profit, so by default it has to be a third sector organisation really (SE2)

Another interpretation was to draw upon or devise another type of sector altogether – the independent sector. The below quote suggests that 'sector ambiguity' left some organisations feeling excluded from the public and third sector, yet keen to avoid perceived negative inferences that could be drawn from inclusion in the private sector:

I don't see it as a public sector organisation and I don't see it as a third sector organisation...I suppose we're a private sector organisation, we're an independent, I'm likely to say probably independent sector organisation. (SE3)

This reluctance to see themselves as being part of the private sector was a common theme, although a number of participants reported that their organisations were willing to develop closer working ties with the private sector in order to exploit new opportunities. The reasons for doing so were in part pragmatic, in that the private sector were perceived to have access to funding and change strategies that could not be easily accessed through other routes. The ability to align with different sectors was seen as providing a competitive advantage if being part of the public, private or third sector created opportunities to access different funding and support options:

Depends who we're talking to, if I'm honest... when we're talking to the commissioners, when we're talking to partners... I do want to see us as still pretty much of, still part of an NHS family...And when we're in third sector provider forums it feels very much as though we're working together with them relating to commissioners. So we're a bit promiscuous and a bit two-faced. (SE5)

The added benefits of these enterprises being potential boundary spanners (or in the words of one participant 'the glue between all the different sectors') were seen not only for the organisations but also for the broader community in that they could broker new partnerships and so lever in additional funding to the local area.

I think there are some real opportunities...in terms of having relationships at local level with people who are looking at local need. And I think being a social enterprise, because we can be a bit flexible and because we can use our surplus ourselves...we can actually use that in partnership to look at investing in the community or investing in initiatives that might help expand capacity in the community (SE6)

Dimensional publicness

To answer research question two, we asked each of the social enterprises about the extent to which they are subject to economic and political authority (dimensional publicness).

Economic authority

To explore economic authority i.e. freedom to make financial decisions (Anderson, 2012), we focused on ownership rights, profit motivation, raising of capital, and retention of financial surpluses (Anderson, 2012). We also considered their freedom (or not) to decide on the pay and financial incentives structure for staff.

The Right to Request process meant that the social enterprises could not own any of the buildings in which they were based, and therefore, from the outset, economic authority over key assets was restricted. That said, participants reported that they had considerably more economic authority than they had in the public sector, as they were now able to diversify income streams beyond the public sector and had the option to raise capital from any available source that would be willing to loan to them (although this was restricted due to their lack of physical assets). Whilst they remained reliant on their initial NHS contracts, all interviewees felt that being independent meant that they could expand into new areas (geographical, services and patient groups) and develop partnership arrangements with other organisations, including private healthcare and service delivery companies:

I'm not financially tied to the NHS in terms of having to seek approval for what we do... Or to the local authority or anything like that. We're an independent business so we, financial decisions that we take are decisions based on, are commercially constructed, which means that we can do things a lot quicker. (SE3)

Furthermore the need to use their enhanced financial freedom to generate a surplus was described as core to the organisational strategy for growth, and also to being able to deliver service improvements through reinvestment in services, staff and the community:

Well, we have to make profit to make it a viable organisation.... When you say it's a not-for-profit organisation, I always found that that was the wrong wording because you have to be profitable to be a viable organisation and take it forward and expand and improve on the services that you're providing. (SE1)

In relation to changing their cost base, most of the organisations had retained the 'NHS Terms and Conditions' even though these can be seen as more favourable than that which would be available to staff working in similar services in the private or third sectors. Despite that lack of change to date, all of the interviewees underlined that they had the ability to determine their own wages and financial incentives for staff and most planned to review these at some point in the future to ensure that they were sufficiently flexible and would enable them to be competitive:

We're looking to see whether or not we could go down a more market rate approach, rather than a national set of terms and conditions (SE6)

From the interviews it would seem that spinning out had increased their financial autonomy; something that was seen as positive as it opened up new opportunities for growth and efficiency. However interviewees also talked about the negative side of increased economic autonomy as they were required to take full responsibility for their survival. Unlike their previous arrangements in the public sector, these services (and perhaps more pertinently the managers responsible for them) could not look to the public sector to provide a financial safety net:

If you overspend you're bust, you've got nobody to bail you out. (SE7)

Furthermore, their current dependency on public sector contracts meant that this financial freedom was vulnerable to changes in public sector contracting. The move to awarding large contracts to lead providers was seen as a particular issue:

What would cause me huge difficulty is if, as appears to be the case at the moment, the government starts wrapping contracts up in much larger amounts and then makes it easier for Virgin and Care UK and other [private providers] to win them rather than...local providers. (SE8)

Political Authority

Political authority i.e. the extent to which the organisation is subject to government control (Anderson, 2012), is indicated here by resource publicness (reliance on government funding) and communications publicness (level of contact between government officials and employees of the organisation).

