

Destabilising our healthcare?

How private companies could threaten the ethics and efficiency of the NHS



Introduction

NHS hospitals play a central role in our healthcare system. They use around three quarters of the £100bn NHS budget and understandably their performance comes under close public scrutiny. Hospital managers are under heavy pressure to meet financial targets, as well as those related to the standards of care. Hospitals that are in regular deficit are often referred to as 'failing', even if they are performing well in terms of the clinical care that they are delivering. On top of the long-term pressure to meet financial targets, there is now a drive for the NHS to make £20bn of efficiency savings and for all NHS hospitals to become foundation trusts by 2014.

Part of the current government's solution is to give commercial companies the chance to take over the entire operational management of NHS hospitals that have persistent financial problems. The first of these schemes has been signed with Circle; the company will now be managing the debt-ridden Hinchingsbrooke Hospital from February 2012. It is very likely that this is just the first of many agreements that will be signed with private companies to outsource the entire management of NHS hospitals in line with the government's commitment towards increasing both competition and the role of the private sector within the NHS. The deal with Circle can be viewed as a test run for a business model which might then be applied to run other struggling hospitals in the hope that it will alleviate debt and reduce costs. The major concern of any 'business model' applied to an NHS hospital by Circle or any other commercial organisation is that in order to reduce costs the first target will be a reduction in services.

In this report we examine the prospects for the scheme expanding and look at which companies are interested in taking up this business opportunity. The deal with Circle attracted a high level of media coverage, with its Chief Executive more than willing to outline the company's business ethos, but many of the other providers that might be interested in NHS hospitals are not often in the public eye. This report looks at the structure, investors and business history of all the major players in the UK's private hospital business, and from these identifies causes for public concern about how the companies' business approach might impact upon the NHS.

We also examine the evidence to support the idea that the private sector offers a solution for the problems of the worst performing hospitals.

Finally we include an analysis of the government's plan to lift the cap on the income that NHS hospitals can generate from private patients. This is already creating interest amongst commercial providers in running private patient units on NHS sites and could be an additional impetus for companies to want to run NHS hospital services.

Questions addressed in this report:

What stage has hospital franchising reached and how will it expand?

Which commercial providers are interested in running NHS hospitals?

What is the structure, business history and who are the investors of these commercial providers ?

How might the approach of these commercial companies impact upon the NHS? What are the issues of public concern?

Is the private sector the best solution for the worst performing hospitals?

Summary

1. The government has been effective in persuading companies that contract opportunities will become available for private companies to manage NHS hospitals and as a result there is considerable commercial interest in these opportunities. The Circle contract is clearly not a one-off, more a test-run for one potential business model that could be taken up by other NHS hospitals in the future.

2. All of the private companies we examined took an optimistic view of the business opportunities which lie ahead within the NHS. They all had plans for expansion and had identified opportunities for more private/NHS partnership and concluded that added pressure on NHS funding will mean a boost for the self pay and insurance market over time.

3. Attitudes to the Government's health bill amongst the private providers were found to be supportive. Ramsay Health noted that the NHS bill is going to be advantageous and Spire noted that it is "very positive for the private sector". Others like HCA have made their support for Conservative policy clear by donating funds to the party. Circle's backers include Paul Ruddock, one of the Conservative party's most generous donors.

4. The two largest players in the UK private hospital market - GHG and Spire, openly admit that they will benefit from NHS spending cutbacks. Spire said, "We believe the private sector will continue to expand in the UK, fuelled by uncertainty around NHS cuts in services, increased waiting times and an increasing desire from patients and doctors for advanced techniques and treatments."

5. Four of the six companies we looked at in detail have large investments from private equity companies. Clearly in the long term their investment strategies may not fit with needs of the NHS or the local populations they serve. At some point they will want to exit the business. NHS services will become less secure as they become more reliant on the supply of services from these companies.

6. GHG and Circle have structured their assets so that property can be disposed of when the market is right, an approach linked to private equity firms. This business strategy is considered to be one of the major reasons for the financial mess created at care-home provider Southern Cross.

7. The business record of some of the new providers raises doubts about their suitability as partners in the NHS. Our research highlighted companies with connections to corporate fraud and illegal kidney transplantation - which brings into question whether some private companies would uphold the values of the NHS, as would be their duty under the NHS constitution.

8. The stated business strategy of some commercial providers will put them at odds with the health needs of the local population. We found that some are honest about their strategy to leave contracts where the financial return is too small.



The First Franchising Deal

The first deal handing over operational control of an entire NHS district hospital has been signed with a company called Circle. They currently run a small number of private clinics and a surgical treatment centre, but have now signed a 10-year contract to operate the NHS Hinchingsbrooke hospital in Cambridgeshire from February 2012. This is a controversial arrangement as it hands unprecedented control of NHS resources to a profit-motivated organisation and offers potential conflict with the traditional values of the NHS.

Labour MP Valerie Vaz, who sits on the health select committee summed up the concern "It is difficult to comprehend how Circle can maintain a proper standard of healthcare while maximising profit; as a company they would have to make a profit, but that can only come if costs are cut – such as a shorter stay in bed to recover, one less nurse. That must compromise patient care."

Others have voiced concerns about the ability of Circle to manage complex services like A&E and maternity without any previous experience. The future for staff is uncertain. Circle portrays itself as a social enterprise, giving staff control and a financial stake in the company: this claim is highly questionable. In reality the company is controlled by a number of investment funds. This is explored in greater depth later in this report.

Despite the criticism the government is clear about the benefits it expects from the deal. It believes the deal secures the future of the Hinchingsbrooke hospital and passes over the financial risk of its debt to the private sector, whilst also retaining the asset within public ownership – "a good deal for patients and staff."

The contract with Circle is certainly ground-breaking as it transfers complete responsibility for day-to-day operations to the company. The only similar experiment with franchising took place at Good Hope NHS Trust in Birmingham, which was privately managed by Tribal Consulting, however it has now been taken over by Heart of Birmingham NHS FT. This experience has been missing from recent media reports on this issue. In fact the contract was terminated by the SHA in August 2006 ahead of schedule.¹ Tribal was criticised for the fact that Good Hope's deficit increased from £839,000 to £3,576,000 under their management, although unlike the deal with Circle, they did not have complete operational control.

What is the deal?

