The mutualisation of public services in Britain: a critical commentary

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Introduction – the loss of mutuality and its rediscovery

The institutional origins of the British welfare state can be traced to three types of organisation: philanthropic societies, local government and friendly societies. In the founding of the welfare state in the period immediately after the Second World War the emphasis shifted to the provision of welfare services by central government, and these earlier forms became marginalized. The role of philanthropy became to add to basic state services and to provide a cutting edge of innovation in service development that, once a need was recognised, the state would eventually take over. Local government lost many of its former services such as health care and unemployment benefit, and, in return for receiving a support grant, became mainly a provider of welfare services required by central government legislation. Friendly societies had already lost their autonomy in provision of health care and sickness and death benefits. From the 1911 National Insurance Act onwards, they had been ›subject to a process of creeping nationalisation‹, becoming agents for the state's compulsory social insurance schemes. (see Mabbett 2001, 118)

The ›architect‹ of the welfare state, William Beveridge, had envisaged a comprehensive social security system, but was against its being delivered by a government agency. He was concerned that the social solidarity generated by the societies would be lost, and doubted whether the state could ›combine soundness with sympathy‹ as they did. (Beveridge 1948, 84) He recommended they deliver basic state social security, supplemented by voluntary insurance. The government chose, instead, to nationalise social security, thus marginalizing the friendly societies and, in consequence, the whole idea of mutual welfare.

The idea of mutuality did not get back on to the political agenda until the 1990s, and then not in relation to public services but as a consequence of the demutualisation of much of the building society and mutual insurance sectors. The New Labour government at first rejected pleas to defend mutuals; Treasury officials were particularly unsympathetic, seeing mutuality as an outdated concept and being content to let the market decide whether or not they survived. However, a debate started concerning the relative merits of mutuals and investor-owned banks, and political commentators became more sympathetic to a sector that was clearly being attacked not because it was outdated but because managers and ›carpet-bagger‹ members were enriching themselves by privatising the assets mutuals had built up over several generations. (see Drake/Llewellyn 2001) The successful defence of their market share by remaining building societies led to a reappraisal of the advantages of mutuality (see for instance Cook/Deakin/Hughes 2001), which made it easier for a discussion to begin on the mutualisation of public services.

For interesting historical reasons, in Britain we have a Co-operative Party, that is funded by the consumer co-operative sector but allied with the Labour Party. It has not, until recently, been very influential, but in the 1997 and 2001 elections it returned a significant number of ›Labour and Co-operative‹ MPs. In a series of pamphlets by well known experts in their fields, called the ›New Mutualism‹ series, the Party set out a policy agenda for mutualisation of both private and public services. It began with Peter Kellner's suggestion that mutuality could give philosophical content to the idea of the ›third way‹, giving the government greater direction and policy coherence; the pamphlet had a foreword by the Prime Minister. (Kellner 1998) Pamphlets followed examining subjects as diverse as social exclusion, football clubs, international development, local government, employee ownership and housing policy, all with forewords by government ministers. (see Hargreaves 1999) Measurable policy developments have followed. For instance, the Government's Dept for International Development has entered into a partnership with the consumer co-operative movement to raise the profile of co-operatives in development. It has given financial support to football trusts, that enable supporters to pool their voting rights as shareholders and gain influence over (and in some cases full control of) their local football clubs.

The idea of mutualisation of public services was explored in more depth by some influential ›think tanks‹. A report from DEMOS made a comprehensive review of the mutual sector, and argued for the mutualisation of public services. (Leadbeater/Christie 1999) The Institute of Directors and the New Economics Foundation worked together on detailed proposals for mutualisation of the National Health Service (NHS). (Day 2000) These led to the current policy of foundation hospitals; hospital trusts are being encouraged to seek ›foundation‹ status, gaining more independence from government, and becoming essentially membership-based organisations governed by a mix of employees, patients and the public.

What do we mean by mutuality?