As indicated above, all of the social enterprises interviewed were heavily or totally reliant on government contracts. Furthermore all were registered with and registered by the Care Quality Commission. This means that the public sector continued to have a strong influence over what services were provided through determining what would be included in the contracts and the standards that were delivered:

And so one way in a sense you're very free because you decide... you know, in a way you decide how you want to invest your money, you decide how you want to pay your staff, but on the other side of that, as you said, you're largely funded by the public sector therefore almost by default they have an influence over the organisation because they are your main funders. (SE2)

In fact, if all government contracts were taken away, most of the organisations felt they would not survive as a social enterprise, again indicating a high level of potential power for the public sector. This reliance on government contracts also led to organisations being affected by local and national policy changes. This includes the effects of public sector cuts which meant fewer contracts available, especially in areas not deemed as essential public services. Furthermore, policy shifts since the Health and Social Care Bill created 'huge uncertainty' for these social enterprises. Despite this continued public sector influence, most felt that since becoming a social enterprise they had been 'liberated' from state bureaucracy and restraint. This came from the ability to seek funding from elsewhere (although at this stage most were not), as well as an increased role of staff and service users in organisational processes:

It feels different because we are an organisation in our own right and so can flex our muscles a bit." (SE7)

To further strengthen their political autonomy there was a strong desire amongst the respondents to diversify income sources both within and away from the public sector:

So we are diversifying our income base. For example, we've got a target this year to generate 15% of our income from private sector workplace services so that's one of our key challenges, is to shift out of areas where the government... you know, and capricious decisions by government can substantially impact on your financial viability. (SE8)

Normative Publicness

To answer the third research question, we asked each of the social enterprises about their normative publicness which refers to the extent to which they express attachment to public (or private or third sector) values and objectives (Moulton, 2009). Indicators used here are the extent to which employees believe that the service is part of social welfare, if it could be suited to private provision or if citizens should have to pay for the service (Anderson, 2012; Antonsen and Jorgensen, 1997). Our interviews suggest that the leaders' themselves, and in their view also their staff group, continued to hold what they interpreted as strong public sector values.

I think that it's the NHS ethos that is still within all our staff. (SE7)

Most of those interviewed expressed a desire to retain what they saw as the positive benefits of NHS values:

We've not really tried to change values...we've tried to retain things like, obviously, putting the patient at the centre and, you know, the importance of teamwork and partnership working with other members of the health community and all of that. (SE4)

Furthermore they commonly reported that spinning out enabled them to better put these values into practice as the previous bureaucracy within the public sector led to inflexible working practices and limited opportunities to engage with staff and patients:

Before we became a social enterprise, we had very strong values but they were always very restricted with the organisation that we worked for. (SE9)

Their organizational values were also described as being distinct from that of the private sector, and that this value base would result in them behaving differently despite a shared need to make a profit:

What we give to our community and the time we spend with our community goes far beyond what a private provider would do. (SE1)

Whilst there was a recognition that the services delivered by the social enterprise could be (and sometimes were) delivered by private companies, interviewees felt that private sector values around profit making and cost-cutting would lead to them largely ignoring disadvantaged and hard to reach groups that are more difficult and therefore expensive to reach. This again highlighted an assumption regarding the characteristics and behavior of the private sector:

So I think the difference between us and the private sector is, if you rock up to my services, even if you're not in the criteria for what our service is supposed to do, I will try and ...find a way to address your problem or put you in the right place or whatever. If I was Virgin Healthcare I would simply say, "This isn't in my contract". (SE10)

Discussion

The Right to Request policy facilitated the transfer of English community healthcare services from the NHS to social enterprises and in doing so enabled the new organisations to take on the perceived strengths of different sectors. The picture that emerges from these findings suggests that those leading the transfer believe that they are 'less' public than when they

were in the NHS. However, the majority saw them as retaining some features of a public organisation as well as adopting those of third sector organisations. They were less comfortable in being seen as exhibiting private sector characteristics although it was recognised that this could provide a route to additional funding and resources. Rather than aligning with a particular sector, these organisations were described as having embraced elements of each, adding further weight to the conclusion that social enterprises are very much 'hybrid' organisations (Allen et al, 2011; Billis, 2010; Battilana and Lee, 2014), located at the intersection between the third, public and private sectors.