Circle will manage an estimated £1bn of turnover at Hinchingsbrooke Health Care Trust, over a 10-year period. It is only required to cover any losses incurred by the trust over that period beginning in February 2012 up to the first £5m. If the trust incurs further losses whilst under Circle's management, either party can terminate the deal, requiring Circle to pay a £2m termination fee to Hinchingsbrooke Health Care Trust. This means the company's potential losses are capped at £7m, or 0.7% of the NHS funds it will manage over the term of the contract.² Any surpluses made at the hospital will be split between Circle and the NHS, with much of the latter share used to pay off the trust's £40m debts.

How big are plans for franchising the management of NHS hospitals?

The success of the Hinchingsbrooke scheme will heavily influence how far the franchising of NHS management expands. It is in effect testing a new business model which could be applied to many other NHS hospitals.

Circle put in a bid on a second contract to run Epsom hospital (although this has now been withdrawn) and its chairman, Ali Parsa has said that his company would “love to do a lot more.” However accusations that this is privatisation of the NHS are of far more concern to the government since the huge controversy surrounding the coalition’s health bill. Ministers remain tightlipped about how far they would want the idea to go. Yet other sources provide indications that planning for more contracts continues and that commercial interest is building.

In September, the Guardian reported that “the Department of Health secretly plans to hand over the running of up to 20 NHS hospitals to foreign firms.” Freedom of information requests revealed that the management consultant McKinsey has been advising the department of health and appears to have been scoping the attitude of several international health providers to franchise opportunities in the UK health market.³

The members of the Private Hospitals Alliance (PHA) – a group of the five largest providers of Private hospital beds in the UK – made their support for the opportunities to expand their business interests in the UK very clear: “In particular, PHA welcomes the White Paper’s commitment to widening NHS choice and commissioning from “any willing provider” and bringing together more effective economic regulation under Monitor”.⁴

The Guardian has also claimed that German company Helios is looking at opportunities in the NHS acute sector, taking part in a workshop on the issue with senior NHS managers in London. Interestingly, this took place a month before the release of the government’s white paper outlining the market-based reforms.

Health minister Simon Burns confirmed that a large number of companies had shown interest in the Hinchingsbrooke contract: “There were eleven bidders at the start, the vast majority of which were private sector bidders, although there were some NHS ones.” In fact the last NHS bidder, Cambridgeshire University Hospital Foundation Trust pulled out of the tendering process in February 2010 and the final three bidders were all non-NHS companies: Circle, Ramsay healthcare and Serco. Despite the government’s nervousness, commercial providers are taking this opportunity seriously. It seems unlikely that they would show this level of commitment unless they were confident and had been reassured that the government was going ahead.

Circle sees themselves as trail blazers in this new market and their chairman clearly wants to gain a head start on the competition from abroad: “If we do not have national champions then we are going to let the Germans and the South Africans come in, in a few years’ time. We will have the Wimbledonisation of the NHS, where no British player ever wins. We need British companies to have management

control, otherwise decisions are taken in foreign countries. Look at what happened with Cadbury's. They closed down the factories. We don't want that in the NHS."

Much of the encouragement for commercial providers comes from the government's intention to push through free market style reforms. Despite the controversy and many amendments to the Health and Social Care bill, its central themes of raising competition and private sector involvement remain strongly present.⁵ The government believes that competition can improve the quality of care in hospitals and the Prime Minister has quoted research by LSE to support this view, but this research has subsequently been criticised by other academics.⁶

So far franchising has been aimed at hospitals long term debt problems. There are a group of twenty trusts which the National Audit Office described as "at risk".⁷ The government is committed to making all hospitals gain foundation status and it is clear that they perceive commercial management as an option for those hospitals that cannot meet the criteria for this change. However, in theory the franchising of hospital management could extend much further than the "at risk" group. So far the government has placed no limit on the numbers.

A further possibility is that the NHS may be forced to allow the private sector to bid to run NHS hospitals by EU rules on competition. A growing body of legal opinion suggests that by opening up the NHS to competition the government will expose the NHS to European law, effectively opening up more NHS services to the tender process.⁸ Commercial companies have stated that they will use the courts to ensure that this happens.

The Private Hospitals Alliance

The Private Hospitals Alliance (formerly the H5) was formed in October 2010 by the five biggest private hospital groups in the UK:

General Healthcare Group (GHG)

Ramsay Health UK

Spire Healthcare

Nuffield Health

HCA International

Together these five groups are responsible for 80% of the UK's private hospitals and 85% of private hospital beds. A major rationale for the group's formation is to influence Government policy on healthcare. Its inception was accompanied by a launch party in parliament attended by over thirty MPs and peers.

Table 1 (below): Eight of the private companies currently involved in providing NHS services, including the five companies of the Private Hospitals Alliance.

Company	Parent or Holding Company	Private, Public or Charity	Country	UK Facilities & Operations	2010 Turnover
Ramsay Healthcare	Ramsay Healthcare (Australia)	Public	Australia	45 hospitals & treatment centres	\$3.4 billion (group) \$628 million (UK)
BMI / GHG	Netcare	Private	UK	73 hospitals & clinics	£855 million (GHG)
HCA International	Health Corporation of America	Public	USA	10 hospitals & outpatient clinics	£3.75 billion (group) £330 million (UK)
Spire Healthcare	Cinven	Private	UK	37 hospitals	£643 million
Nuffield Healthcare		Charity	UK	200 facilities (approx)	£548 million
Circle	Circle Holdings	Public	UK	4 clinics and Hinchingsbrooke hospital	£84 million
Assura Medical	Virgin	Private	UK	25 GP companies	
Capita Health	Capita	Public	UK		£2,777 million

BMI Healthcare

BMI Healthcare is the acute private hospital division of General Healthcare Group (GHG), and is the largest provider of private healthcare facilities in the UK, with over seventy facilities UK-wide. GHG also consists of Care Fertility, a private specialist in fertility treatment, and Netcare, a network of clinics set up in 2002 in the UK by South African company Netcare, which undertakes work under contract to the NHS.

