

# NHS franchise for sale

As the private sector gears up to take over its first entire NHS hospital, **Sam Lister** analyses this “touchpaper” moment for one of the government’s big ideas for the NHS

When England’s health secretary, Andrew Lansley, was threading together the main themes for his radical vision for the NHS, a little district general hospital in Cambridgeshire cannot have failed to catch his eye. Hinchingsbrooke is a 369 bed complex on the outskirts of Huntingdon, the Tory heartland constituency once held by former prime minister John Major. It is also less than 10 miles from Mr Lansley’s own seat, Cambridgeshire South, with both constituencies sharing similar demographics and demands on the health service. But more importantly, Hinchingsbrooke is not only a cautionary tale of the pitfalls of poor management and financial overstretch in the NHS but the test case for the most far reaching (and potentially flammable) of Mr Lansley’s big ideas.

Presenting his white paper on 12 July, Mr Lansley told the House of Commons: “We will allow any willing provider to deliver services to NHS patients—provided that they deliver the high quality standards of care we expect from them.” The strategy of opening up the NHS to the private sector—which was promoted by former prime minister Tony Blair then buried by a succession of Labour health secretaries concerned by its electorally toxic message—was back centre stage. The policy seemed not to warrant much of a mention on the Tory campaign trail. But it is the one most likely to reshape, fundamentally, the way the NHS is run in future generations.



Concerns have been raised by health professionals, unions, NHS ideologues, and traditionalists over what the Tory vision of “any willing provider” will mean. Many envisage that it will be a free-for-all for independent companies and that shareholder interests will be prioritised above those of patients. Unions are sabre rattling over “wholesale privatisation” of health and warning of the dire effect on jobs at a time when projected redundancies are already widespread. The government has talked of how greater competition will lift standards, how the skills of public and private sectors can enhance one another, and the need to break down the NHS’s wasteful and poorly motivated monopolies.

The consultations on the white paper, *Equity and Excellence: Liberating the NHS*, may still have several months to run, but in Cambridgeshire a touchpaper moment—by chance of timing—has already arrived. At the end of July, 4000 pages of submissions to run Hinchingsbrooke Hospital arrived at the offices of NHS East of England. It marked the start of the final phase of evaluation for bids that could fairly be described as rescue plans for a district general hospital burdened with excessive debts that

have rendered it financially unsustainable. And all three of the would be rescuers were independent companies, vying for what will be the first private takeover of an entire NHS hospital.

## Failure

The story of how Hinchingsbrooke came to require such attention highlights some of the problems linked to expansive spending and failures of governance that have dogged the health service in recent years. Built in 1983, the hospital provides a community of about 160 000 people with a typical mix of specialties (many in conjunction with nearby Addenbrooke’s and Peterborough hospitals), with most services purchased by Cambridgeshire Primary Care NHS Trust. A small catchment posed some particular pressures, but these were exacerbated by the transition to the Payment by Results system linking funding to the number of operations and other activities. Miscalculations of tariff rates for treatments saw Hinchingsbrooke amass debts of more than £25m (€30m; \$39m), including £6.5m lost because forms were completed incorrectly.

The opening of a £22m private finance initiative treatment centre in 2005 brought further woes: the level of activity promised by the primary care trust for the centre (a mix of day case and short stay elective surgery plus outpatient and diagnostics appointments) did not materialise. As primary care trusts changed their commissioning intentions away from hospitals and



**Loud and clear:** A local protest against the private sector take over of Hinchingsbrooke Hospital, Cambridgeshire

into the community, in line with government guidance, a deficit of £7.8m opened up.

Hinchingbrooke's plight even attracted the attention of a future prime minister. In November 2006 David Cameron joined more than

1000 people marching through Huntingdon, vowing to fight to keep the hospital open. But by 2008 the accumulated deficit had reached its current level of £38.4m. In the same year auditors from PriceWaterhouseCoopers issued

a public interest report detailing "serious concerns" with the management of finances, warning that it would need substantial cash on top of the multimillion pound bail-out provided 12 months earlier. Hinchingbrooke's statutory duty to break even over five years—to a deadline of March 2009—would not be met, they added.

