Law Commission Review of Co-operative Law

Anthony Collins Briefing Notes

Briefing Note 2: Care

This Briefing Note focusses on the care sector and looks at three questions:

- Do we have a co-operative care sector in the UK and does this matter?
- What about other countries: does the law make a difference?
- Should UK law be changed, and if so, how?

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The Law Commission has been invited by Treasury to review the legal framework governing co-operatives and community benefit societies.[1] It has been asked to consider whether the current statute law which governs these organisations is *fitting to their nature and needs*, and *whether the current form of regulation is proportionate*.

The All Party Parliamentary Group for Mutuals has also announced that it will spearhead a campaign to co-ordinate a cross mutual sector response to the review.

We are producing these briefing notes because Anthony Collins is keen to support the Law Commission itself, the APPG process and all those who may wish to contribute to the review. The briefing notes are intended to assist by helping to raise awareness of this Law Commission review, providing some background information and describing the context for the review and encouraging conversation about important areas that might be included.

These notes are not intended to put forward particular changes to the law; but they are intended to provoke discussion. There is an urgent need for new ideas to address the crises we face today, and it is important that this opportunity for change isn't missed.

If you would like to talk to us about anything in the briefing notes, or anything else that might help you in engaging with the review, please contact one of us.

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[1] Historically known as "industrial and provident societies"

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Do we have a co-operative care sector in the UK and does this matter?

In the UK in 2021/22, the National Health Service provided 86% of health care,[2] and the private sector now dominates provision of social care.[3] Social enterprise is a significant new arrival on the scene.[4] We certainly have some pioneering co-operative care organisations,[5] but they are bucking the general trend: co-operation[6] only plays a marginal role in UK care.

Co-operation and mutuality are generally a bottom-up, community-based response to unmet human need. The existence of the NHS and state-funded social care means that a large amount of need has been met over recent decades; with such comprehensive state provision, community-based self-help has been largely unnecessary.[7]

Since 1948, the big change in the source of health and social care provision has been the growth of private care. From the late 1970s, an ideological drive for competition and market-based provision has been pursued as an alternative to public provision. This has become significant in healthcare, and dominant in social care where local government has become a commissioner rather than provider. Consequently there is no 'cooperative demand'.

Another perspective

That's one way of looking at it; but arguably it doesn't really describe an accurate picture.

"The NHS itself was created on the shoulders of a strong social enterprise and co-operative tradition. The 1942 Beveridge Report recommended that the NHS be structured along co-operative principles, with mutual friendly societies at its heart. As he launched the English National Health service, Bevan announced: 'All I am doing is extending to the entire population of Britain the benefits we had in Tredegar', where Tredegar Medical Aid Society supplied healthcare free at the point of need to all members in turn for an annual contribution."[8]

There were over 25,000 health mutuals with 6.6 million members in 1910; Bevan's description was neither inaccurate nor exaggerated. The NHS was a nationalisation of a vast amount of mutual, co-operative as well as voluntary and charitable provision (hospitals and other medical facilities often have a philanthropic background). Not only does the public or private binary characterisation distort the historical background of what many still call "our NHS", it also fails to acknowledge what has been going on for the last few decades:

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[2] https://www.nuffieldtrust.org.uk/resource/how-much-planned-care-in-england-is-delivered-and-funded-privately

[3] For example, private provision of residential care has increase from 10% in 1960 to 83% in 2022 https://weownit.org.uk/public-ownership/care-work

[4] In 2019, around 1/3rd of community health services were delivered by SEs; health and social care SEs turned over £1.5bn. https://www.nhsconfed.org/publications/social-enterprises-part-nhs-family

[5] Equal Care, Colne Valley Care, Be Caring, Cartrefi Cymru, Leading Lives

[6] This phrase is used to describe care provided by or through co-operative or community benefit societies or other democratic organisations which identify as co-operatives

[7] The hospice movement is an interesting exception to this

[8] Social Enterprises: part of the NHS Family, NHS Confederation and Social Enterprise UK, July 2019

- NHS Foundation Trusts (there are 215) are the format for acute, tertiary, specialist, ambulance and mental health services. Created in 2003 as member-based "public benefit corporations" they are modelled on traditional co-operative and mutual bodies with a form of democratic governance.
- When the out-of-hours regulations were changed for GPs in 2004, many former GP co-operatives, established by GPs themselves to manage out-of-hours duties, converted into broader community ownership, extending influence over the services beyond GPs alone. There is now a national network of these organisations which are members of Urgent Health UK, a partnership of social enterprise providers covering 64% of the UK population.[9] They clearly identify as social enterprises, or not-for-profit, and occasionally mention their co-operative roots.
- Since 2006[10], there has been a substantial growth of social enterprise in health and social care. Transforming Community Services was an NHS programme launched in 2008 to find a new home for the patchwork of services then under the ownership and control of Primary Care Trusts. One of the options encouraged was social enterprise, resulting in a number of employee-owned spinouts.[11]
- There is a significant number of charitable social care providers, particularly in residential care. In 2020, 14% of the care home sector was charitable.[12]

Yes, state provision continues to be eroded today by investor-owned providers.[13] But there is emerging from within the system an alternative, values-based approach. Whether it is labelled co-operative, social enterprise, mutual or charitable, it both predates the market and state, and is now re-appearing. On the evidence above, the UK has a thriving non-market, non-state care sector: it's just more likely to identify as social enterprise than co-operative.

