Social enterprises, health-care provision and ethical capital

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Abstract

Purpose – The aim of this paper is to advance a conceptual understanding of the role of social enterprises in health care by developing the concept of ethical capital. Social enterprises have been an important part of both the coalition and the previous government's vision for improving health-care delivery. One of the central arguments for increasing the role of social enterprises in health care is they can provide the benefits of a public service ethos with the efficiencies and innovatory strategies of a business. Social enterprises are well placed to promote the type of values that should underpin health care delivery.

Design/methodology/approach – This paper explores the conceptual issues raised by using social enterprises to provide health-care services that were previously provided by the National Health Service (NHS) from an ethical perspective.

Findings – It will be argued that conceptualising social enterprises as organisations that can and should produce ethical capital could be a useful way of developing the debate over social enterprises in health care.

Practical implications – The paper provides suggestions on how ethical capital might be produced and monitored in social enterprises.

Originality/value – This paper advances the debate over the use of the concept of ethical capital in social enterprises and explores the relationship between ethical and social capital – both under researched areas. It also contributes to the emerging discussions of social enterprises in current health policy and their role in the radically reformed English NHS.

Keywords Social capital, Health policy, NHS, Social enterprises, Health-care reform, Organisational ethics

Paper type Conceptual paper

Introduction

Health-care policy in the past 30 years has concentrated on introducing market mechanisms into the National Health Service (NHS): first by the creation of an internal market, and then by opening up the NHS to outside providers. The creation of a split between commissioning (buying) services and providing them is now entrenched in the English NHS and the provision of health care by non-NHS providers is a key feature of the current health-care system. Social enterprises have been an important part of both the coalition and the previous Labour Government's vision for improving health-care delivery. Two key pieces of legislation give impetus to the expansion of social enterprises' increased involvement in health-care provision: the Health and Social Act 2012, that has the policy goal of creating competition between providers of health care at its heart and the Public Service (social value) Act in 2012 that stipulates that commissioners of public services should consider the added benefit to the community of purchasing decisions. The stage is set, at least in theory, for social enterprises to play an increasingly important role in health care in England.

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The introduction of providers from outside the NHS, be they private/independent, third sector or charitable organisations, has not been uncontroversial. The NHS is a much loved institution, and the moves to increase non-NHS provision have been seen by some as privatisation by the back door (Mohan, 2009). Pollock and Price, 2011). One of the central arguments for increasing the role of health care social enterprises is that they are able to provide the benefits of a public service ethos with the efficiencies and innovatory strategies of a business (Department of Health, 2006) – and are well placed to promote the type of values that should underpin NHS provision (DH, 2008).

This paper explores the issues raised by using social enterprises to provide health-care services that were previously provided by the NHS from an ethical perspective. Although there is no generally agreed definition of a social enterprise, most definitions include reference to some form of social purpose. The definition adopted by the UK Government is:

> Social enterprise is a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or community rather than being driven by the need to maximise profit for shareholders or owners (Department of Trade & Industry, 2002).

This definition does not include any specific requirement for any particular organisational structure:

> Social enterprise is not a legal form in itself; it is what a business does with its profits rather than its structure, which defines it as a social enterprise […]. What all social enterprises share is an enterprising, innovative, business-based approach to achieving social and environmental aims (Department of Health, 2011, p. 10).

As has been noted in the literature there is important work to be done on theory construction in social enterprise research (Haugh, 2012), and this paper seeks to contribute to this development. The structure of the paper is as follows: first, the policy changes that have led to social enterprises becoming an important part of recent health policy will be outlined, and then how social enterprises can bolster the values that, it is argued, should underpin the delivery of health care will be considered. To provide a conceptual understanding of the role of social enterprises in health care, the concept of ethical capital will be used. It will be argued that conceptualising social enterprises as organisations that can and should produce ethical capital could be a useful way of developing the debate over social enterprises in health care. Finally, suggestions for how ethical capital might be produced and monitored in this environment will be considered.