Business strategy

The history of GHG stretches back to the 1970s when AMI, a private US healthcare group, bought the Harley Street Clinic in London. In 1993, following a period of expansion, AMI changed its name to BMI Healthcare and the new corporate group General Healthcare Group was formed. There then followed a period of further expansion until in 1997 investment funds managed by Cinven Ltd acquired GHG. In 2000 investment funds managed by Cinven Ltd sold GHG to investment funds advised by BC Partners, one of Europe's leading private equity companies. In 2006 BC Partners sold GHG to a consortium led by Netcare, South Africa's leading private hospital group and the private equity firms Apax Partners, London & Regional and the Brockton funds for £2.2 billion.⁹ Netcare now owns a majority share in GHG at 50.1%. Since the acquisition, GHG has gone on to acquire further hospitals in the UK.

In 2006 when Netcare acquired GHG, the company's CEO Dr Richard Friedland, commented that, "We have targeted the UK healthcare market for expansion, as the long-term demographic trends and prospects for development of the private acute care market as well as partnership with the NHS, offer significant future growth potential".⁹ More recently, GHG's attitude to NHS reform was made clear in a press release accompanying the company's annual results for the year ended 30 September 2010. The release – headlined "Sustained growth, expanding footprint and on the cusp of a new era" – clearly outlines the opportunity the company could derive from the NHS White Paper. The company considers there to be significant additional opportunities for private/NHS partnership and added pressure on NHS funding will mean a return of self pay and an increase in insured lives over time. The CEO at the time, Adrian Fawcett, noted in the press release, "We are entering a new, exciting era, driven by the forthcoming healthcare reform that will ultimately change, to our benefit, the landscape in which we operate."¹⁰

Until May 2011 the CEO of BMI Healthcare was Adrian Fawcett and he was highly vocal expressing his opinion on the role of private healthcare in the UK. In a speech at the Reform Health Conference in July 2010, Fawcett called for "greater self-responsibility in healthcare", saying "it is important that those that can afford to pay for themselves should be encouraged to if that makes financial sense to the Exchequer."¹¹ Fawcett was extremely outspoken in an interview with the Health Services Journal in May 2011. In the interview Fawcett is enthusiastic about the potential for private care in the NHS and is adamant that competition on price is inevitable. He told the HSJ: "At a macro level, I'm more excited than ever about what the healthcare marketplace and healthcare reforms mean for

the future” and is also quoted as saying it would be “madness not to end up where price became part of the equation” when providing healthcare.¹² Soon after this interview in June 2011, Fawcett was replaced as CEO by Stephen Collier, a barrister by training – the Health Services Journal hinted that his exit was related to his outspoken opinions expressed in the May 2011 article.¹³ In a statement upon his departure Fawcett noted, however, that the company strategy was “clearly set” and was not going to change with the new leadership: “You won’t get a cigarette paper between what [Mr Collier] is saying and what I’ve said.”¹³ Fawcett remains a leading shareholder in BMI Healthcare. In an interview for Health Investor in October 2011, Collier noted that “the group will also be looking for more joint ventures with “strong NHS trusts”, developing their private patient units over the next 12-18 months.”¹⁴

Who owns GHG?

GHG is owned by a four company consortium: Netcare, Apax Partners, London & Regional and Brockton. According to Apax’s website each of these companies brings something different to GHG; Netcare as a large healthcare provider brings “operational excellence in managing hospitals”, L&R and Brockton would “help to release value from GHG’s property portfolio,” whilst Apax brings an “international outlook on the sector as well as their expertise and relationships in the financial arena.”¹⁶

The majority shareholder (50.1%) of GHG, and consequently the most influential, is the leading South African healthcare provider Netcare. The South African healthcare market has similarities to the UK’s, as it is a two-tier system comprising a public system, that covers the vast majority of people which is overstretched and underfunded, and a private system, of which Netcare is a major component. In South Africa Netcare, a listed company, operates the largest private hospital network in the country, with 49 owned hospitals and four managed hospitals, three of which are public-private partnerships. Netcare noted following its acquisition of control of GHG, that there is little opportunity for expansion in its home market.¹⁷ Before the acquisition of GHG, Netcare was present in the UK market with Netcare UK, an independent service provider to the NHS operating a surgical centre and mobile ophthalmic units; Netcare UK has now been incorporated into GHG.

In its home market, South Africa, Netcare has been embroiled in considerable controversy. In September 2010 Netcare came to the attention of the press when charges were finally laid against the company, its CEO Richard Friedland and several ex-employees after a long-running investigation into an illegal kidney transplantation syndicate. According to the original charge sheet Netcare, Friedland, the prominent kidney specialist Jeffrey Kallmeyer, two specialist surgeons, two doctors, transplant unit staff and an Israeli interpreter were involved in an illegal scheme to give kidney transplants to wealthy Israelis, using organs bought from poor Brazilians, Romanians and Israelis. To legitimise the surgery, documents were allegedly forged to show that the donor and the recipient were related (living donations can only take place between relatives in South Africa). A reported 109 illegal transplantation operations took place between 2001 and 2003. In September 2010 Netcare Limited



Netcare executives were charged in South Africa for involvement in illegal kidney transplantation.

GHG property assets have been separated, ready to be disposed when market conditions are right.

and its CEO, Richard Friedland were charged on 100 counts of involvement with the syndicate. The charges included five counts in which the supplier of the kidneys were minors.¹⁷

However, in November 2010, the criminal charges against Friedland, were unconditionally withdrawn as a result of a plea agreement, although the Netcare subsidiary Netcare KwaZulu-Natal (NKZ) was convicted on charges related to human tissue crimes in October 2010. The company was fined 20,000 Rand for contravening the Human Tissues Act by allowing minors to donate kidneys and a further 4 million Rand fine was imposed for receiving cash and participating in an illegal kidney transplant scheme conducted at the hospital. Netcare also has to pay 3.8 million Rand to the South African Asset Forfeiture Unit.¹⁸

The kidney specialist Jeffrey Kallmeyer, who allegedly set up the scheme, was eventually convicted in early 2011, seven years after his original arrest; he had fled to Canada after the initial investigation.¹⁹ Four other doctors and two operating theatre staff all ex-employees of Netcare have also been charged and this was due to come to trial in May 2011. An investigative article about the scandal by the South African Mail & Guardian is highly critical of the legal process that has taken place, wondering how Netcare's Richard Friedland and other executives at the company have got away so lightly with only a fine for the company, whereas in their opinion the doctors who did the surgery have been left to take all the blame. In the paper's investigation many more people were found to be involved in the syndicate both inside and outside the company and must have known what was going on. The Mail & Guardian notes that "the biggest scandal of the case, which has dragged on since the first arrests in 2003, is the absence from the dock of any decision-maker from Netcare."²⁰ Richard Friedland remains Netcare's CEO.