Ideas about how to repay the historic debt began formulating as early as 2007, but a public consultation showed the restrictions any cost saving reconfiguration might face. All the services at Hinchingbrooke site should stay on site, the people of Cambridgeshire declared—including the more costly accident and emergency and maternity units. As the wider economic climate deteriorated, so fears for the hospital's long term sustainability increased.

In July last year the Department of Health and the Treasury sanctioned plans to invite bidders to run the hospital. NHS East of England chose its words carefully. The tender was open to foundation trusts and the independent sector, but with the caveat that all staff would remain employed by the NHS and assets would stay under health service ownership. A further condition stipulated that it would remain a district general hospital and provide accident and emergency services.

#### Private battle

According to Andrew MacPherson, East of England's director of strategic projects, the process "has not been about an acquisition but about finding a partner." However, the search attracted less positive headlines, and protests, as the partners emerged: five private health companies—Care UK, Circle Health, Interhealth Canada (UK), Ramsay Health Care UK, and Serco Health—and one NHS bidder, Cambridge Univer-

sity Hospitals Foundation Trust. Months earlier, the Labour health secretary Andy Burnham had decreed that the NHS should be the "preferred provider" of services within the health service. But the severe problems affecting Hinching-

brooke—which had allowed the contract to be put out to tender—were enough to dissuade the trust from pursuing its bid. A competition among private sector applicants became the "privatisation of the NHS."

Public service unions and the British Medical Association have warned repeatedly that the contract is an auction of benefit to shareholders but entirely inappropriate for health. Although some have focused on ideological issues, others draw comparisons with the private management contract for Good Hope Hospital in Birmingham. The franchise, which did not carry the full financial risk of the Hinchingbrooke contract, was given to Tribal Group in 2003 but was terminated within two years after the hospital was judged "no longer financially viable" and taken over by a neighbouring foundation trust.

Similar concerns were raised in July by protestors marching in Huntingdon. And yet tellingly there were not the 1000-plus people that walked with David Cameron four years earlier; there were 100 or so at best, and no member of parliament by their side. The hospital's several thousand employees have also been noticeable mostly for their absence.

Mr MacPherson, who was brought in from the rail industry to see through the franchise, believes that the mellowing mood reflects the extent of public involvement and consultation and an acceptance of the hospital's parlous state of affairs. His reassuring mantra—that the partnership is about providing NHS services at NHS prices to NHS standards—has been relayed every step of the way.

"This is groundbreaking, but this is not privatisation. And what is interesting is I think that particular challenge has faded as people have come to understand more about what we are doing. This is a franchise, a right to supply for a fixed period. The competition has been about finding the best for the job."

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**Hinchingbrooke Hospital: A test case for the most far reaching of Andrew Lansley's big ideas**

Mr MacPherson acknowledges that financial resilience, particularly in the current economic climate, plays to private sector bidders. "I think they are in a stronger position right now, but I wouldn't want to suggest that they are at any particular advantage—there are the same skills and capabilities among the top flight NHS organisations as in the independent sector. What's really exciting is combining the two. You have the whole drive and passion of the public service and if you plug into that the innovation and dynamism and fleet of foot from sound international organisations I think that's a really great recipe for the NHS, for patients, and for weathering the economic storms."

This month the search for a solution to Hinchingbrooke's problems narrowed further, as one of the three final contenders, Ramsay Health Care, was knocked out "for not meeting requirements." It leaves Circle Health—best known for its private hospitals and employee partnership business model—and Serco Health,



which has the Docklands Light Railway and the mayor's London bike scheme among its management contracts. Adding to the mix is Serco's junior partner (and, as the sceptics see it, public sector fig leaf), Peterborough and Stamford Hospitals NHS Foundation Trust.