Does this matter?

It matters because the future of care faces challenges. Different options and ideas are needed. By remaining focussed only on ownership and structure, and the state and the market as future long-term sources of care provision, the UK risks failing to consider (a) the other obvious source of provision, namely people doing business to meet human need; and (b) another important feature of the arrangements under which care is provided: contracts.

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[9] Badger Group (Birmingham, Solihull) Bardoc (Bury, Rochdale, Bolton), Bedoc (Bedfordshire), BrisDoc (Bristol, North Somerset, South Gloucestershire), CHoC (Cumbria), DHU Healthcare (Derbyshire, East Midlands), East Berkshire Primary Care, FCMS (Fylde Coast, Lancashire, South Cumbria, South Yorkshire, Greater Manchester, Midlands), FedBucks GP Federation (Buckinghamshire), Herts Urgent Care (East and South West England), IC24 (South and East England), Kernow Health (Cornwall), LCW (London Central and West), Local Care Direct (Yorkshire, Humberside), Mastercall Healthcare (North West and Nationwide), NEMS (Nottingham, Mansfield, Newark), NHUC (North Hampshire), Primary Care 24 (Halton, Knowsley, Liverpool, St Helens, South Sefton, Southport, Formby and Warrington), PELC (East London), Salford Primary Care Together (Salford), SELDOC (South East London), Shropdoc (Shropshire), Suffolk GP Federation (Suffolk),

[10] The year when the NHS set up a social enterprise unit

[11] Leading Lives, Care Plus Group, Aspire, Be Caring, Central Surrey Healthcare, Your Healthcare, Medway, Bevan Healthcare, Here, Thurrock Lifestyle Solutions, Social AdVentures, Navigo, North East Essex Community Services, Sirona, Provide, Spectrum Community Health

[12] https://www.thinknpc.org/blog/charity-care-homes/

[13] "Tenth of elective operations done in private hospitals" the Guardian 9th March 2024

Contracts are useful; they provide the certainty that organisations need to plan ahead and manage risk. They are a market mechanism, designed to enable private enterprises to carry on their business and achieve their objective. They do this by importing the power of the law courts, enabling them to be enforced against a party in default.

But contracts are also brittle, tied to the words on the page, and reflecting an agreement made at a point in time. That can work against them being flexible, responsive to change and difference, or nuance. They are arguably less appropriate between parties that wish to collaborate and avoid an adversarial approach. They are good for market transactions, not so good for social relationships. Contracts and tendering pose the biggest challenge to the sustainability of the many social enterprises that have emerged over recent decades.

Through the purchaser provider split, contracting has become the formal legal mechanism for the provision of care. It imposes a market-mechanism on all organisations, whether they exist to reward investors, deliver a public purpose, have a charitable purpose, or are driven by social values and actually shun private gain. Ironically, contracts now even seek to deliver social value on a contractual basis.

But co-operation and mutuality also provide a mechanism for formal relationships. Members of a co-operative gain access to goods and services through and from their co-operative. For them, it is an alternative to rigid market-based contracts which don't work for them.

In practice this means shifting the focus away from the legal entities that provide care services. Instead, what needs to be explored is the possibility that a co-operative is the mechanism by and through which services can be provided between commissioners and providers, within governance arrangements rather than principally through contracts. The fact that membership is open to anyone who can subscribe to a co-operative's rules and purpose creates a different dynamic and an alternative to the use of competition to select providers. Here there is no divide between commissioners and providers. Rather, everyone with the common purpose of meeting the needs of the vulnerable brings their resources to what is "an autonomous association of persons united voluntarily to meet their common economic, social and cultural needs and aspirations through a jointly owned and democratically controlled enterprise".[14] To be explored further is whether there would thereby be any "public contract" that is subject to the current procurement regulatory regime or the one that is forthcoming under the Procurement Act 2023.

As a broader legal framework, co-operation is capable of providing an alternative home for social enterprise, as other jurisdictions have found and developed (see below). But this has not happened so far in the UK, with the result that the many (non-state, non-market) providers of health and social care do not have a legal and commercial home. They are forced to operate within the market mechanism of contracts, doing their best to anchor their commitment to social values by other means.

