



## Should we turn the NHS into co-ops and mutuals?

DEXTER WHITFIELD [14 November 2013](#)

*As the government again pushes the 'mutualisation' of the NHS, Professor Dexter Whitfield argues all such transfers are privatisation.*



*Image: The first co-op stores, Rochdale*

All transfers of NHS and other public services to social enterprises, mutuals or cooperatives is privatisation, irrespective of the ownership model, staff and user engagement, democratic structures and community support.

This is not a principled opposition to social enterprises or to the use of public money to support their formation. However, they should be formed in the *private* sector, where significant benefits can be achieved, and not the public.

Health Minister Norman Lamb recently [claimed](#) that the problems encountered at Mid Staffordshire Foundation Trust would never have happened in a mutually-owned company.

Hopefully not, but Lamb probably thought that it was very unlikely that the Army would have to be brought in to provide security at the London Olympics because of the failure of a private contractor (G4S), or that the Cooperative Bank would be majority owned by hedge funds.

Lamb's comments came as the government [launched](#) a review of staff engagement to "...identify the barriers preventing some NHS providers from engaging and empowering staff, outline good practices within the NHS and other sectors, and recommend how these can be adopted throughout the NHS. It will look in detail at the hospital sector but will also consider primary and community care and relationships with social care".

The review will assess a range of options including social enterprise and mutual organisations. For all the talk of "employee voices" and "their stake in

organisations" this approach to worker engagement is superficial (and made no reference to patient engagement).

Cabinet Office Minister Frances Maude revealed the real focus is on "alternative solutions" to in-house NHS provision, saying:

"With some of the better established mutual businesses, the health sector already showcases the benefits of giving staff a say in the running of their organisation. We are in a global race and as government looks to support the next generation of innovative health mutuals, I'm excited to see what ideas are generated by the Panel."

### **New paths to the market**

Privatisation was never solely about the sale of state-owned corporations (such as Royal Mail). It has mutated. Over the last decade the government has created new ways to marketise and privatise the health economy - extending personal health budgets, patient choice, piecemeal outsourcing, 'commissioning', and private or 'social' investment.

Mutuals and 'social enterprises' are a key [new pathway](#) to market-based services.

Markets impose competition, the domination of finance over social values, profiteering over public interest. Social enterprises claim to 'rebalance public sector markets' by reducing the size of contracts and seeking to reserve the award of some contracts exclusively to mutuals. But even if they succeed, these measures will hardly curtail the power of national and international companies.

The transfer of health services into social enterprises extends rather than challenges the use of commissioning, competition and markets.

Commissioning is not a benign process. It splits the client (who identifies needs, plans and pays) from the contractor (who delivers). It creates an ideological divide and different vested interests. Even in-house services - if they are not excluded on spurious grounds - are often treated as private contractors.

There is a loss of direct democratic control and accountability. Patients are sandwiched in contractual relations between the NHS and its 'providers'.

The fact that a social enterprise may be a collective non-profit organisation does not reduce the degree of privatisation. It is a contractor as far as the NHS is concerned.

Contracting is [expensive](#). The costs of the transactions divert core funding of NHS services to management consultants, lawyers and staff to procure, manage and monitor contractors. Client costs already account for about **13.5%** of the NHS budget with procurement costs of between 2% - 6%, contract management and monitoring costs of 1% - 3%, contract cost overruns and variations 5%-30% and contractor's profit of between 6%-12% of the annual contract value.

What of so-called savings? After the honeymoon period, they mostly come from reduced scope and quality of services, increased user charges with staff made to work harder and longer for less pay and pensions.

Social enterprises are little different.

They will endure the same commercial pressures as other contractors. They will be under significant pressure from private and voluntary sector contractors who are engaged in a 'race to the bottom' cutting jobs, terms and conditions to remain 'competitive' and win contracts. They must raise capital for investment and finance the high cost of bidding for contracts.

NHS resources should be targeted at improving in-house services instead of new providers.

Both social enterprises and other private companies also lobby for favourable procurement rules, benefit from tax concessions and public subsidies and find it easier to implement low pay which forces employees to rely on state benefits. This is - yet again - corporate welfare.

And what of the future? We are told that asset lock-ins and similar mechanisms can limit takeovers by private contractors or vulture funds. But they have limited value if a social enterprise has financial or performance problems and faces takeover or closure.

Some social enterprises have already been forced to form 'mutual private partnerships' or joint ventures with the private sector (for example, the civil service pensions social enterprise, MyCSP, is only 25% owned by staff members). Central Surrey Health, one of the first social enterprises created from NHS services and the government's flagship social enterprise, failed to win another Surrey community services contract losing to Virgin Healthcare.

What happens if the social enterprise fails? Unless there is radical political change, retendering is almost certain to be between private, voluntary and social enterprise contractors. This is marketisation, and ultimately the privatisation of NHS services.

## Performance

The Coalition government claims - with little supporting evidence - that social enterprises improve quality, productivity and reduce sickness levels. They exist so are assumed to be successful.