#### Final hurdles

After almost a year of scrutiny, the invigilation still has some way to run. Two dozen evaluators—including hospital staff, general practitioners, patient representatives, and specialists in commissioning and management—will grade the proposals in coming weeks. A final invitation to tender will be issued in October, followed by a series of approvals during November and December as the details get finalised. A winner will be signed by 1 February and operating by next June.

No details of any of the plans have so far been made public. The formal structure of the franchise is still being thrashed out, but the contract is likely to be 7-10 years, with the chosen applicant taking full risks for demand and volume with no guarantees on future revenue. It will also be required to help pay back at least some of the outstanding debt owed by the hospital, which has a £90m annual turnover, to the rest of the NHS.

If the strategists at East of England sense that the sting has been taken from the taboo of privatisation, they may feel their hand strengthened further by the change of government. The Tories'

pledge to create "a level playing field" for tendering makes Hinchingsbrooke look, if anything, more NHS leaning: when its contract was first advertised, the private sector complained that the requirements were so stringent that they lacked "commercial reality."

And yet the applicants still came, and many believe they will keep coming. With all hospitals expected to take on foundation trust status by 2013, more will need to lean on the entrepreneurial reserves of the private sector to get there. Mark Britnell, the Department of Health's former head of commissioning, now with consultants KPMG, recently suggested that as many as 20 organisations could follow Hinchingsbrooke's lead in the next year or so.

In the general election campaign Mr Lansley and his minders in the Tory high command probably thought they dare not mention Hinchingsbrooke for fear of the emotional turbulence and electoral damage. The white paper has now set a different tone. Anyone wanting a sense of the health secretary's vision need only look over his backyard in Cambridgeshire: the radicalism is starting close to home.

Sam Lister is health editor, *Times*, London

[Sam.Lister@thetimes.co.uk](mailto:Sam.Lister@thetimes.co.uk)

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FROM [BMJ.COM](http://BMJ.COM)

## Food for thought

Elizabeth Loder attended a charity dinner hosted by an organic farm business in an affluent suburb of Boston, which brings its super crop of luxury tomatoes to less fortunate parts of the population, at drastically reduced prices.

"Brookwood Farms, it turns out, is on a mission, in partnership with the Mattapan Food and Fitness Coalition. The aim is to make fresh, organic local produce available and affordable to the residents of Mattapan, an area of Boston that meets many criteria for being a 'food desert.'

"I'm sure this particular dinner achieved its purpose. I know I will be making a contribution to Brookwood. The event got me thinking that while homegrown tomatoes are a great thing, so is homegrown charity. Americans are used to giving generously to charitable efforts around the globe, but pockets of great need and deprivation exist right here. Contributing to a local effort such as Brookwood . . . surely merits more attention than it currently receives. Perhaps, like the best tomatoes, the best sort of charity is also homegrown."

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FROM [DOC2DOC](http://DOC2DOC)

## Flooding in Pakistan

UK doctor Saqib Noor is dedicatedly continuing his hard work in flood stricken Pakistan. This is from his blog, "It is not Pakistan, it is Perishanistan," recently posted on doc2doc, BMJ Group's global clinical online community.

"If I find a mirror, would I see eyes floating on hope over the flooded rivers of this land or sinking with the weight of despair? How do I tell patients they deserve much more? How do I tell a mother the loss of her newborn was preventable? How do I tell a man his condition should have been treated years ago? How do I ensure a patient understands medication instructions when she cannot read or write? How can I tell staff hygiene is of utmost importance when there are 15 people in one consultation room? With all this confusion, I still have a small vision for the health clinic we found rotting in flood waters: it will hopefully rise to better than it ever was.

"Perishan=sadness; Perishanistan=the land of sadness."