Health-care policy and social enterprises

Health policy over the past 30 years has created a fundamental split between commissioning and providing health-care services (Mohan, 2009). This has resulted in an NHS that is very different from the organisational form of the NHS in its early days that was partly designed to overcome the patch work of health-care providers and bring them together in a cohesive system of provision (Dropson, 2009). Social enterprises have been one of the central elements of both this and the last government's drive to encourage the third sector provision in health care (Department of Health, 2006; Department of Health, 2010). The last Labour Government created the Government Office for the Third Sector in 2006 and began initiatives to actively encouraged third-sector providers in health care. This involvement was seen as a solution to the perceived problems with public service delivery: rising costs, lack of flexibility and local

responsiveness, lack of innovation and lack of public and staff involvement (Kelly, 2007). Various policy documents, such as *Our health our say* (Department of Health, 2006), encouraged NHS staff to set up their own businesses in the form of social enterprises to provide services. In 2006, the Social Enterprise Unit at the Department of Health (DH), to give NHS staff guidance on issues, such as pensions, employment conditions and business skills, was set up and a Pathfinder Programme was also established to give new and existing social enterprises funding and specialist support. Both these initiatives aimed to encourage NHS staff to "spin out" and set up social enterprises to provide NHS services (Hall *et al.*, 2012). In 2007-08, the Social Enterprise Investment Fund was created with a pool of £100 million to be used over a four-year period (Alcock *et al.*, 2012). In 2008 the Darzi review, *High quality care for all* (Department of Health, 2008), argued that health care should be more locally led and that front-line staff should have more involvement in decision-making and in the actual running of services. The creation of employee-owned social enterprises to deliver health care was promoted by introducing the "Right to Request" in 2008 (Department of Health, 2008) which enabled NHS staff to put a case for setting up a social enterprise to their Primary Care Trust. It is estimated that the Right to Request generated 61 proposals for staff to take over services, which will "transfer an estimated £900m of services and almost 25,000 NHS staff into the social enterprise sector", with the government committing an additional £4.4 million to the Social Enterprise Investment Fund (Department of Health, 2010). The National Audit Office estimated that 0.9 billion of public services would be provided under the Right to Request by the end of 2011 (NAO, 2011). At current figures there are approximately 40 social enterprises operating that have been created under the Right to Request (Cabinet Office, 2012).

When the coalition government was elected in 2010, it put forward its proposals for the NHS in *Equity and Excellence: Liberating the NHS* (Department of Health, 2010). This outlined extensive changes in the interaction between non-NHS providers and the NHS. The 2012 Health and Social Care Act aims to encourage a more market-orientated approach to health-care delivery, by reforming provision and commissioning. This reform builds on the existing mechanisms to extend the use of providers outside the NHS. The central aim of this diversification of providers is to increase patient choice and stimulate competition. Commissioning reform will affect how health care is commissioned (bought) by creating a national NHS Commissioning Board, recently renamed NHS England, an independent arms length body, which will commission some services directly and hold contracts for general practitioners (GPs) to provide primary care. However, the bulk of commissioning will be done by Clinical Commission Groups (CCGs) which will be made up of GPs and other clinicians (overseen by NHS England) that will have responsibility for commissioning services for their local populations – replacing Primary Care Trusts and Strategic Health Authorities – to give more local control and be more sensitive to market mechanisms (Roland and Rosen, 2011).

These provider reforms involve setting up mechanisms to extend the use of the private and third sectors in providing health care. Under the "any qualified provider" initiative (NHS Confederation, 2011) patients will be able to choose where they get their care from a range of providers from different sectors: commercial, third sector and the NHS. The central aim of this diversification of providers is to increase patient choice and stimulate competition, with the regulatory body monitor having the role of preventing anti-competitive behaviour (Ham, 2013). The coalition government has also continued

the previous government's encouragement of NHS staff creating social enterprises to deliver services that were previously provided by the NHS. Andrew Lansley, when he was the Health Secretary, said that he wanted to transform the NHS into the largest social enterprise in Europe. This administration has replaced the Right to Request with the Right to Provide.

> The Right to Provide supports and enables staff working in health and social care to ultimately develop staff-led enterprises to deliver more flexible and responsive services, whilst having ownership and real influence in the way the service develops (Department of Health, DH, 2011, p. 7).

