

DIRECTORY OF SOCIAL CHANGE

INFORMATION AND TRAINING FOR THE VOLUNTARY SECTOR

The implications of the Charities Act 2006 and the requirement to demonstrate public benefit for fee-charging hospitals with charitable status

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1. Introduction

In 2004 the Directory of Social Change produced the report, *A Review of the Charity Law Reform and an Evaluation of the Charitable Status of Not-for-profit Charitable Hospitals*, in order to identify the issues surrounding the particular status of charitable hospitals with what was then the Charities Bill.

The report highlighted the issues surrounding:

- The public benefit of independent hospitals with charitable status;
- The recommended and proposed changes to charity law proposed in the Charities Act;
- The history and development of charitable hospitals and the degree to which they provide public benefit to society;
- The problems and criticism of charitable hospitals;
- The extent to which charitable hospitals provided public benefit at the time of the report.

Since the previous report the Bill has become law and guidance has been published by the Charity Commission to address some of the issues that were identified in 2004.

This report seeks to follow on from DSC's 2004 report by demonstrating how the environmental context for independent not-for-profit hospitals with charitable status has changed and what direct implications this has for them. More specifically, it seeks to understand the key implications of the Charities Act 2006 with regard to not-for-profit hospitals and the key elements of the Charity Commission guidance on public benefit that will impact them.

The key amendments of the Charities Act 2006 and the Charity Commission's guidance will have significant implications for independent not-for-profit hospitals; this will be explored through two case studies: the London Clinic and Nuffield Health (formerly Nuffield Hospitals).

As they have charitable status, the major implications for the London Clinic and Nuffield Health will be whether they operate in the public benefit. The report will provide an update on the changing legal and financial operating environment and will consider the new requirement to demonstrate public benefit in this context.

2. History of Independent Not-for-profit Hospitals with Charitable Status and the NHS

Over the last century healthcare institutions have changed enormously, with advancements in medical knowledge and changing approaches to patient care. According to scholars, independent hospitals were historically considered to be 'true' charities during the nineteenth century, dedicated to providing care for the sick and poorest people of society. These institutions provided free healthcare, advice and medicine decades before the introduction of the National Health Service in 1948.

Historically, individual charitable giving in the form of gifts, subscriptions, legacies and one off donations were the traditional modes through which charitable hospitals continued in operation. This level of individual support to charitable hospitals usually only provided for a small amount of the hospitals' revenue, which they gained from nurses' charges for home clinics, private patients and grants from the local authority.

During the latter part of the nineteenth century, many charitable hospitals were facing financial difficulty and began to charge fees, such as pay-wards for middle class patients and nurses' fees for their training. The creation of the NHS in 1948 introduced a new dimension in healthcare provision.¹ The NHS offered a free service, universally available, regardless of the patient's wealth or status, and gave the patient the option to choose their preferred dentist, optician or GP. For the first time hospitals, doctors, GPs, pharmacists and opticians were brought together under the same umbrella. There were also radical changes to many institutions across the country. The report *NHS at 60*, recounts how the NHS:

took over control of 2,751 hospitals containing 533,000 beds, many of them in large mental institutions. For the first time, consultants and senior physicians were paid like other staff and no longer honorary and entirely dependent on private patients for a living.²

The NHS provided stability and assurance for people in poverty who could not afford private health care or who relied on charitable hospitals for assistance. Independent hospitals still thrived from this period onwards, offering people an alternative in healthcare provision for those who could afford to pay privately. The successful operation of independent private hospitals can be seen in the long history of many of these practices, such as the London Clinic, which has been established for nearly 75 years. Continuing today there is still a strong demand for alternative private health care.

The difference between for-profit and not-for profit hospitals in the independent sector is that unlike for-profit organisations, not-for-profit hospitals have charitable status. These charitable hospitals do not distribute their profits or dividends to shareholders but reinvest all their surplus income back into the hospitals infrastructure and activities. Although, charitable hospitals are similar to for-profit hospitals they have different

¹ Jepson, E., Directory of Social Change, 2004. *A Review of the Charity Law Reform and an Evaluation of the Charitable Status of Not-for-profit Charitable Hospitals*. July 2004.

² COI for the Department of Health, 2008. *Sixty Years of the National Health Service, a proud past and a healthy future*.

governance and corporate structures (as just mentioned, i.e. any profits must be reinvested in the charity and not be distributed to the owners or shareholders for their own personal benefit).

Although there are obvious dissimilarities between the two groups of hospitals there appears to be a noticeable similarity in the types of services they both currently provide. Not-for-profit independent hospitals with charitable status and for-profit hospital groups, for example, the London Clinic and the Princess Grace Hospital (which is owned by HCS Inc) offer specialist services in hip and knee surgery and ophthalmology. As is discussed later in the report, the NHS pays independent hospitals, both private for-profit and private not-for-profit, a standard NHS tariff rate to take in NHS patients.

3. The Health Care Landscape

At present, charitable hospitals exist as part of a wider private healthcare sector. Recent figures show that there are 274 privately owned hospitals operating in the UK with just over 10,000 beds available.³ Of the 274 privately owned hospitals, there are currently 48 not-for-profit hospitals operating in the UK sector alone. Nationally, this represents 19.4% of the independent acute hospitals market.

Hospitals with charitable status make up approximately 20% of the hospitals situated in London; this includes Nuffield Health, The London Clinic, The Hospital of St John and Elizabeth, the King Edward VII's Sister Agnes Hospital and St Luke's Hospital for the Clergy.

Overseas owned businesses are now a prominent feature in the private healthcare sector. One organisation in particular, Hospital Corporation of America (HCA Inc) is one of the world's leading providers of private healthcare. HCA Inc has an overseas division, HCA International which is based in the UK. The division owns six world renowned London hospitals: The Harley Street Clinic, London Bridge Hospital, The Lister Hospital, The Portland Hospital, the Princess Grace Hospital, The Wellington Hospital and Harley Street at UCH. In 2007, the division had annual revenues of £330 million and capital investments of £70 million.