Read more of Saqib Noor's reports on the relief effort in Pakistan at [doc2doc.bmj.com/pakistan](http://doc2doc.bmj.com/pakistan)

# Who benefits from treating prehypertension?

With a drug company funded conference on prehypertension set to take place next year, **Ray Moynihan** examines the emergence of this controversial new classification

**W**hen health authorities in the United States were developing new guidelines for the treatment of hypertension in 2003, they decided to create a new diagnostic category. The new category would not be used to diagnose sick people; rather it would label those people whose blood pressure was towards the upper reaches of normal. The problem was what to call this new entity: should it be borderline blood pressure, high normal, or perhaps prehypertension? That's when market research came to the rescue. "We did focus groups to solidify which one would resonate most with the public," says George Bakris, professor of medicine at the University of Chicago and a member of the committee that described the new entity. "Prehypertension was a clear winner so we went with that."

The 2003 guidelines made clear that prehypertension was "not a disease category."<sup>1</sup> Rather it was a new classification for people with normal systolic blood pressure levels of 120-139 mm Hg or diastolic blood pressure of 80-89 mm Hg. The justification for creating it was simple. The higher the blood pressure, said the guideline writers, "the greater is the chance of heart attack, heart failure, stroke, and kidney disease," while the risk of death and disease "increases progressively and linearly" from within the normal range. They were also clear that people labelled prehypertensive should not be treated with drugs but urged to adopt lifestyle changes to reduce their risks.

## Global goldmine or useful classification?

Yet in the wake of the classification—and estimates that up to one in three adults has prehypertension (more than 50 million people in the United States alone)—the new entity is looming large as a possible goldmine for the drug industry. Organisers of a major international conference on prehypertension and cardiometabolic syndrome planned for Vienna next February claim baldly that "pharmaceutical companies are active in testing the place of novel antihypertensive drugs

on patients with prehypertension."<sup>2</sup>

One of the aims of the Vienna conference is to honour Stevo Julius, active emeritus professor of medicine at the University of Michigan, who has been working on prehypertension for more than three decades. "It's my life's work," he says, describing hypertension as a self accelerating disease. "Waiting to see if a patient will develop hypertension, and recommending non-pharmacological treatment, is not likely to affect the public health problem of hypertension."

Professor Julius is not part of the team organising the Vienna meeting; nor is he helping to raise funds for it, but he was the lead investigator of one of the first trials of drug treatment for prehypertension, published in 2006.<sup>3</sup> The feasibility study included around 800 patients with blood pressure just below levels classified as hypertensive. Its results suggested that taking candesartan for two years could modestly reduce the chances of developing hypertension. Some have criticised its methods and questioned its results,<sup>4</sup> but Professor Julius stands by the findings. Of the 11 authors of the published study, seven declared multiple ties to drug companies and one was an employee of Astra-Zeneca, the maker of candesartan. Professor Julius, the paper's lead author, declared financial relationships with four drug companies, and another author disclosed ties to 15 drug companies.

Stressing that his 2006 paper did not recommend drug therapy, Professor Julius says he wants to see much bigger trials conducted among people with prehypertension to assess whether drugs can prevent the harmful consequences of hypertension. Ideally such trials would be run by volunteers from professional societies rather than companies, which he believes are unlikely to fund the long term studies required. So in his view, should prehypertension be called a condition? "I don't know," he answers.

Others are more certain about their answer. "I don't use the word. I don't like it. It's a pseudosyndrome," says Jay Meltzer, a hypertension specialist and emeritus professor from Columbia

College of Physicians and Surgeons in New York. "These are healthy people, coming in to their doctor's offices not feeling sick and being told they have a new disease. It's outrageous." Professor Meltzer has argued that the candesartan study did not prove the drug was beneficial.<sup>4</sup> He also points out that the committee that first described prehypertension in 2003 was heavily populated by experts with financial ties to the drug industry. He believes that many people classified as prehypertensive will not develop hypertension, so treating them could do more harm than good. In his view the Vienna conference in February is a "terrible idea" because there is a danger of "creating a hundred million new patients, as targets for drug treatment."

