# DO SOCIAL ENTERPRISES FULFIL THEIR SOCIAL PROMISE? QUALITY OF SOCIAL CARE CICS AND OTHER LEGAL FORMS

JANELLE A. KERLIN

Department of Public Management and Policy

Georgia State University

Atlanta, GA 30303

MENG YE

Georgia State University

KELLY HALL

University of Birmingham, United Kingdom

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**ABSTRACT**

This study seeks to address a foundational question around social enterprises: does the redirection of profit towards social goals result in expected social outcomes even though profit motives may still be at play? We use ordered logit regression analysis to compare service quality data from Community Interest Company (CICs) social enterprises , charities, for-profits, and government-run organizations operating in the social care sector in England. We find that social care CICs consistently outperformed for-profits on all social care quality measures and did as well as or better than nonprofits and government-run social care organizations on most measures.

**INTRODUCTION**

For many years the academic literature has, on the one hand, decried social enterprises as inferior social mission providers in relation to nonprofits and government while on the other hand, lauded their ability to financially sustain the social missions of organizations (Levine-Daniel and Galasso, 2019). The social enterprise literature, in particular, has been concerned with the unique tension between mission and market objectives found in social enterprises and how profit motives may overwhelm the social mission agendas of social enterprises and lead to poor social outcomes and mission drift (Weisbrod, 2004; Ebrahim, Battilana, Mair, 2014). Resource dependency theory also suggests that a social enterprise may favor certain behaviors supporting a resource it has become dependent on, in this case earned income, to the detriment of other organizational goals (Pfeffer and Salancik, 1978). In this study we examine these organizational and theoretical suppositions critical to the legitimacy of social enterprise (Dart, 2004; Carre et al., 2021; Bitektin, 2011). In the process, we attempt to address the question of whether or not social enterprises fully meet their social promise.

The social enterprise research community has long struggled to rigorously empirically investigate the fundamental question of social enterprise outcomes due to a number of vexing problems. First, for various reasons, the field has had difficulty defining precisely what social enterprise is, making it a challenge to isolate the phenomenon sufficiently enough to study it (Teasdale, 2012; Kerlin, 2010). Second, capturing the “social” activities of social enterprises also tends to be a slippery slope due to subjective understandings of what a social benefit is. Even if agreement can be achieved, service uniformity across a variety of organizational types including social enterprise must be found for it to be studied. Third, the field has had difficulty capturing the program quality of social enterprise outcomes because uniform measures need to be used on a broad enough scale for large dataset research (Paton, 2003). Fourth, different public/private revenue sources and approaches to generating commercial revenue across different legal forms have made it difficult to control for the influence of these factors.

In England, however, we find a mix of conditions that to a large degree overcomes each of these problems. First, the UK’s social enterprise legal form, the Community Interest Company (CIC), provides a concise definition of social enterprise attached to a regulated social enterprise legal form that can be compared with for-profit, nonprofit, and government sector organizations. Second, England offers a strictly defined social service arena in the form of its social care sector in which all of the aforenamed legal structures operate. Third, England also provides regulatory oversight of social care organizations through its Care Quality Commission which conducts on-site assessments of social care facilities once every three years using the same measures across all organizations and makes the ratings publicly available. Fourth, with the exception of start-up costs which are often funded by private investors in the case of for-profits, the social care sector in England is financed the same across all different legal forms through a combination of private pay and public funding (via local government) based on a client’s ability to pay and degree of disability. (Bottery and Warren, 2021). This final component is key to isolating the impact of how the same funding may be used differently across for-profit, social enterprise and nonprofit social care organizations.