This 'hybridity' appears to bring with it both advantages and disadvantages. Advantages include the ability to be more flexible (i.e. take the approach that works for the organisation rather than the sector) and as such be able to make the most of any potential partnerships and opportunities (Hazenbergh and Hall, 2014). Indeed at times these organisations appear to play on this lack of clarity through adapting their sectorial affiliation in response to the audience and opportunity with which they were engaging. Not being part of the public sector also brings potential opportunities as a result of increased economic authority including the ability to borrow money, seek new business opportunities, change the terms and conditions of their workforce and decide how to use any profit.

The disadvantages come from the uncertainty of not belonging anywhere which potentially brings with it low levels of trust from external stakeholders who may not know how to engage with these new organisational forms. Furthermore, their political authority remains limited due to their financial dependence on the state and requirements to meet certain standards and targets. Therefore, social enterprise spin outs are still significantly public, especially in relation to their funding which for many comes wholly from public sector contracts making them especially vulnerable to policy and legislation changes. In addition, as providers of public healthcare, they remain bound by political control and are subject to government decisions over their participation in the NHS (Allen et al, 2011). Furthermore, whilst they have the economic authority to change staff terms and conditions, the danger in doing this is that staff may leave to go back to the public sector. This ongoing 'publicness' therefore makes these organisations vulnerable and limits their ability to develop their own distinct characteristics and practices. Right to Request was designed to unleash public sector entrepreneurship and innovation (DH, 2006a); however, our findings suggest that such

innovation is being constrained as a result of an ongoing publicness. It is however important at this point to remember that the organisations are still in their infancy, and all of them were seeking alternative funding sources to both improve their financial sustainability and provide greater political autonomy.

This leads us to the issue of normative publicness and conceptions of public sector values. Whilst it has been argued that being subject to market competition and profit-making can erode public sector values i.e. market values are substituted for public values (Jorgenson and Bozeman, 2002), these social enterprises have sought to retain (and even strengthen) these values. This is the key area in which social enterprise spin outs reject any allegiance to the private sector. They seemed to generally express a scepticism regarding the motives and priorities of the private sector – this may reflect their many years of service within the public sector and their current need to convince others (and in particular their funders) of their unique distinctiveness.

This is the first paper to provide empirical evidence of publicness within social enterprises. Whilst our research is focussed on a specific sub-set of social enterprises i.e. NHS spin outs, and therefore a particular type of public service delivery, the findings do have important implications for debates around publicness. To date, publicness theory has been based on binary distinctions between the public and private (Allen et al, 2011). Within the context of public service marketization (Eikenberry and Kluvert, 2004) leading to a more prominent role of the third sector in the delivery of public services, we argue that ‘publicness’ debates need to evolve. As such, we suggest the need to develop and refine publicness models to take into consideration the hybrid nature of public service delivery that include the public sector, private sector but particularly the third sector or civil society (however this is labelled).

The recent work of Tenbenschel et al (2014) represents a case in point in highlighting the scope and possibility of extending a notion of ‘third sectoriness’ in the degree to which third sector organisations such as social enterprise can retain their distinctiveness. These authors and others (e.g. Millar 2012) highlight how third-sector organizations that deliver publicly funded health and community services are increasingly shaped by the accountabilities of government funders. The implication of these authors’ findings and our research support

the view that further research is needed in providing ways of understanding and conceptualizing third sector accountability. Tenbensen et al (2014) provide an important contribution in this regard however further work is needed to identify and design new ways of making sense of these new accountability (or in publicness terms political and economic authority) arrangements.

On the other hand, perhaps the most striking finding from the study is that interviewees believed that they did not have to be bound by the characteristics of a particular sector, and that they could choose to align themselves with the public, private or third sector as they saw most relevant for different challenges and opportunities. This could be seen to undermine the importance of studying sectors at all – if it is possible to ‘pick and mix’ then this arguably questions the centrality of sector as a defining feature of an organisation. Therefore the trend for such organisations to become ‘hybridised’ (Billis, 2010), can be interpreted as a move away from publicness or even ‘sectoriness’ altogether.