Apax, a minority shareholder in the consortium that owns GHG, is a well-known speculative investment fund. The company notes on its website that the average length of an investment by Apax Funds is around five years. Once the initial investment thesis has been realised, an exit committee is set up to begin discussions about the future ownership of the business in question. In January 2010 Reuters reported that Netcare plans an IPO in the near future for GHG, although Netcare would remain the majority shareholder in the company. The IPO would allow Apax, L&R and Brockton to exit the business.²² No IPO has yet taken place, however.

The final two owners of GHG are both investment funds with expertise in the property market and soon after the 2005 acquisition, L&R and Brockton separated GHG's operating assets from its property assets. This created a structure which would facilitate the disposal of property assets when the market conditions are right, according to Apax.¹⁶ Interestingly this type of restructuring followed by the sale of property assets is considered to be one of the major reasons for the financial mess that care-home provider Southern Cross found itself in due to having to pay large amounts of rent to its landlords (in the main for properties it once owned).²¹ The IPO for BMI that was discussed in January 2010 would have left the property arm in private ownership.

Political ties

In political terms GHG has close links with the Conservative party. The company's Chairman Sir Peter Gershon was recruited by the Conservative party just before the election in 2010 as one of David Cameron's independent efficiency experts who identified the £12 billion in spending savings an incoming Conservative government could make. His independence is open to debate given that GHG openly admits it will benefit from NHS spending cutbacks.¹⁵

Ramsay Health UK

Ramsay Health UK has twenty-two acute hospitals in the UK delivering both private treatment and care under contract to the NHS. The company currently manages one large government contract, the GC4 contract, under which they have conducted operations over five years through nine centres. Until recently they managed the E05 contract, which delivered 55,000 operations over five years through seven centres in Cumbria and Lancashire. Ramsay hospitals are also part of the Patient Choice scheme and participate in the NHS Extended Choice Network that offers NHS patients a choice of thirty-eight hospitals including ten treatment centres managed on behalf of the NHS. In March 2011 Ramsay highlighted that 60% of its admissions in the UK where NHS work.²³

Business strategy

Ramsay Health was established in 1964 in Australia and through a process of acquisition in its home market has become Australia's largest private hospital operator. The company's largest acquisition was of Affinity Healthcare in 2005, which increased the number of hospitals from thirty-five to sixty-nine. Ramsay also has a history in Australia of moving into the public hospital sector. In 1994-1995 Ramsay Health won bids to privatise two government-owned repatriation hospitals (also known as veterans hospitals) – Hollywood Hospital in Perth and Greenslopes Hospital in Brisbane. Care in these hospitals was paid for by the federal government so providing a steady stream of money to buffer Ramsay's portfolio of private hospitals.

Ramsay's first foray outside Australia was to Indonesia, where it now runs three private hospitals; these were acquired with the acquisition of Affinity Health in 2005. In 2007 the company acquired Capio, at the time the fourth largest operator of private hospitals in the UK. The company noted at the time that this acquisition would provide a solid platform for growth outside Australia. The company's focus for expansion switched to France in 2010, with the March 2010 acquisition of 57% of the French hospital company Group Proclif SAS, now known as Ramsay Santé. Their expansion in France has continued, with the May 2011 acquisition of the Clinique Convert hospital, which Ramsay notes is a first step in expanding the Ramsay Santé business, with plans for further expansion.



If a facility is not commercially viable Ramsay's policy is to close it as soon as possible.

In the more uncertain UK private hospital market Ramsay Health has made few moves since its initial acquisition in 2007. However, in 2010 Ramsay Health was a bidder in the tender process for running-Hinchingbrooke hospital; Ramsay Health eventually withdrew from the process in August 2010 leaving Circle Health as the winner. Ramsay's executives in the UK are not often in the media spotlight, but along with the company's interest in Hinchingbrooke hospital, there are some examples of the company's strategy in the UK. The company's attitude to the changes in the Government's White Paper was noted in a March 2011 briefing for investors in the UK. The company noted that the NHS bill (at that time) was positive for the company and that a key priority for the company was to influence government policy.²²

A major aspect of the company's business strategy that is worrying for the NHS, patients and other potential business partners is the company's attitude to a business enterprise that is failing. In 2007, Ramsay Health agreed a 10-year deal with Bromley Hospitals Trust (now South London Hospitals Trust) for the Princess Royal University Hospital in Orpington to build a £4.2 million, 25-bed unit and rent it to Ramsay Health UK for £500,000 a year. But in June 2009, just two years into the contract, Ramsay closed the unit saying it was no longer commercially viable. This has left the already deeply in debt South London Hospitals Trust having to pay back eight years rent that was paid upfront by Ramsay Health, and with no money to pay the running costs of the unit without impacting on its budget or to offset the £4.2 million the unit cost to build.²⁴ This aspect of the company's strategy was highlighted more recently in March 2011 when Jill Watts CEO of Ramsay Health UK was called to give evidence before the Public Accounts Committee. Although Watts is at first evasive on the issue of failure, eventually she admits that should a business be failing then the company would close it. When questioned on what would then happen to the patients she noted that that would depend "on what the marketplace is". (Box 1)²⁵

Who owns Ramsay?

Ramsay Health was listed on the Australian stock exchange in 1997, however the majority share owner continues to be the founder of the company Paul Ramsay, currently Chairman of the company. In early 2011 Paul Ramsay (via Paul Ramsay Holdings) owned 36.2% of the company, with other large shareholders being investment companies, banks and pension funds, such as JP Morgan, HSBC, Citicorp and UBS.²⁶

Box 1 (below): Jill Watts, CEO of Ramsay Health UK, giving evidence before the Public Accounts Committee in March 2011.

Q258 Chair: We talked about failure regimes for the GP consortia. What do you think the failure regimes should be if one of your units fails?

Jill Watts: Well, if one of my units fails it doesn't survive.

Chair: What happens to the patient?

Jill Watts: What happens to the patient? We don't have a history of failure, because we have expertise .