Pathfinder Social enterprise Central Surrey Health - to which David Cameron gave a 'Big Society' award - scored [below average](#) in all four standards in the new Patient-Led Assessments of the Care Environments (PLACE) inspection regime in April-June 2013. Its scores on cleanliness; condition, appearance and maintenance; privacy, dignity and wellbeing; and food and hydration ranged from 74-90%, compared to a national average of 85-96%.

In other areas of public services social enterprises have also faced significant challenges. A flagship social enterprise, Ealing Community Transport venture was rescued by a private contractor in 2008. EAGA, a national home energy efficiency social enterprise was modeled on the John Lewis partnership, but employee ownership reduced to 37% following a stock market flotation and it was later acquired by Carillion plc.

Employee owned bus companies mushroomed following the 1986 deregulation and privatisation of municipal bus companies. Twenty-three bus companies had substantial employee ownership by 1993 but by 2009 there are none.

Greenwich Leisure Limited is one the Coalition's favourite social enterprises, but operates as a Greater London leisure contractor with private sector bidding and employment policies. Several other leisure trusts have collapsed.

The Tower coal mine cooperative in Wales operated successfully for 13 years but was forced to close in 2008, as it required significant new investment to sink a new shaft to open additional seams.

Mutually-owned building societies have a long history of providing savings and mortgages in the UK. However, ten large building societies were demutualised, either via stock market flotation or takeover by banks, commencing with Abbey National in 1989 and culminating in a frenzy of carpet-bagger and investment bank activity between 1995- 2000 in search of windfalls. All ten subsequently lost their independence. Three are foreign-owned, two exist only as trading names, three were rebranded, and two were nationalised in the bank-bail outs of 2008.

The Cooperative Bank's problems originated in the merger with Britannia Building Society, which had poor-performing commercial property investments. Further problems arose when it sought to acquire 632 branches from Lloyds Bank and the financial regulator revealed the Co-op Bank did not have the capital or borrowing power to fund the deal. But the bank has [another cash machine](#).

*"The Co-operative Bank's expertise in public sector financing has helped us build a strong Private Finance Initiative (PFI) and Public Private Partnership (PPP) portfolio. We have proven experience in both areas and operate as lead arrangers on various transactions. As well as being recognised as one of the UK's lead providers of NHS LIFT finance, we have also been involved in a large number of PFI projects including healthcare" (doctor's surgeries to integrated care centres), education, social housing and emergency services.*

So much for ethical banking and sustainable development!

### The way forward

*Social enterprises in the private sector:* A strategy to expand social enterprises must be rooted in the private sector. Bolivia shows how such an approach could provide an alternative to austerity. The government issued Supreme Decree 1754 in October 2013 that allows workers to establish social enterprises in businesses that are bankrupt, winding up, or unjustifiably closed or abandoned. Article 54 of Bolivia's constitution states that workers:

*"...in defense of their workplaces and protection of the social interest may, in accordance with the law, reactivate and reorganize firms that are undergoing bankruptcy, creditor proceedings or liquidation, or closed or abandoned without justification, and may form communitarian or social enterprises. The state will contribute to the action of the workers."*

Imagine if Boots the pharmacy were mutualised - or the pharmaceutical industry!

*Abolish commissioning:* We must re-integrate client and contractor in the NHS and other public services. Otherwise the commissioning model will permanently reduce directly provided NHS services and will make service provision dependent on markets and contractors. It will systematically de-skill the NHS, expand the market and have a profound effect on the local health economy. Re-integration should involve patient and community organisations, staff and trade unions in the planning and design of services and radically improved democratic accountability and transparency.

*Strategic improvement:* We need NHS staff and their trade unions to work with NHS campaigns to develop a strategy that focuses on improving in-house health services. Learning from campaigns like [Gloucestershire](#) we need to challenge the commissioning model and persuade the Labour Party to rescind its support of the NHS social enterprise model.

More NHS staff and their unions are likely to be put in a difficult position where in-house options are 'eliminated' and the 'choice' of transfer is to a social enterprise, private contractor, or a delusory 'partnership' between the two. Unions must help their members faced with such a choice to promote in-house solutions and build community support. It is not good enough for unions to campaign against the policy nationally whilst negotiating implementation locally.

There is a real danger of social enterprises and 'partnerships' becoming another version of PFI's 'only show in town' with drastic long-term consequences for the NHS, staff and patients.

### Privatisation by another name

Neoliberal public policies, such as commissioning, outsourcing and private finance, have been designed by one government and accelerated by subsequent governments. Formal Labour and trade union opposition has been muted. Policy reversal and a return to public provision has become politically 'unthinkable' - despite the fact that poll after poll shows that this is what the public want.

Social enterprises and so-called 'mutualisation' of public services is being used to shrink the public sector. Transferring services to a new organisation external to the NHS reduces the security and flexibility of NHS services, and transfers financial, employment and operational risks to new organisations that may not be able to bear it.

It is de-facto privatisation.