The conference is being organised by a Geneva based company called Paragon Conventions, whose spokesperson confirmed sponsors would include drug companies. Its latest call for abstracts—sent to doctors around the world, including Professor Meltzer—offered those submitting abstracts the chance to receive a "special award" during the conference. Chair of the committee organising the Vienna conference is Reuven Zimlichman, vice dean of Tel Aviv University Medical School, who has no financial ties to the drug industry. He says sponsors will have no say in the content of the conference and that the aim is to start the development of treatment guidelines for prehypertension, which will in turn be sent to professional associations like the American Society for Hypertension for possible endorsement.

The first international conference on prehypertension was originally being organised by another convention company to take place in Prague in 2008, but it had to be cancelled because the company couldn't raise enough funding. Professor Zimlichman is hopeful of securing major sponsorships for the Vienna conference but says it will go ahead even without it. "We will have the conference anyway," he said, but "maybe with fewer coffee breaks." He says the gathering will help solve the dispute over

whether to treat patients with prehypertension. Asked about his current views on this dispute, he says that if a patient has prehypertension and other risks seen as part of the metabolic syndrome, then they “probably have to be treated.”

**Critics claim it’s not a condition**

“It’s not a condition,” says Curt Furberg, professor of public health at Wake-Forest University. “It’s a way of increasing markets for pharmaceutical companies.” Although people with blood pressure towards the high end of normal are at raised risk of future adverse events, Professor Furberg does not think the level warrants the new classification or the treatment of millions more healthy people. “I don’t see it as a public health problem,” he says.

Professor Furberg was on the committee writing the United States hypertension guidelines in the 1990s, but he resigned after the government authorities overseeing the process refused to require mandatory disclosure of members’ financial ties to drug companies. Ultimately, the growing push for transparency meant such disclosures became inevitable, and when the committee published its guidelines in 2003 creating prehypertension, conflict of interest statements available on the web show that 11 of the 12 members had multiple ties to industry.<sup>5</sup> For Professor Furberg, these ties reinforce his view that too many leading health professionals, and their societies and associations, are financially too close to the manufacturers of the products they prescribe.

One of the authors of the 2003 guidelines, Professor Bakris, declared at the time that he had worked as a speaker, adviser, or consultant for 13 drug companies. He told me in July that prehypertension was not a disease entity but could be described as a “diagnostic category” that does not require drugs but lifestyle changes. Arguing that testing the benefits of medicines could be a “potential dead end,” he said, however, that drugs could be tried in people with prehypertension who did not want to adopt lifestyle changes.

Professor Bakris recently became president of the American Society of Hypertension, which like many similar societies has been financially dependent on industry. Of the 13 voting board members listed in the society’s website, nine disclosed ties to drug and device makers in the 2010 annual meeting programme, with its president declaring he has served as a consultant or adviser to nine drug or device companies.<sup>6</sup>

In the decade before Professor Bakris became president of the society, it was at times wracked by a bitter and complex conflict. One

of the battle lines was financial relationships with industry, with one camp calling for tight limits on the ties between board members and drug companies. That call was unsuccessful, but in response to growing public scrutiny of professional ties with industry the society has introduced some modest changes, replacing the tradition of “satellite symposiums” at their annual conference with new “society coordinated symposiums”—these are still funded by sponsors but with speakers and content chosen by society

**“New pre-conditions will give a medical label to people who are at risk of being at risk”**

committees. According to a written statement from Professor Bakris, funding for the society will now be sought from a wider variety of sources, including “not only Pharma but the food, beverage, and nutrition industry, as well as other companies, with a commitment to improve the health of our country.”<sup>7</sup>

**Move towards predisease**

Whether the creation of the diagnostic category prehypertension is going to improve the health of any country is an open question. It is just one of a growing array of “pre-conditions,” including prediabetes and pre-osteoporosis, generating debates within medicine. Many of the base “conditions” can be regarded as risk factors for future illness, rather than diseases in their own right, suggesting that these new pre-conditions will give a medical label to people who are at risk of being at risk. Over a decade ago David Armstrong, then a doctor at Guy’s Hospital in London, described the inexorable rise of what he called surveillance medicine, saying that it is reconstructing the nature of disease so the problem becomes “less the illness per se but rather the semi-pathological pre-illness at-risk state.”<sup>8</sup>