Recently there have been a number of acquisitions that have affected the landscape of the private healthcare sector. In 2007, BUPA hospitals (a provident society) were sold to a private equity firm, Civen, who re-branded BUPA hospitals to Spire Healthcare. In March 2008, Civen acquired the Classic Hospital Group Limited. According to figures from the Office of Fair Trading: 'Classic's UK turnover in the financial year ended 31 December 2006 was £78.8 million.'⁴

Under the direction of Civen, these acquisitions have brought together two of the top ten private hospital operators in the UK under one umbrella. Following the acquisition of Classic, Spire Healthcare now has 36 hospitals across the UK, with a total of 1,983 beds, providing services for private patients, both of those funded by private health insurance and those who choose to pay outright.⁵

The overall picture of the private healthcare sector indicates that for the first time on record non-UK owned hospital groups' accounted for the largest proportion of the UK healthcare market in an acute medical and surgery capacity. In this context, non-UK hospitals held 46.6% of the market, whilst UK owned hospital groups provided for 42.7%. This was largely as a result of Netcare's acquisition of General Healthcare Group (a for profit group), and also strengthened by overseas entrants securing ISTC contracts.⁶

³ Laing & Buisson, 2008, *Healthcare Market Review 2006-07*. Suffolk: William Clowes Limited.

⁴ Office of Fair Trading, 2007. *Completed Acquisition of Spire Healthcare Limited of Classic Hospitals Group Limited*. [Online]. Office of Fair Trading.

⁵ Spire Healthcare, 2008. *About Spire*. [Online].

⁶ *Healthcare Market Review 2006-07*, 2008.

Private healthcare organisations accrue a large proportion of revenue in the private sector. By 2007, figures revealed that the top three private hospital providers included the General Healthcare Group, Nuffield Hospitals and BUPA. The total earning of these three hospitals accounted for reported earnings of £1.6 million.⁷

In the UK health care market, another important overseas owned business is Ramsay Health Care UK (formerly Capio). The Australian owned business has 22 acute hospitals and 10 treatment centres in the UK, which cater for privately insured, self pay and NHS patients.

In May 2004, Ramsay was selected to undertake the largest ever public sector care contract awarded by the NHS. According to Ramsay, '95,000 patients will be treated between 2005 and 2010 in 10 specialist centres. Five have been newly built, two have been built in NHS facilities and three in existing Ramsay Hospitals.'⁸

⁷ *Ibid.*

⁸ Ramsay Health Care UK, *NHS Treatment Centres*, 2008. [Online].

4. Role of Independent Healthcare in the NHS

In 2008 the NHS celebrates its 60th anniversary. Over this period there have been significant developments in the NHS's practice of offering patients more choice through the level of services it offers. As stated by the NHS Choices website, from the 1970's onwards the NHS began to see its patients more as consumers and began to tailor its services to offer them more choice in the hospital they receive treatment from and through providing patients with more information, enabling them to make an informed choice in choosing their GP.⁹

In 2006, the Government announced the creation of the Extended Choice Network (ECN), an initiative by the Department of Health to reduce the number of NHS patients on waiting lists. NHS patients referred by their GP are now able to choose from a selection of four or five hospitals anywhere in the UK where they want to receive medical treatment. As of 1st April 2008, the network has been put into operation, offering more choice to patients with long term, medical conditions.¹⁰ Patients that are referred by their GP can still access their local NHS hospital in addition to any hospital in the country. This includes NHS hospitals as well as a number of private independent hospitals.¹¹

This initiative has certain implications for the role of private healthcare sector providers in delivering services for the NHS who are a statutory body. Nuffield Health is currently a member of the ECN and according to its website will shortly be providing NHS patients with access to all 39 of its hospitals for elective, non emergency surgery.¹²

Many independent not-for-profit hospitals with charitable status, similar to private for-profit hospitals, provide a variety of specialised services. The four most common procedures undertaken in privately owned hospitals are the extraction of cataracts, arthroscopies (a surgical technique used to inspect, diagnose and repair tissues in joints), knee replacement and hip replacement.

In recent years, the rate at which the NHS has been commissioning independent not-for-profit hospitals and for-profit private hospitals to carry out these types of specialised services has grown. The result of this is appears to be that the central control of the NHS is becoming increasingly fragmented.

The creation of foundation hospitals and primary care trusts, as well the effect of the NHS commissioning services to charitable and non-charitable private health care providers in the sector has meant that the way in which the NHS and the private healthcare sector work together has radically changed.

Although initiatives such as the ECN makes a number of medical treatments freely available to NHS patients, the NHS still pays the independent not-for-profit hospitals with charitable status and the for-profit hospitals a standard NHS tariff rate to take in NHS patients.

⁹ NHS Choices, 2008: *Your Health, Your Choice, Patient Choice in the NHS*, [Online].

¹⁰ *ibid.*

¹¹ Hampshire Primary Care Trust NHS. (2008). *Free Choice*. [Online].

¹² Nuffield Hospitals, (2008), *Patient Information, Nuffield Hospitals and the NHS: Extended Choice*. [Online].

5. The Government's Approach to the Third Sector and Public Service Delivery

Since the publication of the previous report the voluntary sector's role and profile in delivering public services for government has increased. This has had an impact on the daily administration of many charities and voluntary organisations.

One of the most significant developments was the creation of The Office of the Third Sector (OTS) in May 2006. The OTS (which is apart of the Cabinet Office) brings together the responsibilities of the Active Communities Directorate in the Home Office and the Social Enterprise Unit in the Department for Trade and Industry. Ed Miliband was appointed as the first minister for the Third Sector; he was succeeded in 2007 by Phil Hope, MP for Corby and East Northamptonshire. Currently, Kevin Brennan, MP for Cardiff West is in office as the minister for the Third Sector.