According to the latest figures from the Cabinet Office, (June 2012), there are seven social enterprises in health and social care operating under this scheme (Cabinet Office, 2012a)[1]. With these policy initiatives, it is clear that the path is set, at least in theory, for social enterprises to play a much bigger part in health-care delivery in England.

Social enterprises in health care

There are a number of features of social enterprises that have led them to be seen as attractive options for providing health care: employee ownership, more active involvement of staff in organisational decision-making, tackling unmet need, boosting social inclusion and being responsive to local needs (NAO, 2011, p. 11). The developing interest in social enterprises in health care has happened alongside an increasing focus, in health-care policy debates, on what values should underlie health care provision and how these should be promoted.

The development of a "third way" between private and public provision was thought to be able to combine the benefits of private enterprise (innovation, entrepreneurship and flexibility) and the public sector (ethos and public interest) (Giddens, 1998). One goal of social enterprises in health care is to be able to deliver better services without sacrificing the public service ethos and the core (ethical) values of the NHS (Hall *et al.*, 2012). As the Department of Health has said: "because social enterprises share the same public ethos as the NHS, all surplus is reinvested back into the communities they serve[2] meaning the most efficient use of public funds " (Department of Health, 2010a).

The importance of holding on to some form of public sector ethos and recognising that health care is an inherently value-driven endeavour is implicitly recognised in the recent policy focus on health-care values – the values that underpin health-care delivery. Values in this context is often defined as "conceptions of the morally desirable" (New, 2002). Greer and Rowland (2007) argue that "values talk" is becoming more predominant in health due to the new reforms and reconfigurations of the health service and the increasingly devolved nature of UK politics, as they put it, "the language of health politics is the language of values" (2007, p. 14). This focus is not confined to the UK, the EU White Paper, *Together for Health* (2007) contains a section on the appropriate underlying values of health-care provision: equity, solidarity and participation and has recommended that member states adopt a "Statement on fundamental health values" (European Union, 2007).

Lord Darzi's review of the health service in 2008 gave a focus to this consideration of the values that should underpin healthcare delivery. The review addressed what the future model of care should be in the NHS, and one aspect of this was to consider the core values and principles that should guide health-care provision in this sector. "To provide high quality care for all, the NHS must continue to change. But the fundamental purpose,

principles and values of the NHS can and must remain constant" (2008, p. 77). This consideration of values was a recognition that health-care reforms, with the diversification of providers, could fragment a previously coherent system and that this could threat the core common purpose of the NHS. Lord Darzi proposed that the NHS should have a constitution to ensure that these values "are enshrined and protected" (Department of Health, 2008), and the first NHS constitution was published in 2009:

> As the NHS evolves, a wider range of providers, including those from the third and independent sectors are offering NHS-commissioned services. Patients expect that wherever they receive their NHS-funded treatment, the same values and principles should apply. All organisations are part of an integrated system for the benefit of patients. That is why we will set out the purpose, principles and values for the NHS in the Constitution. We propose that all organisations providing NHS services are obliged by law to take account of the Constitution in their decisions and actions. (2008, p. 78).

The Health Act 2009 stated that all bodies (from all sectors) providing NHS services must have "regard" for the constitution in all their actions and decisions, and the 2012 Health and Social Care Act places similar duties on NHS Commissioning Boards and CCGs. The NHS Constitution has a high prominence in all NHS documentation and was recently updated in 2013.

The challenges of a changing health service are recognised as producing the need for a clearer focus on values that can hold an increasingly fragmented and devolved health service together (Institute for Innovation and Improvement, 2008). These concerns have developed alongside the increasing interest in creating and involving social enterprises in the delivery of NHS services. Social enterprises are seen as an ideal form of organisation to take this ethos and promote the social and ethical values that might otherwise be lost in a health service increasingly characterised by market relationships and independent for-profit providers. However, although there has been substantial consideration of how social enterprises might produce social benefit (Ridley-Duff and Bull, 2011; Nicholls, 2006) and the difficulties with how performance can be measured (Paton, 2003), less attention has been paid to how social enterprises can foster ethical values and the relationship between these and social capital.