Before we can assess further the impact of the idea of mutuality on public services, we need to define mutuality more precisely, then to provide a theoretical framework for understanding how public services have developed in Britain over the last 30 years. First, what do we mean by mutuality? The word has sometimes been used as a vague call to involve citizens more closely in decisions made over public services. However, properly used it refers to a membership-based organisation, in which the users of services are in control of provision. A clear example would be a housing co-operative that provides and manages housing for its members. The term does not specify who is a member: normally it is the user of a service, but it can include the providers in a multi-stakeholder mutual. Examples include child care co-ops in Sweden, and some new elderly care co-ops in England. It may be stretching the term to call a worker co-op a mutual, though some people refer to it as such because the members are providing decent work for themselves.

To understand what the mutual approach has to offer, we need to understand better the broad direction of change in public services. It is hard to unravel – there are continuities and discontinuities between the regimes of Labour (1974 to 1979), Conservative (1979 to 1997) and ›New‹ Labour (1997 onwards). There is evidence for marketisation under the Conservatives, but also of resistance to change and backpe-

dalling over the NHS. Their neo-liberal values did not translate straight into policy, but were mediated through electoral strategies and complicated by the policy-making process. There is evidence for continuities under New Labour. For instance there has been continued pressure to transfer public sector ›council‹ housing from local government to the independent, non-profit housing association sector and sometimes to co-operatives. The NHS has been allowed to contract with private hospitals for surgery. But there is also evidence for a rejection of the market. The government has scrapped a ›quasi-market‹ in the NHS whereby general practitioners and primary care trusts bought services from hospitals on contract, and has substituted a much weaker contractual relationship between primary and secondary levels of care, relying not on market pricing but on a more managerialist target-based performance system. More subtly, in some areas the market is being used as a threat to under-performing providers, as in the Best Value regime for local government, and the use of private (but so far non-profit) providers in failing schools.

The dichotomy between state and market, public and private, is not adequate to the task. We need a trilogy that includes mutual forms of welfare. This is not the same as informal welfare delivered by families and neighbours, but is a different way of delivering organised public services.

A framework for understanding the relationship between service provider and user

Let us begin by distinguishing three ideal types of relationship between service provider and service user, labelled:

Bureau-professional
Market-based
Mutual[1]

These are not types of organisation, though different types of organisation tend to be associated with them (roughly speaking, public service agencies and large philanthropic providers have been associated with the bureau-professional type of relationship, for-profit private companies with the market-type, and small voluntary and community organisations, co-ops and self-help groups with the mutual type). They are a way of describing in a pure form three ways in which service producers and users relate to each other. They are ›ideal types‹ because the pure form is rarely reached in real life without elements of the other types also being present.

Bureau-professionalism sums up a traditional, hierarchical relationship in which service users have no say in what services they receive or how they are delivered. They are dependent on experts who define their needs, and on administrators whose job is to make sure the service is delivered according to strict rules of eligibility. The service is overseen and regulated by local or central government politicians. Service users may be consulted, but at the discretion of the provider. A *market-based* relationship is one in which service users are seen as customers of a business organisation that has contracted with government to provide services. The contract is awarded within a competitive market in which there is a strict separation between the purchaser (usually government) and the provider of services (an independent organisation). Individual service users may be consulted through passive marketing techniques

such as opinion surveys and customer panels. They may have rights to information about the provider's performance, rights to complain and seek redress. However, their influence on the service depends mainly on their ability to affect the price and to choose between suppliers; unless they purchase the service directly with a grant or voucher, their reliance on public funding makes them fairly powerless. Finally, a *mutual* relationship is one in which the relationship between service provider and user is transcended, through the users collectively delivering the service themselves, effectively doing away with the concept of service provider. They relate to their own provider organisation through being members of it, and membership automatically confers the right to ownership and control. They may choose to produce the service themselves or to hire their own staff and buy in expertise as and when they need it.

Most relationships between provider and user are hybrids of these three pure forms. For example, bureau-professionals may use marketing methods for measuring user satisfaction. Market-based providers may sometimes offer users a quasi-membership in order to increase customer loyalty. Mutuals may have to submit to regulation by government agencies in order to secure public subsidy. Most public services now incorporate elements of all three types of relationship, which is one of the reasons why service users often become confused about what kind of relationship is on offer. The type of relationship between providers and service users promotes some forms of involvement and constrains others.