Over the last four years, the environment surrounding third sector organisations (TSOs) and Government has developed in part due to the many reports that have sought to evaluate the future role of the sector. The Cross-Cutting Reviews from 2002 and 2004, in the words of HM Treasury have: 'laid the foundation for a new and exciting phase in the relationship between Government and voluntary and community sector (VCS).'¹³

During this period, healthcare has been seen as a key policy area where the government sees potential for the voluntary sector to be more involved in delivering public services. The report: *Exploring the Role of the Third Sector in Public Service Delivery and Reform* sets out an analytical framework for the potential benefits of the third sector in delivering public services. Further to this, the Cabinet Office published *Partnership in public services: an action plan for third sector involvement*, alongside the Pre-Budget Report in December 2006, which indicated health and social care as one of five key policy areas in which the VCS will receive investment in to increase its capacity to be able to deliver more public services.¹⁴

This policy has been supported by several major programmes, backed up by significant financial investment. In 2008, figures showed that from 2004-08 a total of £215 million had been invested in Futurebuilders (a loan fund set up to increase the sector's capacity to deliver public services.) Futurebuilders has now been taken over by the Adventure Capital Fund. According to figures from the Comprehensive Spending Review (CSR) for the years 2008-11, an extra £65 million is planned to be invested in the fund. In addition, the Government has also invested heavily in the Capacitybuilders fund to a total of an extra £88.5 million.

The establishment of the Office of the Third Sector is the culmination of the Government's increased recognition and investment in the sector. Over the years, there

¹³ HM Treasury, 2004. *2004 VCS Review*, [Online].

¹⁴ The Cabinet Office, 2006. *Public service delivery action plan*. [Online]

¹⁶ Cabinet Office, 2008. *About us*. [Online]

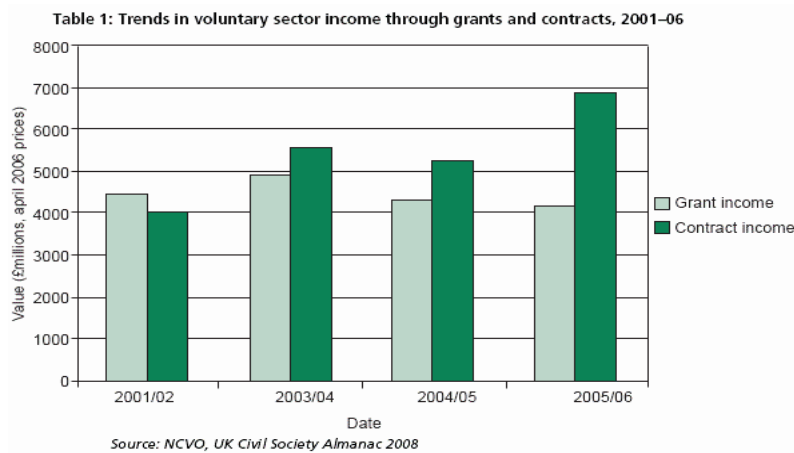
have been numerous developments in third sector policy that have informed the OTS in its aim to drive:

cross-government action to improve partnership working and ensuring better terms of engagement between government and the third sector.¹⁶

The creation of the OTS has had a significant impact within the sector in drawing together different Government departments to work more closely with the third sector. This has particular importance for independent not-for-profit hospitals with charitable status.

6. Report from the Public Administration Select Committee

According to figures published by NCVO, funding from central government and the NHS amounted to £4.6 million in 2005/06, which accounted for nearly 42% of the charitable and voluntary sector's income. The table below indicates the increasing level of contract funding within the sector over the years from 2001/02 through to 2005/06.¹⁷



In the current funding climate of tendering for contracts and, the third sector's role in delivering public services for the Government, we can see how charities have changed over the years in terms of the activities they undertake and how they are funded.

The eleventh report of the Public Administration Select Committee (PASC), published in June 2008, adds a further analysis of the government's attitude and expectations of the third sector to deliver public services. The Committee stated that they were drawn towards further investigation to address the context of the relationship between the government and the third sector in relation to public service delivery.

The report notes that the third sector has a history of providing services to the public, which in many cases have predated those provided by statutory bodies. In the past, there have been many cases where services provided by voluntary organisations have been introduced and then have been taken up by the government and implemented into their working practices as a responsibility of the state.

In order to distinguish between services provided by the state and those provided by independent bodies, the report differentiates between the meaning of 'delivering services to the public' and providing 'public services.' According to the PASC's report, charitable organisations have always provided 'services to the public', but have not always delivered public services that have been commissioned by statutory bodies.

¹⁷ NCVO, 2008. *The UK Civil Society Almanac*. p.p 33-4.

Although hospices (as charities) provide treatment for terminally ill patients, the Government does not guarantee that this service is available to all that need it. However, the State does provide palliative care in NHS hospitals and that means that palliative care is a public service. 'Public services' fall squarely under the Government's set of responsibilities as a statutory body; therefore the hospice (even if it receives funding from the State) is 'delivering services to the public' rather than a 'public service'.

The palliative care provided by the hospice is not available everywhere and is subsidised by charitable donations. It is not something the State is obliged to deliver as a 'public service', as it does the palliative care provided to patients in NHS hospitals.¹⁸ This is particularly relevant to the recent debate over the public benefit of fee-charging charitable hospitals which will be explored later in this report.

The Committee's report examines the Government's rationale of focusing attention on what they believe to be the 'distinctive' qualities of the Third Sector. Rather than simply allowing the Third Sector to participate in bidding for contracts as just another set of competitors with the private sector, it illustrated that the Government believes that the third sector has particular qualities that are ideally suited to carrying out public services.¹⁹ These include:

- a strong focus on the needs of service users;
- knowledge and expertise to meet complex personal needs and tackle difficult social issues;
- an ability to be flexible and offer up joined-up service delivery;
- the capacity to build up users' trust; and;
- the experience and independence to innovate.