Conceptualising social enterprises in health care

Given the obvious need, in this current policy climate, for greater attention to be paid to the underlying values of health-care provision, considering how social enterprises can promote the kind of values set out in the NHS Constitution and other policy initiatives, is another way of showing the utility of social enterprises as health-care providers. In this section, I want to consider how this production of values can be conceptualised. First, I will consider the concept of ethical capital as a way of theorising this kind of value production, and then I shall consider in more detail how this notion of ethical capital can be applied to health-care delivery in the UK.

Ethical capital

There is not, as yet, a great amount of literature on ethical capital as a concept or in relation to social enterprises, and Bull *et al.*'s (2010) paper begins a dialogue over the use of this concept for social enterprises. They highlight a central problem with current conceptualisations of social enterprises that there has been a focus on the economic model of market transactions that privileges profit maximisation as the central goal.

They argue that the social enterprise movement could be in danger of giving up its radical social change agenda, in favour of becoming competitive businesses operating within a market ideology. One way of wresting social enterprises back from traditional market formulations is to explore the value of fostering ethical capital. Ethical capital can broadly be defined as "mobilising moral values" (Bull *et al.*, 2010, p. 252). They argue that society has a problem of "low ethical virtue" and that there is a paradigm shift towards the more ethical operation of businesses and a desire to rethink the "driven purely by profit" business model:

> If the social enterprise movement can widen the conceptualisation away from business and revenue to one that incorporates a view of fostering ethical capital this might help re-frame and achieve radical change (2010, p. 261).

This taps into the supposed paradigm shift in the corporate world, with a greater focus on social responsibility, "the industrial era is being replaced by the compassionate era, which will be based on a profoundly different set of values" (Theobald, quoted in Gupta *et al.*, 2003).

To explore the concept of ethical capital, Bull *et al.* (2010) draw on the work of Wagner-Tsukamoto. Wagner-Tsukamoto's aim is to argue for business ethics on economic grounds – being ethical can be cashed out in terms of increased profitability, "morality is approached as an economic asset, as *ethical capital*. Ethical capital reflects the 'price' a morally minded consumer, employee, investor or other agent puts on active moral agency" (Wagner-Tsukamoto2005, p. 82). This is a critique of the classical and neo-classical view that ethics is eliminated from economics and, in a later paper (Wagner-Tsukamoto, 2007), he casts this as a reconstruction of Milton Freidman's theorem that the only social responsibility of firms is to increase profits, while operating within the legal and ethical customs of that business. Wagner-Tsukamoto argues there are three levels of moral conduct that can be attributed to businesses. Level one is passive unintended moral agency, where the business might produce ethical goods (such as increasing the standard of living or providing employment) simply by going about their profit maximising business; the ethical outcomes are unintended and just a fortuitous consequence of their business activities. Level two is passive intended moral agency in which ethically good outcomes are produced by businesses following the minimum legal requirements and ethical customs. These might be rules against deception and fraud and laws against neighbourhood effects, such as pollution. Here, businesses are subject to laws that promote a greater concern for wider context in which the business operates. For Friedman, corporate social responsibility was limited to these two levels, any other acts that might foster good social or ethical outcomes would adversely affect profitability and therefore should not be undertaken by the business – the economic cost of being ethical was too high (Friedman, 1993).

Wagner-Tsukamoto introduces a third level, active intended moral agency, and this is where ethical capital is created. At this third level of moral agency, economically it is in the business's interests to do things outside the immediate remit of profit maximisation: "Ethical capital indicates an agent's economic willingness and resourcefulness to pay for moral agency of the firm that exceeds standards laid down in laws" (2007, p. 213). Friedman thought that any additional ethical actions by the business would be too costly in economic terms, i.e. paying employees a decent wage. However, what he did not see (and Wagner-Tsukamoto says this is understandable,

given the time he was writing and arguably the theories of choice behaviour used by economists) was that, "some customers, employees or stockholders might be happy to 'self-tax' themselves in order to enact their ethical decisions" (2007, p. 213) – customers would be prepared to pay more for products that were "ethical". This, "allows for the integration of moral judgment with corporate strategy and the pursuit of competitive advantage and profit maximisation" (2007, p. 214). By acting morally the business is creating ethical capital, something that can be traded, in terms of commanding a higher price (such as Fair Trade products). This is a commercial conception of ethical capital, businesses can sell their ethical products for a higher price and either make a greater profit margin or not be penalised for acting ethically (i.e. charging more for garments that have been produced by factories that do not use child labour) and attract customers who want to purchase "ethical" goods.

