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# NEW KIDS ON THE BLOCK

doc 2 doc Will opening up to "any willing provider" lead to the denationalisation of the NHS in England? And which groups are poised to make the most of these new opportunities? **Peter Davies** investigates

In a pre-election "manifesto," the UK's largest private hospital company, General Healthcare Group, declared: "the time is right for the private healthcare sector to have a proper seat at the planning table."[1] It called for a "guaranteed proportion" of elective surgery to be transferred to the independent sector and suggested increasing its share of NHS activity from 5% to 15% during the next five years.

That bullish approach is characteristic of a sector that has steadily expanded its role since the Labour government announced in 2002 that independent providers would become "a permanent feature of the new NHS landscape."[2] So they have. Once largely confined to secondary care, independents now have interests in primary care, diagnostic services, long term care, and outsourced "back office" services such as human resources, information technology, and accounting support. Latterly under Labour, a handful won approval to offer help with commissioning—an important bridgehead.

Now the coalition government's health white paper is opening NHS provision to "any willing provider" and, by handing general practitioners responsibility for commissioning, creating substantial potential for more outsourcing. One player in the market is Tribal Newchurch. Its director of business development, Kingsley Manning, predicted: "This white paper could amount to the denationalisation of healthcare services in England."[3]

## Boom time?

So amid the economic crisis, is it boom time for private healthcare companies? "I see relatively little prospect of many more acute elective providers coming in," says David Furness of the Social Market Foundation, the left of centre think tank. "There's no real appetite from the private sector to do that." This is because it means shifting from its traditional low volume, high margin activity of treating private patients, to high volume, low margin NHS work. "The capital costs and risk attached to any business venture in the NHS are pretty high. People are not unreasonably concerned about government policy changes every three or four years," says Mr Furness.

Instead, commissioning will offer the greatest opportunity to independent sector providers, Mr Furness believes. "I think we'll see everything from big American insurers who want to take the whole of the commissioning burden away from general practice consortiums, right through to people saying, 'I'm particularly good at base coding and can make sure you're paying for what you think you're paying for.' There'll be everything from the real micro stuff to others offering the whole package."

## Social enterprise

No one will dominate the NHS market, he says. "It's not going to be easy for any one group of companies to clean up as everyone is feeling their way. There will be a lot of real competition from social enterprises."

The government aspires to create the "largest and most vibrant social enterprise sector in the world," the white paper revealed. Foundation trusts will be encouraged to become employee led social enterprises. Former primary care trust employees are among those expected to form social enterprises offering general practice consortiums commissioning support. Mr Manning says denationalisation will happen not through privatisation but mutualisation.

Successful prototypes already exist. Nene Commissioning is a community interest company (CIC) and therefore its assets and profits are used to benefit the community rather than for individual gain. It was formed in 2007 and comprises 350 GPs in 76 practices across Northamptonshire. Its chair, local GP Darin Seiger, is convinced CIC status is key to its success, fostering trust in "the new kid on the block" among patients and NHS organisations.

"There are misconceptions that GPs may profit from new services. When people see practices

**"The ideological belief that private sector equals better is absurd and naive . . . Good redesign would often design out the very thing outsourced," says John Seddon**

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**Richard Branson's Virgin Group acquired 75% of Assura in March with the aim of making it "one of the leading companies providing primary healthcare services to the NHS"**

able to put in lifts or air conditioning, rumours go around. Initially some were sceptical about our service redesign proposals and why GPs were leading on this. Explaining we're a CIC quashes that and we're immediately seen as an honest broker."

As a comparatively large CIC Nene can employ several high calibre managers, including a chief executive, rather than a single "jack of all trades," says Dr Seiger. Staff form an integral team rather than having to report to an external organisation, such as a primary care trust. "If you can keep as much in house as possible, you will have much greater control over your own destiny. That's a key theme."

Nene discusses concepts for redesigning services with its "very active" patient participation groups first. "Our approach is a clinically led, bottom-up one. Implementation of any change is facilitated because people have been taken stepwise along the journey." Member practices' priorities can be worked on immediately rather than put in a queue with those of other organisations. Contracts can be more flexible and less costly to amend than those with private providers, Dr Seiger argues.

He is sceptical that private companies add value to service redesign. "Any external company coming in and telling people who've been doing their jobs for 20 years they should be doing them differently isn't going to go down well." Private capital would have only hindered Nene, he believes.

Consultant surgeon Nick Boyle might disagree. He is a member of the management team at Circle, a partnership "co-formed, co-owned, and co-run by clinicians," that has raised more than £120m in private capital. It builds and runs hospitals and is planning a network of 30 across the UK serving NHS and private patients. Circle claims its Nottingham Treatment Centre is Europe's largest day case facility. Its new Bath hospital was designed by leading architect Norman Foster. The company is on a shortlist of two to take over the NHS's Hinchingbrooke Hospital.