Despite the fact that the PASC found no hard evidence for these distinct characteristics, it did acknowledge that the Government seemed to believe they did exist, and that this was partly behind their policy of seeking to involve the sector in delivering public services. The Government believes that the third sector has: 'particular strengths in empowering citizens, in innovation, and in helping the hardest to reach.'²⁰ Further, in response to critics who question the Government's policy as being primarily motivated by cost considerations, the Committee suggested that the Government's strategy to involve TSO's in public service delivery is in full driven more from the point of view of 'transforming' the quality of services for users, rather than as a financial cost cutting exercise.²¹

The publication of the *Third Sector Review* in July 2007 has also had important implications for the Government's drive to increase the third sector's capacity to deliver public services. This report was the result of one of the largest consultations the Government has facilitated with the third sector. It has been influenced by many years of speculation and debate around the role of the third sector in public service delivery and the relationship between the sector and the Government.

¹⁸ Public Administration Select Committee, 2008. *Eleventh Report: Public Services and the Third Sector: Rhetoric and Reality*, p.15. [Online] 9 July 2008. p.13.

¹⁹ Public Administration: *Eleventh Report*, p.53.

²⁰ Public Administration, *Eleventh Report*, p.28.

²¹ Public Administration, *Eleventh Report*, p.29.

Prior to the TSR, the report: *Service transformation: A better service for citizens and businesses, a better deal for the taxpayer* was published by a civil servant Sir David Varney who was tasked with carrying out an internal review of the Government's policy on service delivery. Sir David Varney's recommended that:

establishing and taking forward a service transformation programme with an associated published delivery plan should be one of the Government's top priority outcomes for the 2007 CSR [comprehensive spending review] period. This level of priority will be essential to driving the programme forward and to incentivise collaboration across the public sector.²²

The report, also known as the Varney Review, proposes that there are many opportunities for the third sector and Government to work together to offer joined up services to the public. Sir David Varney's recommendations are central to the Government's plans to further increase its investment in the Third Sector; enabling the sector to increase its capacity, whilst also offering the sector incentives to carry out public service contracts. In relation to the TSR the Cabinet Office website states that:

The Government will build the capacity of third sector organisations to improve public services, through the Futurebuilders Fund, which provides loans and grants to organisations looking to deliver public services, training for public sector commissioners and work to build the evidence on opportunities for the third sector.²³

Since the last report from DSC in 2004, healthcare has remained high on the political agenda and has had much coverage in the media. In 2004, the Department of Health conducted a review of health service provision through a series of consultations with healthcare providers. The product of these consultations was the Public Health White Paper, *Partnerships in the Community*, in which the report stated:

A cornerstone of the White Paper is the promotion of joint action by local authorities with business and voluntary groups, to tackle local health inequalities and issues.²⁵

In 2006, the Department of Health produced another White Paper: *Our health, our care, our say: a new direction for community services*. The paper aims to set out an 'integrated programme of reform for community health and social care.' It commits itself to breaking down the barriers for third sector and social enterprises to participate in working together with statutory bodies in delivering public services. The paper states that:

We have established the Third Sector Commissioning Task Force, which includes representatives of the community and voluntary sector, social services, PCTs, Office of the Deputy Prime Minister, Home Office, Department for Education and Skills and the Department of Health, to

²² Sir D Varney, 2006. *Transforming Public Services: A Better Service for Citizens and Businesses, a better deal for the Taxpayer* [Online]. p.4.

²³ The Cabinet Office, 2007. *Third sector review final report, Transforming Public Service Delivery*. [Online].

²⁵ Department of Health, 2007. *Public Health White Paper: Partnerships in the Community*, [Online]

address the key barriers to a sound commercial relationship between the public and the third sector.²⁶

The changing policy landscape has resulted in reforms within public service delivery and cross-sector partnerships between statutory health care and voluntary sector organisations. Since 2004, there has been greater momentum towards the Government, the NHS and voluntary sector organisations working in partnership. As David Mobbs, chief executive of Nuffield Health mentioned in the group's 2004 annual report:

The liberalisation of the UK healthcare market has presented significant opportunities for Nuffield Hospitals to work even more closely with the NHS.²⁷

In tandem with the developments in public service delivery policy, the passing of the Charities Act 2006 has also changed how charities operate in the sector. The following chapter explores the implications of the 2006 Act, specifically how independent not-for-profit hospitals with charitable status their report on their charitable activities and demonstrate their benefit to the public.

²⁶ Department of Health, 2006. *Our health, our care, our say: a new direction for community services*. (Cm. 6737) [Online]. p.183.

²⁷ Charity Commission, 2004. *Nuffield Hospitals Annual Report 2004*. p.1.

7. Background to the Charities Act 2006

The Charities Act 2006 received royal assent on 8 November 2006 and had been many years in the parliamentary process. In July 2001, the Prime Minister asked the Strategy Unit to carry out a review of the law and regulations of charities and not-for-profit organisations. The review, *Public Benefit, Private Action* was published in September 2002. The report made a range of recommendations that it considered would modernise existing charity law and the status of charitable organisations.

In 2004, a Joint Committee was created, composed of members from the House of Lords and the House of Commons. The committee was tasked with gathering evidence and producing a report of the Draft Charities Bill by September of that year. As a result of the Strategy Unit's recommendations the Joint Committee published the *Draft Charities Bill* in May 2004. One of the main changes was a broader definition of what constituted charitable status, in order to update the concept of charity. This had the consequence of also including types of organisations that could not be considered charitable under the existing four heads of charity. The Committee gave a brief definition of their understanding of the voluntary sector:

The charitable sector is a subset of the wider voluntary or not-for-profit sector. This wider sector encompasses mutual benefit organisations including cooperatives and credit unions and other non-profit distributing organisations which benefit only their members and not the wider public. It also encompasses organisations which are not eligible for charitable status because their primary purpose is to achieve a change in the law or public policy.²⁸

The Bill spent several years in its progress through the parliamentary system. The *Charities Act 2006* is the conclusion of this process of extensive consultation and debate with the third sector, members of the public, representatives of parliament, and the work of the Joint Committee. The aim of the Act is to provide a modern legal framework governing the administration of charitable organisations. The legislation of the Act does not seek to replace previous case law which has developed over centuries, but it does reform previous case law and previous Acts to reflect the needs and practices of the voluntary sector in today's society. The Office of the Third Sector states that the Act reforms charity law and regulation to:

- enable charities to administer themselves more efficiently and be more effective;
- improve the regulation of charity fundraising, and reduce regulation on the sector, especially for smaller charities;
- provide a clear definition of charity with an emphasis on public benefit;
- modernise the Charity Commission's functions and powers as regulator, increase its accountability, and preserve its independence from ministers.