Chair: It's quality, we're competing on quality. Something fails, and it's public money. The difference is this isn't people choosing to buy, it's public money, and therefore there has to be a regime for failure, and I am just interested in your view as to what the regime for failure would be for – God forbid – one of your company's units, a general hospital in Barking and Dagenham, you might take over Queen's, nobody else wants to run it.

Jill Watts: It probably would be not dissimilar, we would do everything that we could. If something's failing, then we would go in, we would look at the management of that to see what are those issues, we would do everything in our power.

Chair: But you fail.

Jill Watts: Then we would close it.

Chair: Then what happens to patients?

Jill Watts: For those patients, depending on what the marketplace is, there would be opportunities for other people to come in and take over that facility, and that is what does happen: something is failing, and then someone will come in and either take that over, or, whether there is no need; you have to understand why somewhere has failed, it may be there no demand for a service in an area, and so that service shouldn't be there in the first place. If there is a demand and we can't deliver that effectively, then there is an opportunity for someone who can.

Spire Healthcare

Spire Healthcare is the second largest private healthcare hospital group in the UK with thirty-seven hospitals and 2010 revenue of £293 million. The major part of Spire's business (61% in 2010) is from the private medical insurance market, but NHS admissions accounted for 25% of its business in 2010, followed by 14% from self-paying customers. Spire undertakes a wide variety of treatments, but major areas of business are fertility, obesity treatment, cosmetic surgery and cancer treatment.²⁷

Business strategy

Spire originated through the management buy-out of twenty-five BUPA hospitals in 2007 funded by the UK private equity firm Cinven. The hospitals were rebranded as Spire Healthcare and a strategy of expansion followed with the Classic Hospitals and Thames Valley Hospital businesses acquired in 2008. Most recently in August 2011, Spire acquired Lifescan Ltd, an independent provider of CT health checks in the UK. The deal was valued at £1.36 million. Spire has also expanded through its partnership with CancerPartners UK, which provides cancer treatments at three Spire Healthcare hospitals. Spire also owns the London Fertility Centre and The Insight Network providing mental health services. In April 2011 the company announced the development of a new hospital in Hove (Sussex, UK).

Spire's business with the NHS is increasing, but the company still regards the NHS work as "a useful supplement" to its main stream of revenue rather than a major component.²⁷ However the company does view the Government's policy in healthcare as "very positive for the private sector" and Spire is "positioning itself to capture opportunities as they arise."²⁷ Spire has noted publicly that it expects business to boom as a direct result of the Government's policy of cuts – "We believe the private sector will continue to expand in the UK, fuelled by uncertainty around NHS cuts in services, increased waiting times and an increasing desire from patients and doctors for advanced techniques and treatments."²⁸

Spire's management includes Daniel Toner, its General Counsel and Group Company Secretary who in an interview in 2009 with *The Lawyer*, said that, "the private sector is a useful safety valve for the NHS – it drives up standards ... In a monopoly it's good to have competition."²⁹

Who owns Spire Healthcare?

Spire Healthcare Limited Partnership is the parent undertaking of a number of separate corporate groups trading under the Spire Healthcare brand. In turn, Spire Healthcare Limited Partnership is controlled by funds managed and advised by Cinven. Cinven's business is focused primarily on the acquisition of European-based companies that require an equity investment of €100 million or more, although it has made a few moves in Asia and other emerging markets. It focuses on six sectors - Business Services, Consumer, Financial Services, Healthcare, Industrials, and Technology, Media and Telecommunications – and normally holds its investments for around four to six years.



Spire expect business to boom as a result of the government's cuts policy.

Political ties

Dan Toner, the company's General Counsel and Group Company Secretary was previously at the Department of Health and Patricia Hewitt ex-Health Secretary is an advisor to Cinven.^{30, 31}

HCA International

HCA International is one of the smaller private hospital groups in the UK, with a network of only six hospitals and four outpatient clinics, all in the London area. HCA International claims centres of excellence in certain medical areas such as cancer, cardiac, neurology (brain and spine injuries), women's health, IVF and fertility. Amongst its advertised achievements are partnerships with leading NHS hospital trusts. Its clinics and hospitals treat more than 200,000 patients every year.³²

Business strategy

At present HCA International's primary source of income is the corporate market, although its hospitals are part of the NHS Choices network. However, HCA is actively developing partnerships with the NHS throughout the UK through its HCA NHS Ventures subsidiary. These include Harley Street at UCH, a partnership with University College London Hospital (UCLH), formed in 2006. Based in the tower at UCLH, the 18-bed acute facility is a specialist cancer unit for complex and rare conditions. The most recent venture is with Barking, Havering and Redbridge University Hospitals NHS Trust to open a comprehensive private patient cancer treatment centre at Queen's Hospital in Romford. The centre, known as Harley Street at Queen's, has sixteen in-patient beds and seven day case chemotherapy beds which are supported by critical care facilities.³²

Who owns HCA International?

HCA International is the international arm of the US corporation HCA (Hospital Corporation America) one of the USA's leading provider of healthcare services. HCA comprises about 164 hospitals and 106 freestanding surgery centres in 20 US states. According to the company, nearly 5% of all inpatient care delivered in the USA today is provided by HCA facilities. HCA today is the result of a merger between Columbia Healthcare Corporation, founded in 1987, and HCA, founded in 1968. Both companies expanded through a series of acquisitions prior to the merger in 1993. With Columbia's 94 hospitals and HCA's 96 hospitals, the resulting corporation became the USA's largest hospital chain. Richard Scott, one of the founders of Columbia, became CEO in 1993. The acquisition strategy continued until the late 1990s, when the company was hit by what is probably the US's largest healthcare scandal.