Staff own 49.9% of Circle; "blue chip City institutional investors" own the other 50.1%. Staff are allocated shares annually "on the basis of what they have done that year," says Mr Boyle. "Everyone's incentives are aligned around the patient, just as at John Lewis [the employee owned store group] they are aligned around the customer."

Circle's founders wanted to reassert their professional autonomy and clinical leadership, which they felt had been eroded in the target driven NHS. Realising they lacked skills to run a complex organisation they sought partners with retail, finance, technology, and property expertise. Mr Boyle says outcomes exceed national targets and patient satisfaction is near 100%. Would Circle's model be easy to replicate? "You need access to capital and expertise to help deliver these sorts of things," he says.

### Who are the NHS market's major private sector players?

**Aetna UK** — Established in 1853 in the US, Aetna claims "relationships and contracts with 783 000 healthcare professionals" in the US and 90 facilities in the UK. It offers help with commissioning, including data management and decision support, disease management, service design, quality improvement strategies, contracting, performance management, training, and education. It does not provide clinical services

**Assura medical** — Sir Richard Branson's Virgin Group acquired 75% of Assura in March with the aim of making it "one of the leading companies providing primary healthcare services to the NHS." Assura has 30 "GPCos" co-owned with groups of GPs to develop "new models of healthcare provision and organisation" and provide "enhanced services, diagnostics and outpatient services"

**CAPITA** — UK outsourcing company Capita employs 36 000 people, made £2.7bn in 2009, and says it works with 70% of NHS organisations. It offers IT and back office services as well as governance, survey, and research support. Its health business, with 600 staff, has grown since 2008 by securing large outsourcing contracts such as NHS Choices and by acquiring businesses such as informatics company CHKS. It recently bought Premier Medical Group, a provider of reporting and screening services

**care UK** — fulfilling lives — Care UK operates 10 treatment centres, 12 GP-led health centres, two stand alone walk-in centres, four clinical assessment and treatment centres, four out of hours services, and primary care in eight prisons. It also offers social care, mental health, and learning disability services

**GHG** General Healthcare Group — GHG's main businesses include BMI Healthcare (formerly AMI, a US hospital chain that arrived in the UK in 1970) and Netcare, South Africa's largest private hospital group. GHG claims to be the UK's largest private acute hospital provider with 70 hospitals and clinics, 9000 staff, and 7000 consultants treating one million outpatients and 250 000 inpatients a year

**HUMANA** Guidance when you need it most — Humana's US parent has 10 million customers and 28 000 employees. The London arm was set up in 2006 to offer commissioning support to primary care supports. It claims expertise in service design, data and knowledge management, contracting, performance management, communications, and "motivational programmes that promote healthy behaviour." Its experience of US health insurance "gives us the leading edge in developing back-office commissioning systems."

**serco** Bringing service to life — Outsourcing company Serco's 70 000 staff made £3.9bn in 2009 through contracts that included defence, education, transport, and health. It employs over 300 doctors and nurses in primary care and community health services, including out of hours care. Serco also provides facilities management in three NHS hospitals and prison health care

**Spire Healthcare** — Spire claims to be the UK's second largest private hospital group. Formed from the sale of BUPA Hospitals to venture capitalists Cinven in 2007, it has since acquired two other hospital groups, works with 3000 consultants, and has 7600 staff treating 930 000 patients a year in 37 hospitals. It offers "a small proportion" of its capacity to treat NHS patients

**TRIBAL** — UK based Tribal provides public sector services in 65 countries. It acquired healthcare consultancy Newchurch last year to offer "end to end support to healthcare organisations, from strategy and organisational development to frontline change management." The company sees a major opportunity in providing infrastructure for general practice consortiums

**UnitedHealth Group** — US based UnitedHealth Group purchases health care for 70 million people and contracts with 5000 hospitals and 560 000 doctors. In the UK it is "working to improve commissioning for 2.5 million people," from supplying analytical tools to managing the commissioning process on an interim or long term basis. It also manages general practices and has worked with 40 primary care trusts on care for long term conditions

## No more than a logo

But many remain pessimistic about private sector participation. Public sector management guru John Seddon of Vanguard Consulting is an outsourcing sceptic. "The ideological belief that private sector equals better is absurd and naive," he says. Many public sector outsourcing contracts set managers targets for maximising revenue rather than improving services. If savings are made they benefit shareholders not taxpayers, and outsourcing can inhibit service redesign. "Good redesign would often design out the very thing outsourced."