Bull *et al.* argue that Wagner-Tsukamoto's formulation can be extended beyond this third level of moral agency (where ethical capital is created solely for economic gain) to a fourth level where ethical capital is actively created rather than solely for profit maximisation[3]. "Profitability is an important but secondary goal, a by-product of ethically informed action" (Ridley-Duff and Bull, 2011, p. 96). In Wagner-Tsukamoto's conception of ethical capital, the goal is to achieve profit maximization and creating ethical capital is one means to do this. Whereas, in Bull *et al.*'s extension of ethical capital to a fourth level, economic success is a means to ensure the provision of ethical capital, active moral agency is an end in itself. The exact relationship between creating economic value and sustainability and the creation of ethical capital, which should take precedence and what the ultimate goal of the enterprise is, will be discussed below.

The relationship between ethical and social capital

To further elaborate on the concept of ethical capital it is useful to consider its relationship to another form of capital, social capital, which is often cited as a key benefit of social enterprises (Evers, 2001; Laville and Nyssens, 2001). It can be debated whether ethical capital is a distinctive concept or is best seen as part of social capital, and the discussion here will concentrate on the relationship between social and ethical capital rather than the wider debates over definitions, manifestations and applications of social capital. One view of social capital is that it is a morally neutral resource that is about social relationships and networks: social capital is seen as something that can be used for good or bad ends and have good or bad implications (Adler and Kwon, 2002), something that would be true for all forms of capital. The negative effects are sometimes been called the "dark side" of social capital (Field, 2003; Ayios *et al.*, 2010). Gupta *et al.* (2003), however, argues that the concept of social capital has to include some ethical dimension or it is not properly social capital. The Mafia for example have trust and close bonds – a form of social capital – but for Gupta, if social capital results in bad consequences, increased transaction costs for the poor, for example, then it is not social capital. In this vein, Preuss (2004) argues that discussions of social capital incorporate an implicit normativity and that social capital has become seen as the positive consequences of social relationships and networks rather than simply descriptions of sociability (Portes, 1998). Putnam (2000) exemplifies this for Preuss, with his analysis of modern America and the ills he lays at the door of the loss of social capital. Preuss argues that discussions of social capital need to recognise this normativity and bring it to the fore in analysis. This should be done by using an ethics test to consider: "whether it is

ethical for an individual to leverage his or her social capital in a specific situation […] [and] whether the use of social capital in any given situation is good for the society to which the individual belongs" (2004, p. 158). This is important not just to see the consequences of the application of social capital, but because inherent in the concept is a conception of the morally right way of mobilising social capital, which the social capital theory cannot determine a priori.

It can be argued that there are two conceptions of social capital here. The first is a formulation of social capital as a morally neutral resource; and second, one that incorporates within the definition, some notion that this capital will be used for the common good (i.e. Gupta's conception). The second definition of social capital is one that produces ethical capital by the mobilisation of social relationships, networks, bonds, etc. There is a blurring here of the concepts of social capital, in its second formulation and ethical capital. Gupta says:

> […] that trust accompanied with reciprocities in a social network bound by pursuit of a common good in the larger social interest does constitute social capital. However, when this good is pursued through ethical means and for non-sectarian interests, one could argue that it constitutes ethical capital (2003, pp. 978-979).

Therefore, if the second definition of social capital is taken, elements of social capital could be placed within the concept of ethical capital, such as initiatives that seek to promote the common good and the flourishing of individuals or society by mobilising social. In this way, it could be argued that ethical and social capital overlap. Some forms of social capital will lie within ethical capital and others outside (such as the dark side of social capital, if the first morally neutral definition is adopted), and some forms of ethical capital will be unrelated to social capital (such as personal ethics or legal codes).

How the mobilization of moral values and agency is to be achieved in practice and how to give this broad conceptualisation substance needs further debate (Bull *et al.*, 2010). To start this debate, possible issues with applying the concept of ethical capital to the provision of health care by social enterprises will be discussed in broad terms.