In March 1997, the company's facility in El Paso, Texas, became the subject of a federal healthcare fraud investigation. In July 1997, the investigation broadened in scope when approximately 500 federal

agents raided Columbia/HCA facilities in seven states. The investigation focused on Medicare billing practices and home health operations. The investigation had actually begun as early as 1993. By June 2003, following two settlements, one in 2000 and one in 2002, Columbia/HCA had paid the US government a total of over \$2 billion in criminal fines and civil penalties for systematically defrauding federal health care programs. HCA was found to have unlawfully charged the government in its cost reports for running its hospitals, that it paid kickbacks (incentives) to doctors in return for Medicare and Medicaid referrals, and that it unlawfully charged the government for costs in connection with wound care facilities. Despite the severity of the crimes, no senior executives went to prison, although a few mid-level executives were found guilty of fraud.^{35, 36, 37}

The investigation alarmed both investors and the company's board members. The company's CEO Richard Scott resigned as did the COO, David Vandewater. Scott was replaced as chairman and CEO by Dr. Thomas Frist, Jr, the vice-chairman of Colombia/HCA (and founder of HCA in 1968).³⁵ In an effort to create a new public image and make a break from the business strategy of aggressive acquisition, which was largely attributed by industry commentators to Richard Scott, the company changed its name to HCA – The Healthcare Company, and made a number of divestitures.

In 2006, HCA was taken back into private ownership through a buyout worth \$31.6 billion. The buyers were three private equity firms - Bain Capital, Kohlberg Kravis Roberts & Co. (KKR), Merrill Lynch Global Private Equity (now BAML Capital Partners) – and the Frist family, who altogether invested only \$5.5 billion in cash. The rest of the \$31.6 billion price tag is being financed by debt, which the firms hope to pay down, like a mortgage payment, using HCA's income.³⁴ In March 2011, HCA once again went public with an IPO on the New York Stock Exchange. HCA Holdings (the parent company) raised \$3.8 billion, making it the largest ever private equity-backed IPO on a US stock exchange.

HCA is not the only company in the US that has been prosecuted for fraud in relation to Medicare, but it was the largest fraud uncovered. The history of HCA is an example of what can go wrong in the relationship between private companies, doctors and a large healthcare system funded by the state. Colombia/HCA indulged in various practices that fell foul of a section of the US Social Security Act known as the "Anti-kickback Statute" introduced in 1987, legislation that anticipated the problems that can occur between private companies and state healthcare systems. This anti-kickback statute prohibits providers and others from directly or indirectly soliciting, receiving, offering or paying any remuneration with the intent of generating referrals or orders for services or items covered by a federal health care program (Medicare/Medicaid). When HCA cleaned up its act in 1998, one particularly important change that was made was the discontinuation of contracts with doctors that allowed them to invest in the company's hospitals. This situation was considered to lead to doctors doing preferential referrals of lucrative cases to one hospital and less lucrative patients to competitors' hospitals. However, it was not just the partnership deals that were an issue at Columbia/HCA. From the start, Columbia



The history of HCA is an example of what can go wrong in the relationship between private companies, doctors and a large healthcare system funded by the state.

had used a variety of incentives to attract doctors to its company - free office rent and supplies, luxury trips, and loans. Columbia/HCA was found guilty of paying kickbacks to doctors to refer Medicare and Medicaid patients, but was also found guilty of fraud related to overcharging federal health care programs for services. In 2000 and 2003, the US Justice Department revealed the extent of the fraud including that Columbia billed Federal Healthcare programs for lab tests that were not medically necessary or not ordered by physicians; the company attached false diagnosis codes to patient records in order to increase reimbursement to the hospitals; and Columbia billed the government for home health care visits for patients who did not qualify to receive them.^{38, 39}

Political ties

In 2010 HCA International donated £8,500 to the Conservative Party.⁴⁰

Nuffield

Out of the PHA, Nuffield Health is the only business that is a registered charity and as such is a not-for-profit organisation. The vast majority of the company's income is derived from fees that are charged for services and any profit must be invested back into the company, under the rules of charitable status. Nuffield Health has three arms to its business – hospitals, stand-alone health clinics, and fitness and wellbeing centres – which together total around two hundred facilities across the UK that in 2009 served over 700,000 people.⁴¹ In 2010 it had a group turnover of £552.2 million, making it one of the five largest charities in the UK. Its facilities include thirty private hospitals (29 in England and one in Scotland), one joint venture private hospital (Vale Healthcare in South Wales), and over 50 health clubs.

Business strategy

Nuffield Health was founded in 1957 as the Nursing Home Charitable Trust, using money from Provident societies. Nuffield Health has no shareholders, but although it is registered as a charity it does not provide any of its services for free, and only a small amount at low cost. In most respects Nuffield Health operates as any other corporate entity in that it undertakes acquisitions and aims to maximise profit. Since its inception the business has expanded through acquisitions, one of the major ones being that of Cannon fitness centres in 2008.

It might be viewed as incongruous that a company which operates like Nuffield should be a charity and as a result the company has come under scrutiny by the Charity Commission. Questions have been raised about how much 'public benefit' Nuffield Health offers – as required by charity regulations.



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Other interested parties

Interest in the NHS is not restricted to the five businesses that comprise the Private Hospitals Alliance. Indeed, the most vocal and active business interested in gaining a foothold in the NHS, Circle Health, is not in the PHA and its founder Ali Parsa has been openly critical of the companies in the PHA.

Circle Health UK

Set up in 2004 by Ali Parsa, previously an Executive Director of Goldman Sachs' European Technology Investment banking team, and Massoud Fouladi, a hospital consultant, Circle Health was conceived as a new model for providing private healthcare in the UK. By 2011 the business had become a complicated network of clinical, property and offshore businesses. Private healthcare is provided via the company's CircleBath, Circle Clinic Stratford, and Circle Clinic Windsor and NHS work is undertaken via an NHS treatment centre in Nottingham.³⁴ In November 2010 Circle won the government contract to manage the Cambridgeshire Trust's Hinchingsbrooke Hospital, and this was finalized a year later in November 2011.^{43, 44} In mid-September 2011 Circle Health formed a partnership with the Royal Surrey County hospital foundation trust to bid to take over Epsom hospital, but has now pulled out of this agreement.⁴⁵

Business strategy

Circle Health is 49.9% owned by its staff and 50.1% owned by private investment funds. The 50.1% ownership was channeled via the company Circle Holdings (previously Health Investment Ltd) registered in Jersey and the majority of investors were funds based in offshore tax havens. In June 2011, Circle undertook a limited public offering with a listing on the Alternative Investment Market (AIM). In May 2011 just prior to this flotation on the AIM, the Board of Directors, chose to move Circle Holdings' registration from Jersey to be domiciled in the UK for tax purposes. The flotation raised £45 million, which values the company at £95.4 million. Circle's properties are managed through a number of separate companies all registered in Jersey.