NHS Consultants Association co-chair Jacky Davis fears the result will be "a service franchised out with an NHS logo," in which costs rise, inequalities widen, and care fragments. Private providers like only "predictable" work, she says, and patients with complications are returned to the NHS. Gradually some may find themselves excluded from certain treatments, though they will find it difficult to perceive exactly who is responsible.

"There will be a system of top-ups and you will be told to get insurance. The creeping erosion of what used to be free will leave the NHS as a core service."

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# LOST WITHOUT TRANSLATION?

Translational research has shot up the agenda, but what will all this attention yield in practice for patients? **Geoff Watts** investigates

Translational research—the term is everywhere. The Cooksey report on research funding emphasised the need for more of it.[1] So do the Medical Research Council (MRC),[2] the Academy of Medical Sciences, and the Office for Strategic Co-ordination of Health Research—the government body set up to coordinate health research.[3] Several universities now have departments of it. You can do an MSc in it. There will be more attention to it in the European Commission's 7th framework programme.[4] The planned UK Centre for Medical Research and Innovation[5] trumpets an intention to feature lots of it, and promises to grant it the prestige usually accorded to discovery research. There are several journals devoted to it. In 2007, fearful perhaps of falling out of fashion, the long established *Journal of Laboratory and Clinical Medicine* restyled itself *Translational Research*, with its original name downgraded to a subtitle. In short, translation has shot up the agenda, has become the indispensible ingredient. Which is, on reflection, rather odd.

The term "translational medical research" has generated a stack of definitions with different emphases (see box). Some definitions stress the laboratory end of the process of turning a scientific finding into something clinically usable; some stress the clinical end. Some draw attention to the two way traffic of insights and questions. Some read like a first year sociology essay. But all enshrine the same core intention: that scientific research findings should be exploited for the benefit of people with diseases. And herein lies the oddity; isn't the whole point of medical research to do just that? In which case why the need to single out one element of the process, give it a special name, and start behaving as if it's a novelty? What is going on?

In a word, embarrassment. For several decades, and largely unnoticed outside the biomedical research community, our runaway success at understanding human biology has outstripped our capacity—or in some cases, regrettably, our inclination—to apply what we already know. Shelf loads of potentially valuable insights go unexploited.

## Disinterest and uncertainty

A little over a decade ago I had cause to talk to some of the scientists working in a large research organisation specialising in the cell and molecular biology that underpins most attempts to tackle cancer. From time to time I thought I would display my grasp of the researchers' aims by leaping ahead in the strategy I imagined they were about to outline. "Yes," I would say, once I'd heard about their progress in unravelling the detail of some intracellular signalling system or whatever. "I see where you're going. If you can sort out the steps in this chemical pathway, you can identify new targets for drug therapy." Far from responding, "Exactly. You've got it," some appeared almost surprised by my conclusion. "Yes, I suppose you're right," was a not untypical response. Although employed in an organisation devoted to curing cancer, the horizons of at least some of the (mostly non-clinical) researchers were so focused on their delight in understanding the systems they were studying that they seemed to have forgotten why they had been hired to do the work. What counted was the search for understanding; exploitation was, for them, a secondary consideration.

The problem now seems more often to be one of uncertainty than of indifference. Lee Nadler, professor of medicine at Harvard Medical School, is a leading champion of translational medicine. He recalls a meeting at which a Harvard neurobiologist remarked that his department was discovering new molecules and new pathways all the time but that he and his colleagues didn't know how to relate what they had found to human illness.

Professor Nadler can remember hearing people speak about "translating things from the lab to the human" when he joined the US National Institutes of Health (NIH) back in the mid-1970s. And long before that, translation (the concept rather than the word itself) was what motivated the late 19th century creation of the Johns Hopkins Hospital in association with Johns Hopkins University. However, it's really only since the beginning of this century

**"One driver of the current enthusiasm [for translational research] has been the relative failure over the past 10 years of the pharmaceutical and biotech industry to come up with new products"**

that the phrase translational research has been ubiquitous. Stephen O'Rahilly of the Cambridge Institute of Metabolic Science at Addenbrooke's Hospital chairs the MRC's Translational Research Group. "One driver of the current enthusiasm," he says, "has been the relative failure over the past 10 years of the pharmaceutical and biotech industry to come up with new products." This shortfall fostered a nervousness that the hitherto successful way of doing things had run out of steam. There needed to be a new way of combining the strengths of industry and academia.