Ethical capital creation in the health sector

While the concept of ethical capital could be a way of counterbalancing the dominant market ideology that currently pervades debates over health-care provision, there are potential issues with using this concept that need further consideration.

The use of the term capital immediately frames the debate in economic terms – capital as an asset, that can be invested in, utilised for economic gain and shapes business models and processes. This use of the term "capital" to refer to mobilising moral agency poses similar problems as it does in the use of the term to analyse social relationships. It is argued that there are significant differences between social and other forms of economic capital – it cannot be traded easily, and social capital is a by-product of other activities, so there is little investment in it directly (Werner and Spence, 2004). Navarro (2002) questions whether capital is an appropriate term to be applied to social relations and argues that it is part of the language of social science being overtaken by economics, and related to "the triumph of capitalism", which forecloses debate on what kind of economic system we want. There has been extensive debate over how social capital can produce economic benefit, by stimulating innovation, knowledge exchange and professional networks (Adler and Kwon, 2002). However, justifying ethical actions in terms of the economic benefit they bring seems more controversial.

Wagner-Tsukamoto's conception of ethical capital explicitly conceptualises the economic benefit of being "ethical" and highlights the economic implications of mobilising ethical values. There is an argument that ethical behaviour is something that should not be instrumentalised; one should do it for its own sake, not as a means to other ends – a type of Kantian argument – making a profit might be a by-product, but it should not be the overriding aim of ethical action. This raises the key question of the relationship between ethical capital and economic objectives and which should be given priority.

This can be seen as a key tension for social enterprises. Conventional commercial businesses aim to make enough money to generate a profit and to sustain the business, whereas, social enterprises, with their dual aims of creating profit and producing some form of social good, need to attend to how these two, possibly conflicting, goals can be managed and balanced. One way of conceptualising ethical capital is that it can be seen as an abstract concept, which motivates the overriding aims of the enterprise. For example, social enterprises might aim to reduce health inequalities in their area – this will be the overriding aim of the enterprise (that is based on the ethical claim that inequalities in health are wrong). The means of reducing such inequalities might be to produce social capital or some form of social value, and this in turn might be supported by the production of economic capital. In this sense, ethical capital becomes the overriding aim and other forms of capital are means of achieving this; profit and economic sustainability are *means* to this end, not ends in themselves. Framing the debate in this way could give a clearer sense of the central purpose of social enterprises so that the non-economic goals are not lost in the push to encourage the third sector, "to adopt the entrepreneurial practices, language and mindsets associated with the private sector" (Baines *et al.*, 2010, p. 50). Allyson Pollock *et al.*'s extensive literature review of non-profits in health care demonstrates that this could be an issue in health-care provision: "The evidence suggests that in a competitive environment non-profit providers behave much like for-profit providers and this has a negative impact on quality of care and staffing levels" (Pollock *et al.*, 2007, p. 7). Conversely Baines *et al.* (2013) argue that there is no one single narrative of social enterprises. In their study, that considered how those working in social enterprises conceptualised the "social" and "economic" aspects of their work, they found many contradictions, paradoxes and ambiguities in this relationship. Therefore, how social enterprises and those working in them manage the dual aims of creating profit and producing social good could depend on the context and individual circumstances of the particular social enterprise.

Mobilising ethical capital can motivate the overriding aims of an enterprise – to provide some form of social and economic benefit to those who are in need. Ethical capital can also be mobilised in the everyday actions of the enterprise – how ethical business and social enterprises behave in their dealings with their stakeholders. In health care, there will be different standards for such encounters; for example, health-care professionals have exacting codes of ethics and we expect a higher level of ethical conduct from them than in other sectors of the economy.

Measurement of ethical capital

If ethical capital is to be a useful concept, then it is necessary to consider how it might be measured. The Department of Health commissioned a research project to determine how social enterprises in health care produced social value (Department of Health, 2010b).