Conclusion

This perspective on publicness provides new insights into emerging social enterprise organisational forms within healthcare. It has shown how core, dimensional and normative dimensions of publicness can be applied to better understand the organisational and political landscape within which they are operating. However, the findings have indicated that current conceptions of publicness and privateness need to be revised to show greater sensitivity and recognition to the third sector as part of this space. Publicness frameworks to date tend to represent a simple linear understanding of publicness and privateness, and so also need to recognise that organisations can take on elements of all three sectors and even potentially move between the different sectors.

Our research only refers to social enterprises that have spun out of the NHS and therefore cannot be generalised to all social enterprises that may operate within different environments and those which have a different starting point and history. For example, a social enterprise which began as a small scale voluntary endeavour may have a different perspective than one which has been created from the public sector through a particular

policy initiative. We also only present a small sample of case studies which are further limited to the perspectives of those in senior positions whose experience and opinions may not match that of other staff. As such, we suggest that further empirical research is needed to encompass a wider range of perspectives such as wider staff groups and service users, as well as further work to develop conceptual and theoretical perspectives. This study also does not enable us to comment on arguably the most important issue; how the behaviour and impact of spin-outs has changed following their externalisation from the public sector. Such organisations remain relatively young and therefore long term impacts on staff, service users and the wider healthcare environment are difficult to ascertain. These are however important issues that need to be explored in due process to inform future policy making in health care and other areas of public service

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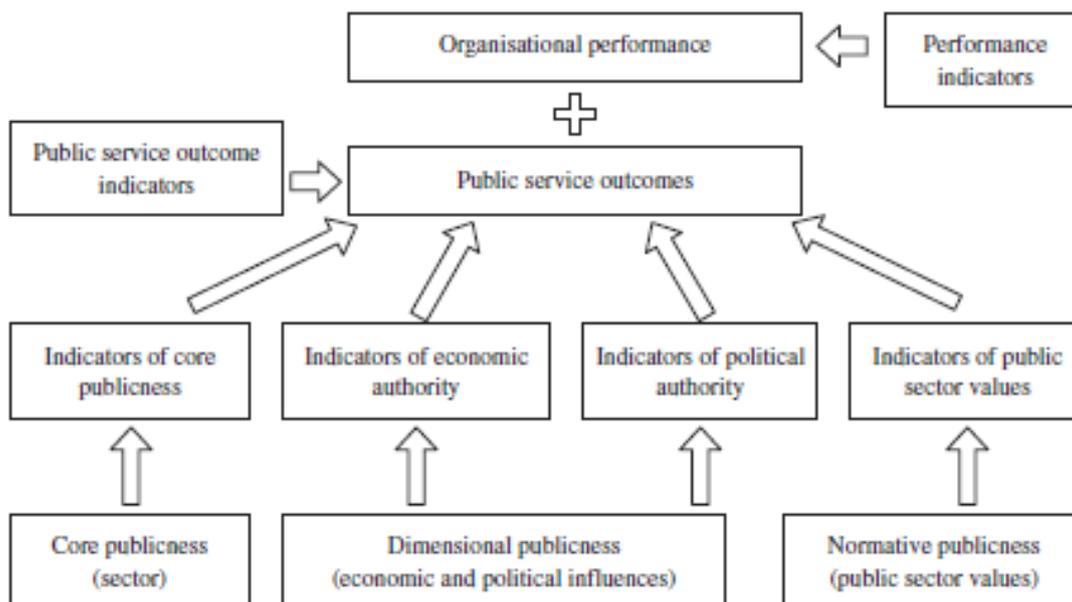


Fig 1: A 'Publicness' Framework (taken from Anderson, 2012)

Table 1 – Participant Organisation Characteristics

Service	Location	No of Employees	Year Established
Wellbeing	Urban	92	2008
GP	Urban	40	2010
GP	Urban	50	2009
GP	Rural	56	2011
Community health and social care	Rural	1200	2010
Community health and social care	Rural	1100	2011
Community health and social care	Urban	1100	2011
Community health and social care	Rural	700	2011
Community health and social care	Urban/Rural	700	2011
Community health and social care	Urban	1300	2011
Community health and social care	Rural	550	2011