In 2005, the Community Interest Company (CIC) was established in the UK as a new type of limited company designed for social enterprises whose activities operate for the benefit of the community rather than for the benefit of the owners of the company (Nicholls, 2010). A CIC can be established as a company limited by guarantee (a nonprofit form) or by shares (a for-profit form) but must meet a number of criteria including: the satisfaction of a community interest test; a dividend cap of 35% of the distributable profits if it is limited by shares; and an asset lock that ensures all CIC assets are retained for the benefit of the community and cannot be directed to members or shareholders (Nicholls, 2010). There were over 26,000 CICs operating in the UK in 2022 (CIC Regulator, 2022).

There are two defining features of the social care social enterprises in our study. First, we are investigating social enterprises that are considered differentiated rather than integrated (Ebrahim, et al., 2014; Levine-Daniel and Galasso, 2019). In basic terms this means that the clients are not also employees of the social enterprise and such space between them may shield the client from direct commercial decisions that are not social mission friendly (Cornforth, 2014; Ebrahim et al., 2014). The other defining feature is that most of the social enterprises in our study use CIC legal structures that do not distribute profit (company limited by guarantee - CLG) and therefore act a lot like nonprofit social enterprises that generate commercial revenue that is directed back into the organization or other social mission.

In the 1990s, adult social care in the UK moved from being largely state provided to being mostly outsourced to the ‘independent’ sector (Lewis and West, 2014). A competitive ‘quasi’ social care marketplace emerged whereby the state continues to fund and commission through local governments many social care services. Around three-quarters (74%) of services are now delivered by the private, for-profit sector, the voluntary sector delivers approximately 18% of services leaving around 8% in the public sector (Barron and West, 2017). This mix of sector models should theoretically lead to higher quality, more efficient and equitable services due to competition (Le Grand, 1991). Experience, however, has shown this not to be the case due to limitations around information asymmetry, measurement, and lack of alignment between supply and demand (Bach-Mortensen and Montgomery, 2019; Needham et al., 2022).

The benefits of social enterprises are derived from their hybrid organizational model that combines elements from the public, private and third sectors. Thus, over the last two decades in the UK, there has been considerable policy investment in social enterprises, in particular to ‘spin out’ social enterprises from government-run agencies to deliver public health and social care services (Hall et al., 2012). The assumed benefits of social enterprises include their reinvestment of profits into the service (or other social mission), reduced bureaucracy compared with the public sector and strong engagement with staff and users (DH, 2008, 2011; Hall et al., 2012). However, despite this investment there is a dearth of research that compares social enterprises with other ownership models in social care.

**LITERATURE REVIEW**

Research on ownership models in social care has largely focused on comparing legal forms across the government (public), for-profit (FP) and not-for-profit (NFP) sectors. These studies consistently show that the NFP and government sectors have higher quality ratings than FPs (Bach-Mortensen and Montgomery, 2019). In England, Barron and West (2017) analysed regulation data on residential and nursing homes and found that both NFP and public providers were significantly more likely be rated higher quality than FPs. In the USA, a systematic review and meta-analysis by Commondore (2007) similarly indicated higher quality outcomes in NFP nursing homes than FP nursing homes.

Looking particularly to the literature on nonprofit social enterprise, there is also little research that compares nonprofit social enterprise outcomes with the outcomes of more traditional nonprofits and other legal forms. Nonetheless, there has been much discussion and small ‘n’ case studies in the nonprofit space looking at the impact of commercialization on nonprofit functioning and outcomes including concern that nonprofits would be distracted from their social missions and price poorer groups out of the market (Weisbrod, 1998, 2004; Salamon, 1993; Cooney, 2006; Garrow & Hasenfeld, 2012; Hustinx & De Waele, 2015; Adams and Perlmutter, 1991; Guo, 2006; Manzi and Morrison, 2018). Business scholars have also begun to explore the institutional logics of hybrid tensions in social enterprises (Pache and Santos, 2010, 2013; Battilana et al., 2015). Scholars generally found that there were tensions between mission and market and evidence of mission drift, though these were for “integrated” social enterprises.