To understand this further, here are four levels of analysis:
1. Values
2. Systems
3. Organisational forms
4. Practices[2]

Service providers have *values* that provide direction to their work and help them to make sense of what they are doing. Service users do, too, but their values only count when they are able to put them into practice. Such values include the famous trilogy of liberty, equality and solidarity, but also less abstract values such as representation, freedom of choice and so on. They lead to deeply held, more or less articulate, beliefs about what is important and how we should measure success. Values tend to find their expression in different *systems* of organising such as hierarchy, competition, or co-production, or in *organisational forms* such as local authority social service departments, tenant management co-ops, private nursing homes, self-help groups, primary care trusts and urban renewal partnerships. It is at the fourth level of *practices* that services are delivered, and the relationship between provider and user becomes more tangible. Practices include actions and behaviours. They often occur in interactions between providers and users at what is referred to as the ›front line‹ (a military metaphor that reveals a lot about how, in some organisations, users may be seen as the enemy in everyday interactions).

It is important to note that these four levels are not a hierarchy – if values produce systems and organisations then organisations and systems also produce values, and practices feed back into all three. The system or form of organisation both constrain and are constrained by the values and the daily practices. The four levels are, however, different levels of abstraction; it is easier to talk concretely about practices than about the way the organisation turns behaviour into routines, or the way values underpin

– or undermine – a common sense of purpose. Here is a matrix that combines the three types of relationship with our four levels of analysis, and provides some useful insights into what kinds of provider/user relationship are on offer in public services.

Figure 1: Ideal-types of relationship between service providers and users

Ideal-type Relationship	Values	Systems	Organisational Forms	Examples of Participation Practices	Status of service user
Bureau-professional	Equity, Need	Hierarchy/ Expertise/ Discretion	Govt agency/ Arms-length agency (some autonomy but govt owned)	Voting, Contacting elected officials	Political client
Market	Freedom to choose, Demand led	Independence/ Competition	Private contractor Purchaser/ provider split	Complaints procedures, One-off focus groups	Individual customer
Mutual	Solidarity, Mutual aid	Self-provisioning/ Co-production	Co-operative/ Self-help group	User groups, forums, committees	Member/ Collective service user

A Short history of the user/provider relationship in Britain[3]

Before the founding of the welfare state, the dominant types of relationship were market-based and mutual. For instance, in the health services middle class people tended to have to buy care while working class people were insured through their own friendly societies. This meant that members of societies were in charge of their own health care, hiring doctors on a panel system that approached the mutual ideal type, but with some government funding and regulation. The post-war welfare state in Britain was founded on the very different premise of bureau-professionalism. The dominant values were equality and universalism, and this made it hard to distinguish between citizens and consumers (even when, as council tenants, the latter were paying directly for the service). Service users were meant to be – and generally were at first – grateful for what they were given. Redress could be sought by individuals through politicians. Anything more would have been regarded as undue influence, since the aim was to meet professionally-assessed needs through rule-bound allocation procedures that treated everyone the same.

What first broke down this set of relationships was not the rediscovery of poverty in the 1960s; that could be dealt with by extending the welfare state. Nor was it the discovery that the health service was unequally distributed; that called for more centralised planning and a cumbersome, three tier system of ›authorities‹ to implement it. It was the forced, mass break up of working class communities through slum clearance that first led this ideal type to be questioned. In the period between 1955 and 1975 millions of households were displaced from poor quality housing in high quality communities (in which, of necessity, much mutual aid was practiced), to council estates on the edge of cities or in new satellite towns. A combination of social

dislocation, poor estate design and shoddy construction meant that these planned ›communities‹ never became real communities (without the quotation marks).

By the late 1960s, resistance to this policy began to grow and for the first time the assumption of bureau-professional power was questioned. In the new general improvement and housing action areas bureau-professionals faced a large number of private owners and had to consult, negotiate and provide incentives in order to achieve their aims. Participation began in some neighbourhoods whose residents resisted the ›bulldozer‹ (sometimes literally, by sitting in front of it) and who set up independent, more mutual, forms of organisation to rehabilitate rather than demolish their homes. Enlisting the help of sympathetic experts who began to put the word ›community‹ in front of their specialism (community planners, architects, workers), they turned naturally to forms such as community housing associations and co-operatives that would guarantee them a stake in governance.