They used the social return on investment analysis and calculated that between £2 and 5 was created for every one pound invested over the five social enterprises they surveyed. Despite the possible limitations of this measurement tool and the debates over how social value is best captured (Paton, 2003), in today's policy environment if such value is to be taken into account, it needs to be measurable in some way. As argued above, if one way of mobilising moral agency (ethical capital) is to incorporate it into the overriding aim of a programme, then this is not something that can be measured in the same way as social value production. For example, Stockport Foundation Trust set up a Volunteer Learning Scheme to give local people the opportunity to secure a permanent post in the Trust by developing their skills through volunteering. This scheme is premised on the claim that the lack of opportunities for some sectors of the population is morally wrong and should be addressed. This ethical stance triggers the overriding aim of the programme, to improve employment opportunities for this group of people. To measure the success of this programme, the outputs can be measured on how many volunteers get jobs and how much social value is produced. Whereas, the aim of the programme cannot be measured in the same way; what the appropriate aims of a programme are and what type of "good life" they wish to promote are matters of debate rather than measurement (Preuss, 2004).

Ways forward

Having considered how values in social enterprises' health-care delivery can be theorised, in the form of ethical capital, how this could be developed in practice will now be discussed.

At a macro and meso level, the production of ethical capital could be encouraged by commissioners acting in compliance with the Public Service Act and ethical capital included as an explicit part of good health-care commissioning. In the health-care market, as it operates in England, the customers of health-care social enterprises (providing services previously provided by the NHS) are not the consumers of the products themselves, but will be predominately commissioners of health care (for instance, the new CCGs). Therefore, it is these groups that need to consider the ethical and social capital that might be produced when considering different service providers as well as financial elements. The passage of the Public Services (social value) Act that requires public sector commissioners to take into account social value when commissioning services could have an important impact.

Social enterprises need support from commissioners, and this has been recognised in the general context of ensuring that social enterprises flourish in this sector (Addicott, 2011; Miller and Millar, 2011; Marks and Hunter, 2007). Without such explicit support, social enterprises may find it hard to establish themselves in this new health environment. There are clearly complex issues to be addressed in enabling social enterprises to be able to bid for public sector contracts, and the commissioning policies and procedures need to be supportive and provide opportunities for long-term contracts (Social Enterprise, UK, 2012; Addicott, 2011). It has been argued that the health-care reforms are not creating an environment where social enterprises and other third-sector providers will find it easy to compete with the large corporations when bidding for health-care contracts (Thiel, 2012). The recent survey by the Social Enterprise UK (2011) has found that this emphasis on social enterprises at a policy level has not been translated into a flourishing involvement of social

enterprises in the public sector market and 61 per cent of those surveyed thought that the government did not take their views into account.

At a micro organisational level, how can social enterprises approach the creation and production of ethical capital? It is increasingly recognised that organisations need to pay attention to the moral dimensions of their practice and the effects their actions have both on internal and external stakeholders (Spencer *et al.*, 2000). Some organisations have implemented organisational ethics programmes that review policies, procedures and actions from an ethical perspective and consider how this aspect of organisational functioning could be improved (Frith, 2013; Fox *et al.*, 2010). In larger enterprises, an organisational ethics programme could be established to coordinate and oversee the production of ethical capital. In small enterprises, such a formal programme is probably not feasible, but such issues could be discussed in general meetings and staff encouraged to be aware of this aspect of their operation. Some areas that could be relevant to the organisational ethics of social enterprises are suggested here, but there are many more that could be examined under this rubric, depending on the concerns of the particular social enterprise. Topics that might be relevant to the organisational ethics of social enterprises are as follows:

- The organisation's general aims and objectives need to be clarified – who they view as their stakeholders; how and whether they involve users of their services in their decision-making; how they might handle the tensions between running as a business and patient care – all can be addressed by an organisational ethics programme. This programme could be part of the organisation's broad approach to strategic management that aims to shape the internal culture and ethos to further the organisation's agreed strategic aims (Jasper and Crossan, 2012). As argued above, it is at the level of deciding on the overriding objectives of the enterprise where the notion of ethical capital can play a key role.
- Issues that relate to the working conditions of people in a social enterprise would be a key area of consideration. The employment conditions of those moving from the NHS to these new social enterprises has been subject to much debate (Marks and Hunter, 2007). Staff moving from the NHS under the Right to Request maintained their NHS pensions under Transfer of Undertakings (Protection of Employment) Regulations. It has been argued that this could cause problems within a social enterprise when employing staff with different pension entitlements (Miller and Millar, 2011) and the employment conditions of later spin outs (Roy *et al.*, 2013). How to manage staff recruited from different sectors with different expectations and employment patterns to ensure that all staff was treated fairly and equitably is something that would need to be addressed. The ethical implications of how an organisation approaches its Human Resource Management could be something social enterprises could develop as part of their social and ethical capital creation (Greenwood, 2013).
- Organisational decision-making processes could also be examined. One of the aims of social enterprises has been to provide internal value – value to those employed. Employee control of resources, organisational direction and the creation of innovative organisational forms have been explicitly stated aims of setting up social enterprises by staff from the NHS. For instance, all Bromley Healthcare employees (that is a community interest company) have one share that gives them a say at the annual meetings. Therefore, how ownership is managed and decisions are made is a key area