Missing from this body of research on the impact of market activities on social mission are large-scale studies as well as studies of “differentiated” social enterprises, where market and mission activities occur separately in the organization. Relevant to our study, the research reviewed above also suggests there may be a hierarchy of mission outcomes across organizational types with for-profits performing at the low end in terms of social goals, social enterprises in the middle due to mission drift related to profit motivation when market and mission are blended, and nonprofits performing the best due to the nonprofit distribution constraint and “pure” social mission motivation.

**THEORY**

Resource dependence theory posits that once an organization becomes dependent on a source of revenue it will favor behaviors that support that revenue source even to the detriment of other organizational goals (Pfeffer and Salancik, 1978). Thus, a social enterprise may favor certain behaviors supporting earned income it has become dependent on, even if it undermines other activities or behaviors that support mission-related objectives. We see this happening in the social care space when for-profits prioritize profit maximization for investors rather than funding staffing at appropriate levelsof care (Bayliss and Gideon, 2020). We therefore posit that since social enterprises also face pressure to maximize profits they will also experience social outcomes that are lower though not as low as for-profits due to their social mission.

**HYPOTHESES**

We base our rationale for our hypotheses on the evidence in the literature that points to compromised social missions in social enterprises and resource dependence theory as discussed.

* H1 – Social care CICs will have better service quality outcomes than social care for-profits.
* H2 – Social care CICs will have poorer service quality outcomes than social care nonprofits.
* H3 – Social care CICs will have similar service quality outcomes compared with independently-run social care entities.

**METHODS**

This study draws on the quality rating data by the Care Quality Commission (CQC) for residential and homecare services for older people as of September 2021. Given the CQC rating is conducted every three years, our dataset is comprised of ratings given to social care locations between 2019 and 2021, spanning the time before and during the COVID-19 pandemic. The quality rating assessments are conducted at the service location level and one service provider can have multiple locations and thus several different ratings. The full CQC data set contains CQC ratings for 23,264 social service locations, from which we drew a sample of 13,545 locations to code for the provider legal form and conduct the analysis. Since the number of CICs is much smaller than the number of organizations in the other sectors and they are the focus of our research, we over-sampled CICs to include all the CICs in the CQC data set. After merging in the additional CICs, we ended up with a sample size of 13,567 locations, or 84,711 observations (locations are rated in six domains).

The dependent variable in the study is the CQC quality rating for social care locations across five domains: safe, effective, caring, responsive, well-led, and an overall rating aggregating the first five domains. The ratings use a four-point ordinal scale, specifically *outstanding, good, requires improvement, and inadequate*. The CQC service quality rating is drawn from a variety of sources of information, including patient survey data and feedback, national and local regulator information, the NHS Friends and Family test, and on-site inspections by experts with practical experience (CQC 2022b).

The independent variable is the provider’s legal form or, in other words, the sector it is affiliated with. These include for-profit, nonprofit, government-run, CICs and independently-run which includes both individuals and partnerships (similar to sole proprietorships in the US). We coded the organizations based on the legal names of the providers as they appeared in the CQC dataset, specifically “CIC”, “Ltd.” and “local authority” and checked our coding against the England’s Charity Commission (nonprofit regulator) and Company House data. The number of observations for for-profit, nonprofit, government-run, CIC and independently-run providers was 64,187, 12,399, 2,431, 504 and 5,153 respectively.

We included several control variables in the model. These included the *category* variable to account for community-based versus residential care and the *inherited* dummy variable to control for when a rating was inherited from a previous provider in situations such as mergers and acquisitions. We also included *region*, a categorical variable that indicates in which of the nine regions each service location is situated to account for socio-economic differences and the dummy variable *during\_covid* based on the date the CQC rating was published, using a cutoff point of Jan. 1, 2020 because we expected quality ratings would be lower during the pandemic.