Many ›built environment‹ professionals deplored this turn of events. One of the advantages for them of slum clearance had been that they could replace many landlords with just one – the local council – and could start again with a ›blank sheet of paper‹ on which to draw their utopias. However, others jumped at the chance to work directly in partnership with residents and service users, despite the uncertainty of outcome. Their influence spread quickly, and it is not surprising that in the early 1970s experiments began to give council tenants a similar chance to be consulted; after all, if some tenants could become their own landlord, surely council tenants should have a say in how their landlord manages their homes.

Yet change was painfully slow, and the resistance to change was deeply entrenched. Most local authorities encouraged tenants' associations, some set up consultative forums and the more progressive even gave places on sub-committees for tenant representatives. But during the 1970s the profession as a whole was arguing against giving tenants fundamental rights to a secure tenancy. By 1980 these rights had been granted, but even in the early 1990s surveys were still showing that the incorporation of tenants' groups into governance was far from complete. (see Birchall 1992) The move from bureau-professionalism to mutual-type relationships is not an easy one. It goes against many bureau-professionals' deeply-held belief in the value of ›technical competence‹, and threatens the interests of those who find a paternalistic relationship with ›their‹ service users psychologically rewarding. In housing management a paradigm shift away from the notion of the ›good tenant‹ to that of the co-op member was therefore resisted by local authority housing staff who argued that only a minority of tenants were willing and competent to take on such responsibilities. (see Birchall 1988)

Elsewhere within the ›social welfare‹ professions the arguments for involvement were easily extended during the 1970s to cover other types of service user. However, once again the move towards more mutualistic relationships was painfully slow. In the health service, patient involvement began in 1974 with the establishment of community health councils. They were outside the body of the NHS, with no powers, and with members appointed from local authorities and voluntary organisations. There was no challenge to bureau-professional values here; if the NHS were a mansion, this would have been the garden shed. However, patient participation groups also began to be formed at health centres, and these did enable direct patient participation. In education, during the 1970s most schools began to encourage parent governors. By

1979; 90 percent had parents on the board, and it was due to parental pressure that in 1980 they gained the statutory right to be represented. In other sectors participation was resisted. In social security, plans to involve claimants in local committees were prevented by civil servants. In social services, the Seebohm Report[4] had recommended advisory committees but, apart from those areas where social workers were developing ›patch-based‹ approaches to their work, participation remained a vague aspiration. In planning, the high point of interest in citizen participation was 1968, when a Town and Country Planning Act made consultation over local plans mandatory, but during the 1970s interest among the profession actually declined. (see Richardson 1983)

The growth of the welfare state added social rights to other citizenship rights within the terms of the ›social contract‹. However, the move towards equity and universalism under bureau-professionalism also served to undermine other key values, such as freedom of choice and solidarity. When the Conservative government came to power in 1979 with the rhetoric of the ›dismantling of the welfare state‹, defenders of public services expected service users to rally to the opposition. However, given that the attitude of public sector workers and professionals to user involvement had been at best lukewarm, perhaps it is not surprising that they were disappointed.

The Conservatives brought a change in political values, which heralded a change to more competitive, market-based systems, organisational forms and practices within the public sector. This held some potential advantages for service users. Values such as responsiveness and good customer care were added to the public service repertoire. (see Pollitt 2003) Charters set out explicit standards and practices that service users could expect, often tied to individualised forms of involvement such as formal procedures for complaint and redress. Moreover, as the welfare state was ›dismantled‹, some of the service agencies that were created provided new, localised opportunities for service users to participate directly in governance. In education, parents replaced local councillors in the driving seat of school government, and were given a much larger share of the budget to spend. In housing, financial pressures put on council housing led to the transfer of housing stock to new agencies that opened up opportunities for tenants to become board members. In England they were kept in a minority by Housing Corporation staff who were suspicious of tenant power, but in Scotland (with its tradition of community-based housing associations) the transfers were to tenant-controlled co-ops and associations that were closer to the pure mutual type of relationship. The attempt to create a market in social care also led to a more pluralist system in which providers became keen to demonstrate a ›partnership‹ with service users, while in some areas such as mental health and disability self-help groups began to be seen as co-producers. In health care, the results were more muted. The attempt to develop a market stopped at general practitioners (local doctors) who as ›GP fundholders‹ acted as purchasers of care. The setting up of health trusts gave freedoms but not to patients, who were left out of governance. (see Pollitt/Birchall 1997)