²⁹

²⁸ Home Office, 2004. *Joint Committee on the Draft Charities Bill: First Report 2004*. [Online]

²⁹ Cabinet Office, 2008. *Charities Act 2006*. [Online].

These points summarise the main purposes of the Act and reflect four of the major changes that have taken place within it.

8. Independent Not-for-profit Hospitals with Charitable Status and the Charities Act 2006

The passing of the *Charities Act 2006* brings with it considerable changes in the way that charities are regulated. The 2006 Act is one of the biggest pieces of legislative reform to have affected the voluntary sector in decades. It transforms the powers of the Charity Commission and its ability to enforce tighter regulations on charitable organisations. This will have a significant impact on many organisations regardless of size within the sector.

The 2006 Act has significant implications for the future administration of independent not-for-profit hospitals with charitable status; the exact nature of the implications will only be evident in the future, after the law has been fully implemented and the regulations have been applied. However, there are several areas where the law has significantly changed, which can be identified and discussed.

The definition of charitable purposes

Prior to the Charities Act 2006 the definition of 'charity' was widely acknowledged to be based on an original statement of charitable purposes in a 1601 Act of Parliament. The statement developed over time into a list of four main categories or 'heads' of charity, which are outlined as follows:

1. the relief of poverty;
2. the advancement of education;
3. advancement of religion;
4. other purposes beneficial to the community in a way recognised as charitable.

³¹ *Charities Act 2006*. (c.50), London: OPSI.

The Charities Act 2006 lists 13 new charitable categories (a-m) under which a charity's purposes must fall, these are listed as follows:

- a) *The prevention or relief of poverty*
- b) *The advancement of education*
- c) *The advancement of religion*
- d) *The advancement of health or the saving of lives*
- e) *The advancement of citizenship or community development*
- f) *The advancement of the arts, culture, heritage or science*
- g) *The advancement of amateur sport*
- h) *The advancement of human rights, conflict resolution or reconciliation or the promotion of religious or racial harmony or equality and diversity*
- i) *The advancement of environmental protection or improvement*
- j) *The relief of those in need, by reason of youth, age, ill-health, disability, financial hardship or other disadvantage*
- k) *The advancement of animal welfare*
- l) *The promotion of the efficiency of the armed forces of the Crown, or of the efficiency of the police, fire and rescue services or ambulance services*
- m) *Any other purposes which may reasonably be regarded as analogous to the above including existing charity law.*

Previously, independent not-for-profit hospitals with charitable status would have come under the charitable head the *relief of poverty*. Traditionally, the 'relief of poverty' category was sometimes considered to have encompassed other types of hardship or disadvantage such as the relief of the 'aged, sick or impotent'. This is now not the case.

The *advancement of health and the saving of lives (d)* is one of the new categories to be included under the 2006 Act. This category is specifically stated to include the prevention or relief of sickness, disease or human suffering. For charitable hospitals there are also considerable overlaps between this new category and two other new charitable categories that are likely to apply to them. So under the 2006 Act the purposes that are likely to apply to charitable hospitals are:

- *Advancement of Health and the saving of lives (d)*
- *The relief of those in need by reason of youth, age, ill-health, disability, financial hardship or other disadvantage (j)*

- *The promotion of the efficiency of the armed forces of the Crown or of the efficiency of the police, fire and rescue services or ambulance services (l)*
- *Any other purposes which may reasonably be regarded as analogous to the above including existing charity law. (m)*

Independent not-for-profit hospitals with charitable status can satisfy the requirement that they fall under one or more of these categories in a number of ways, for example, providing medical care to service men and women and their dependents would demonstrate *The promotion of the efficiency of the armed forces of the Crown, or of the efficiency of the police, fire and rescue services or ambulance services*. However, under the 2006 Act, existing within one of the thirteen charitable categories on its own merit is not sufficient for a charitable organisation to secure the benefits of having charitable status.

New regulations in the 2006 Act pertaining to the categorisation of a charity's aims and new draft guidance to demonstrate public benefit work together to ensure that charities must prove how their aims and objectives are charitable and how their activities are directly beneficial to the public through a test of the charity's public benefit.

New regulatory powers for the Charity Commission

Prior to the 2006 Act, the Charity Commission was made up of a board of five commissioners. As of February 2007, the Charities Act 2006 replaces the five individual commissioners with a new corporate body that is the Charity Commission for England and Wales. The Charity Commission now comprises nine commissioners whose responsibilities and duties are officially brought under the law. Notably, for the first time the Charity Commission now has a list of specific objectives under British law. As quoted from the 2006 Act those objectives are stated as follows:

1. The public confidence objective is to increase public trust and confidence in charities.
2. The public benefit objective is to promote awareness and understanding of the operation of the public benefit requirement.
3. The compliance objective is to promote compliance by charity trustees with their legal obligations in exercising control and management of the administration of their charities.
4. The charitable resources objective is to promote the effective use of charitable resources.
5. The accountability objective is to enhance the accountability of charities to donors, beneficiaries and the general public.³¹

What this means for independent not-for-profit hospitals with charitable status is that the Charity Commission now has greater scope to direct the administration of charitable organisations if it has grounds to believe the organisation has fallen foul of the new regulatory requirements. The Charity Commission has always had sufficient power to direct charities, but as Gareth Morgan the author of *The Charities Act 2006: A Guide for*