### Accountability

Professor O'Rahilly identifies a second issue. "The Human Genome Project over-promised what it could deliver in terms of health gains. It was a fabulous piece of science, but there was too much hype. Politicians and paymasters are now asking, 'Where's the beef?' Turning the promise into new therapies hasn't happened with the speed that some of these initiatives suggested." Which is why another "translator," Roland Wolf, speaks of "the increasing emphasis by government on the commercial and medical exploitation of government-funded research." As the scientific director of the Biomedical Research Institute at Ninewells Hospital and Medical School in Dundee, Professor Wolf helped to forge the Scottish Translational Medicine Research Collaboration and the link to its commercial partner Wyeth Pharmaceuticals. Back on the further margin of the Atlantic, but thinking about both sides of it, Nadler talks of accountability. "The MRC, the NIH, and other bodies in the world have funded people who do basic science, and the issue is one of return on investment. Is it benefiting our patients?"

But how is translational research supposed to "bridge the gap" or "unblock the pipeline" between bench and bedside? "Science and medicine are becoming more and more specialised," says Professor Wolf. "To expect a clinical oncologist to develop the biomarkers that may reflect patient responses to a new drug is just not realistic." Which means what, in practice? According to Professor Nadler, ensuring that a large slice of the funding goes to groups who not only do basic science but also want to tackle the clinical questions. "Translational science requires not an individual but a team to look at a problem." And how do you assemble such teams? With difficulty, he admits. They need to be multidisciplinary. They also need the right incentives—and that doesn't mean just money. Team science is harder, takes longer, and doesn't earn the same recognition as discovery research. Indeed, the ultimate exemplar of scientific recognition, the Nobel Prize, offers a singularly unhelpful model. Far from recognising teams, it limits the number of winners to three.

Through what they call their Harvard Catalyst project,[7] Professor Nadler and his colleagues have already secured substantial investment in translation: $75m (£48m; €57m) from the university and its collaborators together with a five year $117.5m grant from the National Institutes of Health. Their conviction is that the university and its associates already possess the key ingredients for successful translation: the brain power, the technology, and the clinical expertise. "What is missing is a systematic way for investigators from disparate disciplines and institutions to find each other and form teams, to gain open access to tools and technologies, and to obtain seed funding to embark upon new areas of investigation." This is what Harvard Catalyst can provide.

On its more modest scale, how effective is the MRC strategy for boosting translational research? Professor O'Rahilly thinks that it can make a difference to the movement of ideas and findings along the pipeline to clinical application. "Imagine you have scientists beavering away in the lab and finding that molecule X prevents immune cells sticking to one another. Then they find a simpler smaller molecule that can do the same thing, that might be good for treating rheumatoid arthritis, and might be taken through into human trials." The aim would be to encourage those scientists not to stop work when they have elucidated the lymphocyte biology but to play a part in furthering it. Fine. But is the strategy paying off? "The time from the inception of an idea through to a trial is often a decade," says Professor O'Rahilly. "So it's still too soon to know."

Paradoxes remain. "Britain's place in the forefront of biomedical research has come from its commitment to basic science," Professor Wolf points out. And Professor O'Rahilly adds that staff at the celebrated Laboratory of Molecular Biology in Cambridge have never been required to keep practical applications at the forefront of their thinking—which has not prevented their work from having a big effect on clinical medicine. Hence the fears (which Professor O'Rahilly well understands) that "too much concentration on seeing findings through into the clinic could lead to a diminution in the number of basic insights being brought to light in the first place."

Insofar as scientific discoveries have been finding their way into clinical practice for two centuries, and will continue to do so, it's self evident that translation (by whatever name) happens, and will go on happening. The point now at issue is how far the biomedical research community can take firmer control of the process. How far it can be speeded up and given direction. How far it will be possible, years from now, to be certain that without all the current effort, this drug or that diagnostic would still be a mere speculation in *Nature* or *Science*—lost without translation.

#### DEFINITIONS OF TRANSLATIONAL RESEARCH

Just three of the many definitions to chose from...

"Translational research involves moving knowledge and discovery gained from the basic sciences to its application in clinical and community settings. This concept is often summarized by the phrases "bench-to-bedside" and "bedside-to-community" research."—US Institute of Translational Health Sciences (www.iths.org/about/translational)

"It's the bridge from discovery to delivery. It has a clinical goal or target in mind, which isn't the case for basic research."—Eric Rose, dean for translational research at Columbia University Medical Center[6]

"Research going from bench to bedside, where theories emerging from pre-clinical experimentation are tested on patients with a variety of disease conditions, and from bedside to bench where information obtained from preliminary human experimentation can be used to refine our understanding of the biological principles underpinning the heterogeneity of human disease."—Institute of Applied Health Sciences, University of Aberdeen (www.abdn.ac.uk/ims/translational/)

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