While there had been a change in values, the mutual emphasis on solidarity had been a small voice compared to the shrill political voices calling for marketisation. Thus, the situation fell short of claims that citizens were regaining control of government through their participation as users and governors. (Rhodes 1997) To some extent, bureau-professionalism had also successfully resisted attempts to reduce its

influence, adapting itself to new organisational forms[5]. The above changes were therefore rarely able to effect a radical shift in the distribution of power away from producer interests. (Potter 1994) Nevertheless, by 1997 the bureau-professional voice had become much more uncertain, and was now using the rhetoric of user participation as a matter of routine. In some areas significant shifts had also been made towards mutual organisational forms: tenant self-management, patient self-help groups, local development trusts.

Public services under New Labour

With the public sector in flux, it was a patchy, unsatisfactory and ambiguous scene that was inherited by the incoming New Labour government in 1997. This has since been compounded by the adoption of a pragmatic philosophy of ›what matters is what works‹. Pragmatism tends to operate at the levels of organisational form and practices. It thereby tends to sideline its sister concept, ›principle‹, which is more bound up with values and systems. (see Simmons 2003; Leggett 2004,12-19) Big changes are now occurring, not just at the level of practices (where ›innovative‹ forms of consumer involvement continue to be rolled out), but finally at the level of organisational form. Government policies, and the local reactions to them, are creating opportunities for mutuality to be built into the fabric of the service delivery agency. Foundation hospitals will be governed by directors who are no longer appointed by a government minister but by their members, signalling a fundamental change in relationships between not only service users and providers but also providers and their bosses (since employees can become members too). The transfer to mutual forms of organisation of local authority services such as housing, social care and leisure are opening up new opportunities for users to take part in governance, not just as a concession but as a right. However, what is not yet clear is the extent to which these organisations, and the opportunities for new participatory practices that go with them, signal a change in the values and systems that underpin service provision.

Do we want the pure form of mutuality?

There are good arguments for mutual welfare, deriving from communitarian political philosophies that are as coherent as those driving the bureau-professional and market-based approaches to welfare. (see Birchall 1988) However, it is not necessary to advocate wholesale adoption of the ›mutual‹ ideal-type. In some cases it *is* possible for users to reach the ›pure form‹ of mutuality, and become their own providers. Housing co-ops are a good example that has consistently been shown to be more satisfying as well as being more efficient and effective than the traditional landlord-tenant relationship. (see Rodgers 2001; ODPM 2003) However, only a minority of tenants of social rented housing want to take on the burden of being collectively their own landlord. Another good example is the enormous range of self-help groups in health care that have been shown to have clear, measurable health benefits. (Halpern/Bates/Beales 2003) However, nobody is suggesting that they replace the traditional health services. A better location for the provider-user relationship may be at a point along the line between the bureau-professional and the mutual forms, at which they become partners and to some extent ›co-produce‹ the service.

If we were to move to a fully user-controlled service, problems would arise. A membership-based system does not guarantee coverage to all those in need, and does not take into account other stakeholders such as employees and the wider citizen interest (though multi-stakeholder mutuals are beginning to do this). A mutual system needs regulating on behalf of those who are not, or not yet, members. Equity, the balancing of consumer and citizen interests, the need for regulation, these are all strengths of the bureau-professional model. The market-type relationship also has some advantages. It provides individual rights of complaint and redress, and its methods (surveys, focus groups) make the consumer voice better understood. Service users may just want to have individual choices and be consulted, in which case a more market-based relationship may be acceptable. The key point is that it should be up to the users as much as to the providers as to where, on the three-cornered map of possible relationships, they want to be. This implies, of course, that their decision is a considered one; they should be made aware of different options, and be able to choose. A good example of this is in public sector housing, where (under the ›right to manag‹ and proposals to transfer to a new housing provider) council tenants often have a range of options set out for ownership and management.