Foundations and Grant-Making Trusts in England and Wales points out, under the 2006 Act these powers have been enhanced to include the following:

- Power to give direction for protection of property (s20);
- Power to direct application of charity property (s21);
- Power to enter premises and seize documents (provided the Commission has a warrant) (s26);
- Power to suspend someone from membership of a charity (not simply suspending them as a trustee or an officer. (s19)³²

Cy-près schemes (cy-près – as near as possible)

In certain circumstances the Commission has the authority to direct a charity's funds or property if they cannot be applied for their original purposes to new purposes that fit with the spirit of the gift. Under sections 13-15 of the Charities Act 1993, the Commission already had extensive powers to direct a charity's funds or property, in the context of appropriating a charity's funds to a new purpose that was as close to the original purpose as possible. The passing of the 2006 Act modernises the framework for which new purposes can be created and, funds raised can be applied. There are three main areas in which the Act alters the provisions of the cy-près doctrine, which are as follows:

1. The Charity Commission as well as taking into consideration the spirit of the gift can now also consider external factors such as social and economic circumstances at the time of the decision. This can apply when purposes are changed within the original charity or when a scheme is used to transfer money or a property to a new charity.
2. Previously where a charitable appeal has failed, for example, when insufficient funds are raised for a specific project, it is not always possible to contact all the donors to return their donations. The 1993 Act allowed such funds to be applied cy-près for new purposes after sufficient advertisements were placed to offer the return of funds. This did not apply where money came from cash collections, lotteries or competitions. In these cases application had to be made to the High Court, following the 2006 Act this has been amended to allow the Charity Commission to make the Order.
3. A new section, 14A, has been added to the Act making it explicit that charitable appeals can include a statement that explains how funds will be applied cy-près if the original purpose of the appeal cannot be achieved, although donors must also be given the option to opt out of such arrangements at the time of making the gift.³³

³² Morgan, G, 2006. *The Charities Act 2006: A Guide for Foundations and Grant-Making Trusts in England and Wales*, Association of Charitable Foundations. p.42.

³³ Morgan, G, 2006. *The Charities Act 2006*. p.27.

Through the cy-près doctrine the Charity Commission now has more power to assist charities that are failing to meet the Commission's regulations to demonstrate their charitable purposes and to meet the public benefit requirement. The 2006 Act confirms that the Commission can implement the cy-près doctrine when considering the needs of the relevant charity to 'have purposes which are suitable and effective in the light of current social and economic circumstances.'³⁴ This could be reassuring for charities that struggle to meet the public benefit requirement as it provides an alternative solution to prove how they exist for the benefit of the public. Through the cy-près doctrine it could be as simple for a charity to alter their objectives to match the activities they carry out in order to meet the public benefit requirement.

According to an extract from the Charity Commission, one of Nuffield Health's objects is: 'to prevent, relieve and cure sickness and ill health of every kind'³⁵. Under the cy-près doctrine, Nuffield Health could extend their objects to fit under a wider variety of charitable heads other than *the advancement of health or the saving of lives*, which the previously stated object would sit beneath. This would have the effect of clarifying what objects an independent not-for-profit hospital with charitable status carry out and how this satisfies the discipline of public benefit.

The 2006 Act incorporates many changes that have important consequences for independent not-for-profit hospitals with charitable status. The 2006 Act modernises the legislation that both the Commission and charities must adhere to. Although the 2006 Act allows charities greater flexibility in complying with the Commission's regulations within the Act and the public benefit guidance³⁶, it also puts in place many restrictions where in the future the Commission might intervene in the application of a charity's income or investments.

Much of the 2006 Act focuses on the new powers of the Charity Commission to supervise and regulate charitable organisations more stringently through being granted more legal authority to direct charities in their administration where they see fit. Major changes such as those made by many independent not-for-profit hospitals with charitable status over the last few years to expand their services in order to compete in the market place, i.e. Nuffield's acquisition of Cannons Health & Fitness, could in future fall under the Charity Commission's scrutiny.

³⁴ *Charities Act 2006*. (c.50), London: OPSI.

³⁵ The Charity Commission, 2008. *Extract from the Central Register of Charities maintained by the Charity Commission for England and Wales: Nuffield Health*. [Online]

³⁶ See page 24 for a discussion of the 2006 Act and the guidance on the public benefit requirement.

9. The Law and Charitable Hospitals: the Case of *Re: Resch*

The Charity Commission's guidance *An Analysis of the Law Underpinning Public Benefit and Fee Charging* brings to bear many of the key issues in the debate surrounding independent charitable hospitals that charge fees.

In developing the definition of public benefit, the Commission has relied in large part on the case of *Re: Resch* (1969). The case of *Re: Resch* concerned a gift from a will to a charitable hospital which charged fees. The family of the donor contested the decision. The main principles of the case are closely reflected in the *Charity Commission's Draft Supplementary Guidance on Public Benefit and Fee Charging Hospitals*. These include:

1. The fact that the charitable services and facilities will be charged for does not mean that the charitable organisation is not set up for the public benefit.
2. An organisation that completely excluded people considered to be poor from any benefits, either directly or indirectly, would be deemed to be not for the public benefit.
3. The direct or indirect benefits in conjunction with benefits reaching a large section of society will also be taken into consideration when assessing how an organisation provides public benefit.³⁷

The family's case focused on the argument that the independent charitable fee-charging hospital provided services for more affluent people and excluded poorer people from participating; therefore the hospital was not set up for the public benefit. However, the hospital had links with a nearby public general hospital; although it did not have a constitution of its own, the court decided that its activities were in the public benefit because it provided a particular type of medical and nursing care that the nearby public hospital did not provide for which there was a need. Lord Wilberforce (the Judge presiding over the case) acknowledged:

that expensive services and facilities could be charitable but that limiting services to the rich, excluding those who could not afford the fees, could not be charitable.³⁸

However, he ruled that overall the hospital did provide benefit to the public because only some of the poor had been excluded in this case. These were namely people:

1. who had not contributed sufficiently to a medical benefit scheme
2. needed to stay longer in hospital than their benefit would cover
3. could not get a reduction or exemption from the fees³⁹

³⁷ The Charity Commission, 2008. *An Analysis of the Law Underpinning Public Benefit and Fee Charging*.