Until now the definition of what constitutes a condition, or pre-condition, and the guidelines for treating it, have been left

largely to senior members of the medical profession and their esteemed societies, often meeting in drug company sponsored forums like the coming Vienna conference. But for people like Professor Furberg, the profession has become too close to industry. He wonders whether it may be time for society at large to take more of a role in deciding who should be classified as sick. Clearly, preventing the devastating effects of heart attack, strokes, and hip fractures is in everyone’s interest, but whether medicalising billions of healthy people with a predisease label is the best way to go requires vigorous debate among a much wider group of voices. How to constitute more independent and broadly representative panels that can deliberate well outside the long shadows of the drug industry, may be a question worth pondering.

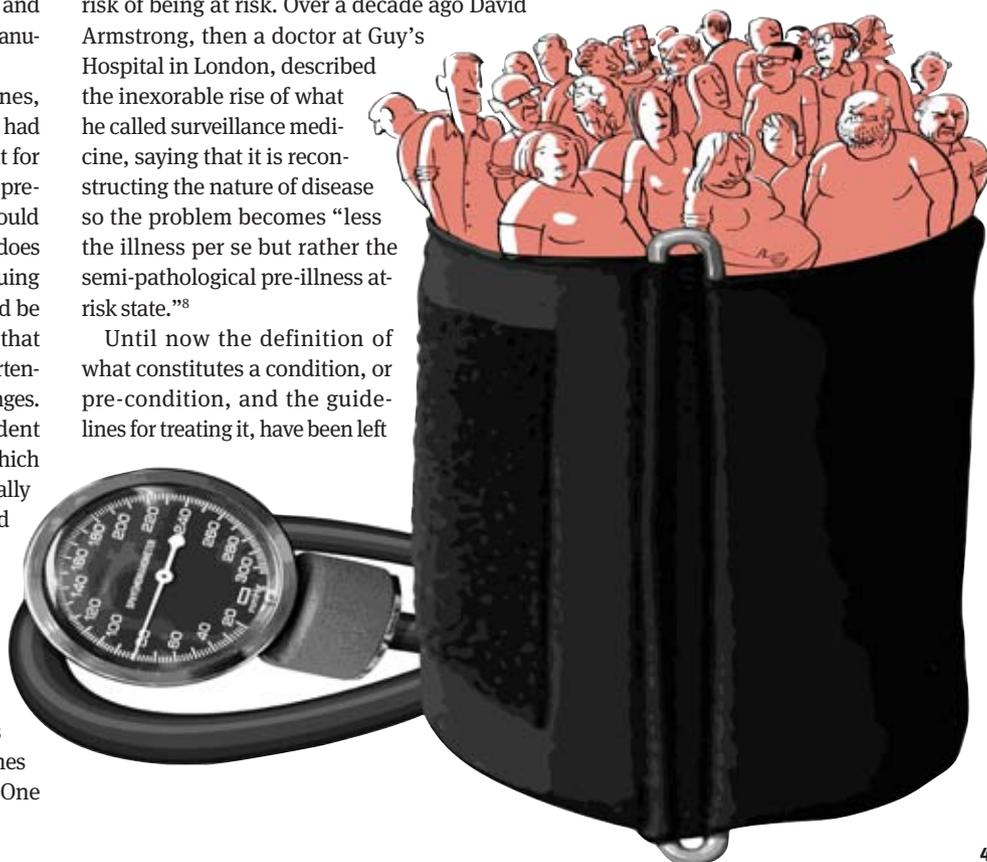
Ray Moynihan is conjoint lecturer, University of Newcastle, Newcastle, Australia  
[ray.moynihan@newcastle.edu.au](mailto:ray.moynihan@newcastle.edu.au)

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MALCOLM WILLET