Who owns Circle Health?

From its beginnings Circle has sought to differentiate itself from the PHA companies by emphasizing the close involvement of its staff in ownership of the company. Indeed Circle has claimed the title 'social enterprise' or 'John Lewis' of healthcare and made much of this label in the media. A social enterprise is generally considered to be a business owned by its employees where any profit is reinvested in the company. The company is 49.9% owned by its staff through the Circle Partnership, a company registered in the British Virgin Islands, a tax haven. But despite the claims of social enterprise, majority

ownership (50.1%) of Circle is in the hands of large private equity companies. Originally this portion of the company was channeled via the Circle Holdings business in Jersey and included investors such as funds managed by Balderton Capital, BlueCrest, and Lansdowne, primarily registered in tax havens worldwide. The flotation on the London Stock Exchange's AIM (Alternative Investment Market) in June 2011 did little to change the share ownership of the company with the shares continuing to be in the hands of virtually the same private asset management companies.⁴⁶ These companies have invested in Circle in order to make a profit from the company, which appears to be at odds with the motives of a social enterprise. In the document produced by the company for its listing on AIM (the "admissions document") Circle notes "It is the current intention of the Directors not to pay dividends or distributions to the Company's shareholders in the near term, using current cash flows to support the strategic growth of the business."⁴⁷ This sort of situation is common to all new enterprises, however, and therefore its lack of dividends for external investors does not make Circle a social enterprise per se, indeed the company has yet to make any profit at all so it's not surprising that no dividends will be paid; Circle had an operating loss of £35 million in 2010. What will determine whether the 'social enterprise' epithet is valid for Circle is what happens if or when a profit flows. Under the social enterprise model the profit should be re-invested, however if this were the case it is hard to see how the private asset management companies would get a return on their investment. It is more likely that the private investors will take a share of profits, which would contradict the social enterprise model of business.

Another worrying facet of Circle's business is its financial stability. Prior to the flotation in June 2011 media articles highlighted the company's operating loss and that as of December 31 2010 the company had debts of £82m.⁴⁸ More than half of 2010 revenue, £48 million, was generated from just one contract for the Nottingham NHS Treatment Centre. This contract with the Department of Health, has just two years left to run, although Circle is guaranteed an inflation-linked income for the Nottingham Centre for this time. However, its other NHS business has fallen in recent months as contracts for treatment centres in Burton and Bradford were not renewed. These two contracts were together worth £27 million.⁴⁸

Another concern is the situation with the property arm of Circle Health. The company does not own its hospitals, instead it chose to lease them and pay rent, and according to flotation documentation, there are already financial complications surrounding the lease on its flagship hospital – CircleBath. The set up of separate ownership of property recalls the situation with Southern Cross, which eventually led to that company's business problems. Circle's accounts reveal it was forced to delay a number of key hospital building projects as finance dried up. The company has secured £50 million in institutional funding from the real estate investment arm for BP's pension fund for the development of a hospital in Reading, but a project in Edinburgh has been delayed. Developments in Manchester, Plymouth and Tunbridge Wells announced in 2010 have also been delayed.



Despite the claims of social enterprise, majority ownership of Circle is in the hands of large private equity companies.

Circle's set up of separate ownership of property recalls the situation with Southern Cross.

Political ties

Circle's backers include Paul Ruddock, whose company, Lansdowne UK, owns 28.9% of Circle Holdings (Circle Holdings website, Oct 2011). Ruddock is one of the Conservative party's most generous donors. Other shareholders include Odey Asset Management with a 16.6% share; its founder, Crispin Odey, also funds the Conservatives; although there is no evidence that either Ruddock or Odey were personally involved in these investments.

Helios

The UK market may prove attractive to companies that do not yet have a base here. In July 2011 there were unsubstantiated rumours that the German Company Helios, a subsidiary of the large blood and hospital products company Fresenius, was interested in the UK market.⁴⁹ The company has since denied that it is interested. The German Government began a process of hospital privatisation a few years ago and Helios has acquired many hospitals. In 2011 Helios owned 64 hospitals, several of which it took over when they were in considerable debt and deemed to be 'failing' financially. Helios has bought some at a low cost to itself in return for promises of complete modernization. One of its most recent acquisitions in October 2011 was of 51% of the share capital in Katholisches Klinikum Duisburg hospital (KKD) in Duisberg (Germany); KKD was in severe financial trouble.⁵⁰ Prior to this in March 2011 Helios bought two debt-ridden hospitals, one in Rottweil and the other in Schramburg.⁵¹ There may be a limit to the possibilities for expansion in Germany and the UK market could be an interesting market for Helios to explore.

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Appendix:

The private patient income (PPI) cap and how it could affect the NHS

The private patient income (PPI) cap was included in the legislation that established Foundation Trusts the Health and Social Care Act 2003¹ and also the National Health Service Act 2006.² It was designed to reassure the public that giving some hospitals more autonomy would not lead to them prioritising income from private patients at the expense of NHS patients. Every hospital had its income capped at the proportion of PPI it was already generating in 2002-3,³ which was to ensure that there was no change in the access of NHS patients to services. However, there have been ongoing issues about the PPI cap, because it only applied to Foundation Trusts (FTs), and the level was not the same for every hospital.⁴

The critical clause

It is clause 162 of the Health and Social Care Bill that proposes to abolish the PPI cap – so that Foundation Trusts have freedom to generate any amount of private patient income.⁵ The BMA is opposed to the abolition of the cap, which is seen as having “the potential to act as an incentive for foundation trusts to undertake more non-NHS activity at the expense of NHS patients’ ability to access services.”⁶ In a joint letter to the *Times* on 6th September 2011, the BMA, RCGP, three other Royal Colleges and two other NHS professional bodies said that they “share a number of [...] concerns, including the removal of the private patient income cap.”⁷

In the current climate, where NHS funding has been frozen even though demand is rising, Foundation Trusts will be tempted to prioritise schemes by which they can increase their private patient income rather than those that benefit NHS patients directly. The NHS has key priorities to maintain quality whilst finding £20bn of efficiency savings. Total income in NHS and Foundation Trusts from treating private patients amounted to just £421m in 2010-11,^{8,9} and Trusts are likely to generate no more than a £50m surplus from that. Therefore the argument that increasing private patient income by removing the cap will play a significant role in meeting the £20bn efficiency target is clearly wrong. However, the removal of the private patient income cap will undo the current safeguards, and encourage hospitals to embrace a fully two-tier health service, making profits from private patients in any way that they can. This will be at great cost to the values of the NHS.