Since our dependent variable *rating* is measured at the ordinal level, we used ordered logit models to regress the overall quality ratings and ratings in each domain alternatively, on the legal forms of social care providers, with the control variables listed above as covariates. Given our large sample, we also ran OLS models, treating the four rating levels as numerical (1-4), to serve as a benchmark model and a robustness check for the model specification across different models. Our interpretation of the results is primarily based on the ordered-logit models.

**RESULTS**

In terms of the overall rating, CICs, nonprofits and government-run locations performed better than the reference group of for-profit locations. CICs are the highest-achieving sector: the odds that a CIC location is rated higher are about 1.64 times as large as the odds for a for-profit location to be rated higher, significant at the 0.1 level. The overall ratings of nonprofit and government-run locations are similar, their odds of having a higher rating are 1.36 and 1.34 times the odds of for-profits, and both are significant at the 0.05 level. Independently-run entities, however, tended to have the worst rating among all the sectors. Their odds of having higher ratings are 71% of the odds of having a higher rating of for-profits, significant at the 0.05 level.

The general pattern that emerged was that CICs, nonprofits and government-run locations tended to cluster together and have higher ratings than for-profit locations. Independently-run organizations tended to have lower ratings than for-profits across the five domains. CICs performed particularly well in the “caring” domain. Here the odds that a CIC provider had a higher rating was 2.23 times (significant at the 0.05 level) the odds for for-profit locations. CICs also performed significantly (at the 0.1 level) better in the “safe” domain. Government-run locations performed better than for-profits in the “safe”, “well-led and responsive” domains at the 0.05 level and were also more likely to have a higher rating in the “effective” domain at the 0.1 significance level. With a larger sample size, nonprofit locations had significantly (at the 0.05 level) higher odds to be rated better in all the domains. Independently-run entities were significantly less (at the 0.05 level) likely to have a higher rating in the “safe”, “effective”, and “well-led” domains. We also note that the coefficients size of “during\_covid” is the largest among all variables. For the overall rating, the odds that a location is given a rating during the COVID period are only 17% of the odds that a comparable location before COVID is rated higher, significant at the 0.05 level. This confirmed our assumption that social care for the elderly was greatly impacted by the pandemic. The OLS regression results show the same relative relationships of the quality ratings of locations across different sectors, which means our models are robust across different models.

**DISCUSSION**

Our analysis showed that our first hypothesis held true, that is, social care CICs did have better service quality outcomes than social care for-profits. However, our other two hypotheses were false. For hypothesis two, social care CICs in fact did not have poorer service quality outcomes than social care nonprofits and actually performed as well as or better than nonprofits. For the third hypothesis we found that social care CICs did not have similar service quality outcomes compared with independently-run entities, instead they outperformed independently-run entities in every domain. Our analysis additionally showed that CICs performed as well as or better than government-run social care organizations. Generally, our findings align with studies that show that nonprofits perform better than for-profits in the social care industry (Commondore, 2007). However, our findings diverge from the qualitative case studies of integrated social enterprises that indicate social enterprises are vulnerable to mission drift. This may be because social care CICs are differentiated social enterprises rather than integrated and therefore able to buffer their clients from some of the direct impact of commercially-focused decisions (Cornforth, 2014; Ebrahim et al., 2014). These findings also suggest a more nuanced picture than what resource dependency suggests at face value because nonprofit social enterprises were able to maintain a focus on social mission in contrast to for-profits. A key factor may be that when investors are removed from the equation - as is the case with CICs that do not distribute profit (the majority of those in our dataset) - all profits go to support the mission. Thus, we propose that commercial profits and even profit motives, in and of themselves, are not necessarily bad for organizations – the specific conditions under which they are generated and used however are key and can lead to the stabilization of social mission rather than mission drift. A policy implication directly stemming from this conclusion is to encourage the movement of more profits back into for-profit social care organizations. Further investigation into social care CICs that are specifically Companies Limited by Shares which distribute shares that are capped to retain profits in the organization would shed more light on the efficacy of this approach.

**REFERENCES AVAILABLE FROM THE AUTHORS**