[Online]

³⁸ *ibid.*

³⁹ *ibid.*

The judge concluded that those who were excluded, who could not afford the fees, represented a minimal number of people and the exclusion had happened by chance. The fact that the hospital had treated poorer patients free of charge or at reduced rates was also a factor in deciding that the hospital did provide enough benefit for the public.

At the time, the Australian case came to the UK High Court to be judged by Lord Wilberforce. The *Re: Resch* case is considered to be one of the cornerstones of case law in relation to public benefit and how it is assessed in the UK by the Charity Commission.

10. Public Benefit Requirement and Fee-Charging Charitable Hospitals

The Charity Commission has used case law from *Re: Resch* and other cases to develop its guidance for how it will interpret public benefit. The ability of fee-charging charities to satisfy the public benefit test will depend on the following factors, as outlined in *An Analysis of the Law Underpinning Public Benefit and Fee-Charging*:

- the charitable purpose;
- the need and nature of the services and facilities provided;
- the extent and level of the charges or fees which need to be paid to access them, and consequently the exclusionary nature of the charge;
- the extent to which those charges are moderated in whole or part to permit access to those who cannot afford the charges or fees or to give them other access (direct or indirect) to the benefits of the charity arising to such persons;
- the nature of the benefit, including whether it is of a singular or longer term benefit; as well as the general circumstances and modern context in which the charity operates.⁴¹

Definition of public benefit

Demonstrating public benefit is not a new requirement for charities. Prior to the 2006 Act, a charity would have to demonstrate how its aims and activities would be for the public benefit, when applying for registration or when having its charitable status determined.

The main change brought in by the 2006 Act is that a charity must now demonstrate that it continues to meet this requirement year on year through a statement of its activities and achievements in its annual report and accounts. Charities already in existence, perhaps for hundreds of years, must now explicitly demonstrate their public benefit to the Commission.

According to the Charity Commission:

Public benefit' is the legal requirement that every organisation set up for one or more charitable aims must be able to demonstrate that its aims are for the **public benefit** if it is to be recognised, and registered, as a charity in England and Wales. This is known as 'the public benefit requirement'⁴²

This is the most comprehensive explanation of what constitutes public benefit. The Charities Act 2006 does not present any clear cut definition of what public benefit is or explicitly state how a charity might set about demonstrating public benefit through its activities.

⁴¹ Charity Commission, 2008. *An Analysis of the Law Underpinning Public Benefit and Fee Charging*. [Online].

⁴² *Ibid.*

The draft supplementary guidance on public benefit from the Charity Commission is an accompaniment to the Charities Act 2006; it does not provide a legal definition of what constitutes public benefit, but provides a framework from which to assess a charity's case for demonstrating public benefit. It is not statutory guidance as such, but trustees have a legal duty to pay regard to the guidance in carrying out their duties as trustees.

The 2006 Act highlights the issue of public benefit by making it a part of the working definition of what constitutes a charity's purposes. The Commission emphasises that an organisation must be set up with exclusively charitable purposes that are for the public benefit in order to be a charity.

The Commission state that:

Benefits to the public that are not related to an organisation's aims cannot be used as a way of demonstrating that the aims are for the public benefit.⁴³

If the charity carry out charitable acts that are not a part of its original aims then these acts no matter how worthy cannot be submitted as actions that demonstrate a charity is performing a service for public benefit. This is a key question independent not-for-profit hospitals with charitable status need to ask themselves their efforts to demonstrate public benefit.

The Commission state that it is a positive thing for charities to provide details of the good work that they do for society. The key legal change in the Act is that it is the trustees responsibility to demonstrate that their organisation does provide public benefit and this must be included in the trustees' annual report.

Principles of public benefit

The main elements of public benefit are outlined in the Charity Commission's general public benefit guidance, *Charities and Public Benefit*. There are the two key principles that underlie the understanding of what public benefit means in relation to fee-charging charitable hospitals and where it applies and who it applies to. The two key principles of public benefit are set out as follows:

⁴³ Charity Commission, 2008. *Charities and Public Benefit*, [online], p.12.

Principle 1: There must be an identifiable benefit or benefits

Principle 1a - It must be clear what the benefits are

Principle 1b - The benefits must be related to the aims

Principle 1c - Benefits must be balanced against any detriment or harm

Principle 2: Benefit must be to the public, or a section of the public

Principle 2a - The beneficiaries must be appropriate to the aims

Principle 2b - Where benefit is to a section of the public, the opportunity to benefit must not be unreasonably restricted:

- By geography or other restrictions; or
- By ability to pay any fees charged

Principle 2c - People in poverty must not be excluded from the opportunity to benefit

Principle 2d - Any private benefits must be incidental

Source: Charities and Public Benefit

The two principles that are likely to be the most problematic for fee-charging charitable hospitals are principle 2b and principle 2c. Both principles have repercussions for independent not-for-profit hospitals with charitable status, because the fees they charge could create restrictions for potential beneficiaries based on their ability to pay the fees charged, or exclude people in poverty from the opportunity to benefit. Elaborating on Principle 2c, the Commission maintains that:

an organisation that excluded people from the **opportunity** to benefit because of their inability to pay any fees charged would not have aims that are for the public benefit.⁴⁴

The general guidance on public benefit states that when assessing the overall public benefit provided by a fee-charging charity it will take into consideration the totality of the 'benefits arising from carrying out its aims.' However, where the people who are intended to benefit from the aims of the charity do not make up a sufficient proportion of the public, the aims of the organisation will not be deemed to be for the public benefit. People must at least have the opportunity to benefit and this must cover a large amount of eligible beneficiaries.