[14] The International Cooperative Alliances definition of a co-operative, cited by the Financial Conduct Authority as its basis for registering a co-operative in paragraph 4.10 of its guidance on registration.

Other countries have a co-operative care sector; does the law make a difference?

Co-operation is a worldwide movement. Its apex body is the International Co-operative Alliance (ICA) which is custodian of the internationally recognised Co-operative Identity Statement.[15] Most European countries have co-operative laws (see further below), as do many in Asia, Africa, the Americas and Australasia.

A global review of co-operatives and mutuals in health and social care in 2014[16] found that:

- 43 countries had clinics, medical centres or hospitals owned or managed by mutuals and co-operatives
- there were 18,806 social care co-operatives worldwide
- UNIMED in Brazil brings together 354 medical co-operatives representing 110,000 doctors
- Italy had 10,836 co-operatives in the social sector, mainly social and personal care
- co-operatives existed in pharmacy at all levels worldwide: retail, wholesale and production.

As in the UK, the care economy elsewhere is shaped by history. Brazilian doctors established UNIMED in 1960 in the absence of a public health system and as an alternative management model based on ethics and the social role of medicine. Italian social co-operatives are particularly concentrated in an area where co-operation is deeply embedded culturally dating back to the mid-19th century and has been intentionally pursued by communities, local institutions and municipalities as the state has withdrawn from provision. In other countries, co-operation has provided a home for non-state, non-market care.

International comparisons need to be treated cautiously; history and culture cannot be replicated. Laws can have an impact, but generally are enacted to support an already existing initiative, rather than establishing new ones. Where there is already a groundswell of collaborative or co-operative endeavour, changes to the law can have a significant impact. For example, in Italy the introduction of relief from corporation tax on surpluses transferred to indivisible reserves, and the protection of assets, played a part in the growth of social co-operatives.

There is strong encouragement from within the ICA and from the United Nations and the Secretary-General for individual countries to establish supportive legislative and regulatory frameworks for co-operatives. The International Labour Organisation's recommendation 193 on the Promotion of Co-operatives,[17] the ICA's Blueprint for a Co-operative Decade[18] and the

[15] https://ica.coop/en/co-operatives/co-operative-identity

[16] https://www.socioeco.org/bdf_fiche-document-4238_en.html

[17] https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_code:R193

[18] https://ica.coop/en/media/library/fact-sheets-brochure-leaflet/blueprint-co-operative-decade#:~:text=The%20Blueprint%20for%20a%20Co-operative,Identity%2C%20Legal%20Frameworks%20and%20Capital.

Secretary-General's report to the UN Council during the pandemic all call for a supportive environment for the development of co-operatives through legislation and regulation.[19]

In this respect, the UK significantly lags behind other jurisdictions. In a review of UK co-operative law as part of the joint ICA/EU legal framework analysis mapping co-operative laws around the world, the conclusion was that UK co-operative law remains comparatively under-developed with the result that the UK is an unfriendly environment for the establishment and promotion of co-operatives.[20]

An analysis of the co-operative laws of EU member states found that the UK was in a minority in not requiring the setting aside of indivisible reserves, a core feature of co-operation.[21] The review observed that six member states expressly refer to co-operatives in their national constitution, which tends to result in their co-operative laws including a number of key features including: legal recognition of co-operatives as a business form, a legal definition of a co-operative, a requirement for indivisible reserves and protection of those reserves on winding up (an asset-lock).

It is in looking at the international legal context that the under-developed state of UK co-operative law is more apparent. It does not provide an alternative legal and statutory home for values-based commercial provision. In the context of care, such a move could be beneficial. It might help to strengthen an already existing initiative for purpose driven care. It might help to open up strategically a further option beyond state or market-based provision. Doing so would also bring the UK more in line with other countries. The United Nations recently declared 2025 as the International Year of Co-operatives, highlighting the pivotal role of co-operatives in achieving Sustainable Development Goals.

So there is a broad international drive to encourage supportive co-operative legal frameworks, and there are examples of where they have made a difference; but the UK is lagging behind here. In the context of care, the question is whether changes in co-operative law would assist the broader non-state non-market care sector here.

Should UK law be changed, and if so, how?

If care providers generally identify as social enterprises rather than co-operatives, would changes to co-operative law be of interest to them?

A minority do identify with co-operation.[22] Some may specifically not wish to do so. But there will be many for whom labels and structures are less important than the underlying substance. If there is an option of being values-driven, and anchored to legal arrangements which recognise and protect that commitment, this is useful, particularly if it brings other advantages. Being "co-operative" could be defined by reference to features rather than structures.