Does this mean it does not matter what form the organisation takes that provides services? It does matter, because some are more open than others to the user voice. Organisations that start from the bureau-professional relationship tend to bolt participation on while protecting the existing professionally and politically dominated governance structures. Organisations that are locked into the pure market type of relationship can measure the consumer ›voice‹ and offer some individual choices, but ultimately accountability to consumers is low – they are answerable to their shareholders. The more an organisation builds service users into its governance structure from the start, the more likely it is to empower service users in practice.

Prospects for mutualisation in the UK in the future

The prospects for continued mutualisation of public services depend on the performance of the foundation hospitals. The model could be extended to the other half of the English health care system, the primary care trusts (PCTs) that organise non-hospital forms of care and contract with the hospitals on behalf of patients. Recently, the government has legislated to make these PCTs set up representative bodies called ›public and patient forums‹, which means they have had to develop their own membership strategy. The overlapping of memberships between the two parts of the system is potentially inefficient and confusing for patients. If the Scottish alternative, which is to bolt participation on to a monolithic system of health boards, is successful in practice, it may prove a counter example around which the traditional left can gather (though the latest studies show that Scottish health care is the most inefficient in the UK, despite being the best funded).

It depends, also, on the outcome of transfers of housing stock to new social landlords. In Glasgow, for instance, the new housing association may split its stock among local community housing associations and co-ops, or if tenants are not able to drive the changes may just become another very large landlord. In social care, mutualisation depends on the extent to which local authorities and co-operative development agencies can create social care co-ops rather than leaving it to the market to provide.

The residential care market is already dominated by private providers, but they are in a crisis of profitability caused by low fee levels being set by local authorities. A new model of co-operative care being developed by consumer co-ops could grow rapidly, if it is not undermined by the same problem.[6]

The wider environment for the idea of mutuality will become more sympathetic, if private sector mutuals such as retail co-ops and financial mutuals continue to compete successfully with investor-owned businesses, and if innovations such as the football trusts continue to expand. The danger is that the rhetoric of mutuality is used too widely, and becomes merely a synonym for service user participation. One test of whether public services are being mutualised is in the criterion of member-ship. Members of mutuals are the owners of the business, and ultimately they should control it. Control is often mediated through elected boards, but these are subject to regular re-election and can be removed. To find out whether a public service is a mutual, we simply have to ask whether the members make the important decisions and, if not, whether they have the power to dismiss the decision-makers. Policy-makers and service users have to be aware of the remarkable ability of public service managers and ambitious politicians to turn the idea of mutuality into mere rhetoric that leaves existing power relations undisturbed.

Endnotes

1   These terms are derived from the cultural theory of Mary Douglas, adapted for public
     services by Christopher Hood. See Hood 1998. Here we adapt Hood's typology to suit our
     own purposes.
2   This idea synthesises the authors' previous work. See Conclusion in Birchall 2001; Simmons
     2003, Chapter 5.
3   We do not include Northern Ireland in this analysis, as it has separate legislation and
     a different policy process dominated by the need for fairness between two divided
     communities. Scotland also has separate legislation. Since the setting up of the Scottish
     Parliament and the Welsh Assembly in 1997, their social policies have begun to diverge in
     some respects from those of England.
4   The Seebohm Report was initiated in 1968 by the Labour Government. It discussed the
     reorganisation of the public sector and proposed to enhance democratic participation of
     users in the definition and organisation of public, in particular, communal social services.
5   This is encapsulated in the idea of ›dynamic conservatism‹ (or ›changing to stay the same‹),
     in Pollitt/Birchall 1997.
6   Though it does not need to make profits, a co-op does need to balance the books, and care
     co-ops in the USA have gone out of business through having inadequate fee income.

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