for an organisational programme to consider and what form of ownership model is appropriate (i.e. a cooperative ownership model (Teasdale, 2011).

- An organisational ethics programme could consider how a social enterprise handled any profits, as the definition of social enterprises is very broad and could encompass a variety of business forms, there is ambiguity over exactly how much and in what way profits should be reinvested: how social does a social enterprise have to be? In a survey of all social enterprises conducted by the Social Enterprise Coalition, 45 per cent of respondents had the motive of putting something back into the community (Social Enterprise, UK, 2009). Although the study concluded that social and community benefit are key motivating factors for those working in social enterprises, < 50 per cent of respondents expressed these type of "social motivation" goals. In the subsequent survey, 71 per cent of respondents reported reinvesting their profits locally "to a large extent" (Social Enterprise UK, 2011). These issues need to be addressed, and the policies on profits clarified.
- The organisational form of a social enterprise would also be of key importance in how ethical capital might be created. If a social enterprise becomes a community-interest company, then there is a statutory "asset lock" on assets and profits to ensure that they are used for the benefit of the community (Department of Trade & Industry, 2004). Other organisational forms would not have such a requirement on how surpluses are managed, and therefore, the legal form of the social enterprise dictates to a certain extent how that enterprise can operate.

Conclusion

This paper has sought to develop an argument that social enterprises in health are an ideal place to foster the development of ethical capital in this sector. This area, as Bull *et al.* (2010) note, is still nascent, and there is a possible danger that, like social capital which has the characteristics of an umbrella concept (Adler and Kwon, 2002), ethical capital could be defined in such a broad way as to become meaningless. Therefore, more work needs to be done theoretically to explore the concept of ethical capital and how it can be applied to health care. Practical considerations also need to be addressed, such as how ethical capital might be operationalised and overseen. The passage of the Public Services (social value) Act, with it requirement for a more holistic approach to commissioning, if developed and utilised well, could provide an impetus for considering not only the economic and social value added but the ethical basis and effects of commissioning decisions as well. Social enterprises need to be able to compete with the better financed and more experienced private sector contractors, and if commissioners really enter into the spirit of this Act, this could give social enterprises some advantage – where social and ethical value are seen as important facets of any viable bid and value for money is not just cashed out in economic terms. In Liverpool, for example, the Fairness Commission aims to promote a fairer society by including it as a key policy aim that will be "at the heart" of all decisions (i.e. allocating resources and commissioning services) – the principle of fairness will direct policy, and social enterprises have a key role to play in this (Fairness Commission, 2013). At a time of rapid health-care reform, this aspect of health-care delivery – producing ethical capital – needs to be kept to fore in policy debates so that the interests of the users of these services can be genuinely met, increased social value can be generated and social enterprises can fulfil their aims of providing an alternative to for-profit provision.

Notes

1. These are Barts and the London NHS Trust, Birmingham & Solihull NHS Cluster, Halton Borough Council, NHS Sefton, Norfolk Community Health & Care NHS Trust, North Lincolnshire & Goole Hospitals NHS FoundationTrust and University College London Hospitals.
2. It should be noted that it is not technically true that all social enterprises have to or will invest all their surplus back into the community, as a social enterprise is not a defined legal type of entity, unlike the Community Interest Company (CIC), which has specific requirements for the dispersal of surpluses.
3. They extend this notion to a further fifth level, which they see as charitable provision where there is no profit generated.

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