[19] https://undocs.org/Home/Mobile?FinalSymbol=A%2F76%2F209&Language=E&DeviceType=Desktop&LangRequested=False

[20] https://coops4dev.coop/en/4deveurope/united-kingdom#general (See link to Legal Framework Analysis)

[21] Journal of International Co-operative Law, issue 3 page 186 https://iuscooperativum.org/issues/

[22] For example, Leading Lives in social care

The UK differs from other jurisdictions in that it does not define “co-operative” in legislation. It is left to the body responsible for registering co-operatives, the Financial Conduct Authority, to decide whether it is satisfied that a new society is a “bona fide co-operative” or not.[23] The FCA now publishes guidance explaining how it approaches this question, which is mainly based on the ICA definition and the first three Principles.[24]

This arrangement does not provide a sufficiently strong and secure basis for establishing co-operative identity. The FCA (or a future registrar) could change that guidance. It relies on individuals interpreting it. And it leaves the word “co-operative” open to a range of uses and meanings in the UK.

Why does this matter? In legal terms, the essence of co-operation, as initiated in Rochdale in 1844 and captured in the ICA Identity Statement, is that unlike other businesses:

- a co-operative carries on business not for any private reward but for the general benefit of current and future members;
- fairness and equality (democratic control) are at the heart of its way of operating;
- the underlying value of the business is generally held by the members for the time being on a form of trust for themselves and future members, and in many cases they have no entitlement to that underlying value should the co-operative be wound up.

These features could and arguably should be captured within a definition of co-operative. Most if not all of these features are shared by social enterprises and employee-owned businesses operating in health and social care. Few would have difficulty with them.

As noted above, as well as defining co-operative, the majority of EU states require co-operatives to set aside a portion of their profits to an indivisible reserve, which cannot be distributed to members. This is an important aspect of identity and differentiates them from investor-ownership where all profits are by default appropriated to the owners.

These core features of mutual benefit, fairness and equality and disinterested ownership are both the reason why co-operation contributes to the wider public good of the nation, and what gives co-operation its particular identity elsewhere. It is why countries with written constitutions might include express reference to co-operatives,[25] recognising the social value that they bring to citizens and residents.[26]

By identifying in law these core legal features as essential aspects of being co-operative, the law can provide a basis for government policy, should it wish to do so, to encourage that type of enterprise. If government wanted to encourage the emergence of co-operative or social enterprise forms of care, it could choose to do this by fiscal or regulatory arrangements which provided a legitimate incentive to those setting up new businesses.

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[23] https://www.legislation.gov.uk/ukpga/2014/14/section/2

[24] https://www.fca.org.uk/publication/finalised-guidance/fg15-12.pdf

[25] “The Republic recognises the social function of cooperation with mutual character and without private speculation purpose. The law promotes and favours its growth with the most adequate means, through appropriate controls, its character and purposes.” Italy, Constitution of 1948

[26] The UK does not have a written constitution, but the Welsh Government is addressing this through the overarching Wellbeing of Future Generations Act, and the sector specific Social Services and Well-being Act which requires the promotion of social enterprises and co-operatives

If such changes could be made to UK co-operative law, should they be made?

The public provision of care in the UK faces substantial challenges. The provision of care for profit is prevalent elsewhere and growing in the UK but raises serious questions. Welsh Government recently adopted a policy to "eliminate profit from the care of looked-after children", which may be the first overt attempt to force an exploration of alternative options.[27] Some argue that the profit motive does not sit well with care of any kind.[28] Giving is at the heart of care and giving conflicts with the aim of maximising private gain.

Care needs a legal home where giving, collaborating and meeting human need are the driving imperatives. The market and the state have a role to play, but the law needs to facilitate arrangements which provide a viable, sustainable alternative which is aligned with the aims of those who care.

Post-script

There is an important point of detail to add, which many have commented on: namely the current polarisation between bona fide co-operatives and community benefit societies. The legislation and the way it is implemented by the FCA tends to see these as two hermetically sealed options, with separate titles (e.g. 'co-operative' cannot be included in the name of a CB societies) and clearly distinct features (e.g. co-operatives are for the benefit of members and CB societies are only for the benefit of the community and not members).

This polarisation is unhelpful for what is in reality more of a spectrum. It also takes community benefit societies 'outside' co-operation as if it was not part of the same movement, where in other jurisdictions this is not the case at all. From certain perspectives, such as that of the state or public sector, it tends to result in a strong preference for CB societies and loss of interest in co-operatives. This is unhelpful and should be addressed.

Further questions

Do you have any reflections on what is set out above?

Are there particular areas of existing co-operative law where you believe changes would be helpful in helping to broaden the provision of care in the UK?

Are the existing provisions relating to co-operative share capital an inhibiting factor in care?

[27] Wales is significantly more progressive in promoting cooperatives than England (see footnote 26 above)

[28] These are the words of Greater Manchester Mayor Andy Burnham at Co-operative Congress in 2022