As waiting lists rise due to lack of NHS funding, we will see more private patient queue jumping, with no restriction on the number of patients hospitals can allow to queue jump. This serious concern was recognised in the Bill’s Impact Assessment, which states that “there is a risk that private patients may be prioritised above NHS patients resulting in a growth in waiting lists and waiting times for NHS patients.”¹⁰ In addition to getting faster treatment, there may well be new services on offer for those who can pay.

In the *Guardian* on 20th October 2011, Dr Clare Gerada, Chair of the Royal College of GPs, said “I worry we’re heading towards a situation

where healthcare will be like a budget airline. There'll be two queues: one queue for those who can afford to pay, and another for those who can't. Seats will be limited to those who muscle in first. And the rest will be left stranded on the tarmac."¹¹

Conflict over priorities

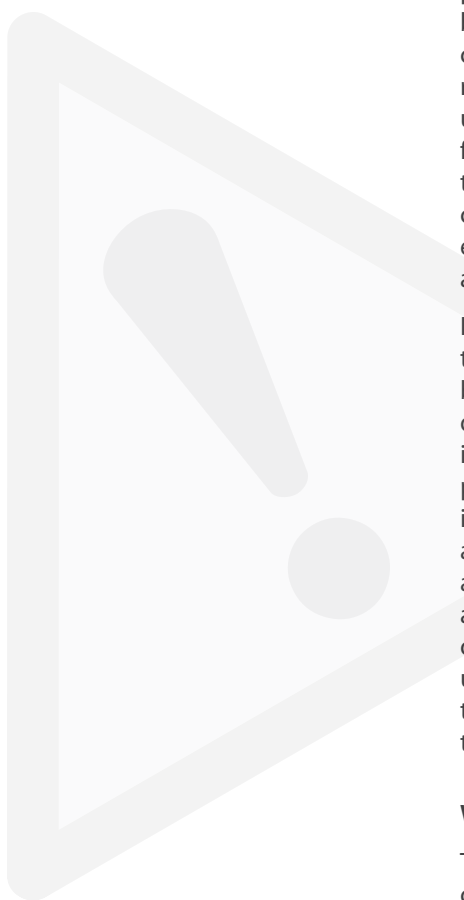
The removal of the cap is a clear indication from government that treating more private patients is a good thing and should be encouraged. This may well change the behaviour of all Trusts, NHS and Foundation, who currently do not focus on private patient activity to any significant extent. Private sector providers will approach Trusts to encourage them to enter into joint ventures and partnerships – hoping to exploit the new opportunities presented by the removal of the cap. In addition, removing the PPI cap will create new conflicts of interests for Trusts and their clinicians. The rules surrounding when and how a consultant is allowed to undertake private work are not detailed. The BMA's code of conduct for private practice states that "private patients should not prejudice the interests of NHS patients"¹². However, it also states "There will be circumstances in which consultants may reasonably provide emergency treatment for private patients during time when they are scheduled to be working or are on call for the NHS."¹³

Inevitably, if Trusts increase their volume of private patient work, there are likely to be more circumstances where a conflict arises between private and NHS work. If Trusts encourage consultants to do more private work, clearly Trusts may choose to follow their own interpretation of what level of activity is not prejudicial to NHS patient care. Furthermore, Trusts will be able to argue that increasing their private work will help them improve NHS services, as suggested by the government.¹⁴ So staff will be asked to operate a two-tier health service, with the implication that, if they do not agree, NHS services will suffer in terms of quality that could be offered, or even potentially be unsustainable. This is an unacceptable pressure to put on staff, who want to run a service that is fair for everyone. Many staff did not join the NHS to offer a two-tier service.

What the government says

The Impact Assessment states that there are a number of mitigating circumstances that will prevent FTs concentrating on private patients to the disbenefit of NHS patients.¹⁵ One is that FTs will risk losing NHS patients if their volume of private patients makes NHS waiting lists rise. However, this would depend entirely on the length of NHS waiting lists, and whether NHS waiting lists are rising in all surrounding FTs for the same reason.

The Impact Assessment states also under B155 that governors will ensure FTs retain a focus on the public interest. However, a review of the evidence undertaken by the Kings Fund in 2011 found there was a very mixed picture about the effectiveness of Foundation Trust governors, including their impact on FTs' strategic decision-making.¹⁶ The Impact Assessment also provides evidence under B155 that most FTs have operated below their PPI limit, and therefore concludes that "many FTs will not automatically make use



of any ability to earn private income offered to them.” However, up until now FTs had been operating in an environment of increasing NHS activity and increasing NHS investment. It is impossible to rule out the fact that FTs will choose to behave differently during a freeze in NHS funding.

Simon Burns, Minister of Health, said that removing the private patient cap “would allow foundation trusts to earn more income to improve NHS services.”¹⁴ Therefore the government clearly is expecting an increase in PPI. The Impact Assessment states that, “To provide assurance and transparency, FTs will be required to produce separate accounts for NHS and private-funded services”,¹⁷ and an amendment to the Bill to this effect is due to be debated in the final stages of the Lords’ Committee.¹⁸ Showing separate accounts might allow governors and commissioners to see more explicitly the Trust’s strategy towards private patient income, and whether this is being achieved to the detriment of NHS patients. However, without any rules stating that a two-tier service is wrong, it is hard to see how governors or commissioners can make the case that NHS patients are being treated unfairly in terms of services or access to care. The government is confident that FTs will invest surplus from private patient income to improve services for NHS patients. However, this would require FTs to have fully audited accounts demonstrating the use made of surpluses, as otherwise surpluses could be reinvested solely for the benefit of generating more private patient income.

There is also a danger that increasing private patient income overall risks the opposite situation, where a loss on private patient income is cross-subsidised from NHS income, directly to the disbenefit of NHS patients. In fact, there is already evidence that NHS funding is subsidising private patients treated in NHS hospitals. An investigation into private patients by *Health Service Journal* in 2007-8 found that, “30 per cent of patients who pay to receive private treatment in NHS hospitals are charged less than their care costs the trust.”¹⁹

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