The Charity Commission state that the issues they take into consideration when assessing public benefit includes the following points:

1. Whether the levels at which fees are set have the effect of preventing people who are unable to pay the fees from benefiting from the services or facilities.

⁴⁴ Charity Commission, 2008. *Charities and Public Benefit*, [online], p.20.

2. If this is the case, whether it is possible to show that people who are unable to pay the fees are not excluded from the opportunity to benefit.
3. Whether and how people who are unable to pay the fees may otherwise benefit from the services or facilities.
4. The nature and extent of the other benefits provided.

In the first instance, the price of the fees can dictate the number of people who can benefit from the charity's services or facilities and consequently those who are excluded from benefiting. This can vary in different circumstances, for example, different services that a charity charges for may be more or less affordable or different people in different geographic areas or socio-economic strata may be more or less able to pay. The Commission asserts that in setting the fees for a charity's services the onus is placed on the members or trustees of the charity concerned.

The Commission accepts the fact that there is not a one size fits all rule that can be applied to the way a charity sets its fees. For example, a charity that provides a higher level of service (such as long term medical treatment) would be justified in reflecting this in a higher fee charge to cover the costs of that particular circumstance and length of treatment. However, regardless of the level of fees charged for services a charity must still demonstrate in other ways how beneficiaries might be able to benefit materially from the range of activities and services the fee-charging organisation has to offer.

Principle 2c which states that people in poverty must not be excluded from the opportunity to benefit, follows closely on from the main points that principle 2b addresses. Whatever restrictions there are on who can benefit, the Commission states that, 'charities must in all cases ensure that people in poverty are not excluded from the benefit from each of their aims.'⁴⁵ The Commission clarifies that this does not introduce an element of relieving poverty into the charity's aims nor is it that a charity is restricted to helping people in poverty alone or, even that this group of people have to benefit. The main principle is that they must not be excluded from the opportunity to benefit from the charity's aims.

The meaning of the word 'poverty' in a legal charitable context extends to people who are financially disadvantaged. The meaning of 'people in poverty' will be taken into consideration in individual cases against the organisation's aims, of where they carry out those aims and for whom they are intended to benefit. The Commission maintains that the context and aims of each organisation is crucial in deciding who 'people in poverty' might include and whether or not they are or have been excluded from the opportunity to benefit.

These are some of the ways that independent not-for-profit hospitals with charitable status have traditionally argued that they have demonstrated that they provide wide access and sufficient benefit to large sections of the public.

- The existence of accessible insurance or other benefit schemes, for example medical insurance schemes. This would depend, though, on the cost of such schemes and what sorts of services people are entitled to receive under them;

⁴⁵ Charity Commission, 2008. *Charities and Public Benefit*, p.22.

- The benefits of free access to specialised medical equipment not available in the local NHS hospital, or through a number of beds in the charitable hospital being made freely available to NHS patients.
- Providing medical training to nurses or doctors at an NHS hospital which would indirectly benefit the non-fee-paying patients at another hospital.⁴⁶

However once the public benefit requirements are implemented in the financial year 2009, it remains to be seen whether independent not-for-profit hospitals such as Nuffield Health and the London Clinic continue to report these types of activities under the heading 'charitable activities', as they have done so in their most recent accounts at the time of this report.

However, it is clear that the decision to set fees can have an impact on a charity's ability to show the level of benefit they give to the public. It can have the effect of restricting access to some of the services, which contradicts the principles 2b and 2c of the draft guidance on *Public Benefit and Fee-Charging*.

According to the Charity Commission's *Draft Supplementary Guidance for Consultation: Public Benefit and Fee Charging Charities*, charities that set fees for their services or facilities must consider the following points:

- What fees might be needed to cover the charity's costs?
- What other income sources are available to the charity, which might (in full or in part) subsidise fees?
- Who are the charity's intended beneficiaries?
- To what extent will the fees be used (in full or in part) to finance other charitable activities undertaken by the charity?
- What are the implications of charging the fees on who can access the service or facility that is charged for.⁴⁷

It is for the trustees of any fee-charging charity to determine the price of the fees they charge beneficiaries. However, the trustees must also consider what effect charging fees for its services could have on restricting access or excluding those in poverty from the opportunity to benefit from the organisation's activities. The Commission's guidance states that such restrictions 'can affect the charity's ability to meet the public benefit requirement, and, consequently, its charitable status.'⁴⁸

Private medical insurance

All independent hospitals (charitable or non-charitable status) have three types of patients; in order of profitability these are:

- Those who purchase services at the time of need

⁴⁶ *Ibid.*

⁴⁷ Charity Commission, 2008. *Draft Supplementary Guidance for Consultation: Public Benefit and Fee Charging*. [Online] p.21.

⁴⁸ *Draft Supplementary Guidance for Consultation: Public Benefit and Fee Charging*. 2008. p.18.

- Subscribers (those with insurance cover for acute conditions whether funded by themselves or by their employer)
- NHS patients (who are funded by the NHS under contracts or the Extended Choice Network)

The Charity Commission state that one way that a fee-charging charity may fulfil public benefit potentially is through the provision of medical insurance either privately or through employee schemes as a way of opening up access to their services or facilities. The idea is that the provision of health insurance schemes helps people unable to pay the fees up front by spreading the cost of the repayment over a period of time. However, this is not very likely to enable poorer people to access the services of an independent not-for-profit hospital's services, PMI is on an annual basis not a continuous basis so PMI companies could up their prices year on year if they wanted to.

In the Commission's draft supplementary guidance *Public Benefit and Fee-charging*, the Commission suggest that the existence of Private Medical Insurance (PMI) might offer some opportunity to benefit from an independent not-for-profit hospital with charitable status's services but, it is not a simple solution. The Commission state that some factors that might limit these types of insurance schemes ability to provide benefit to people who can not afford the fees include:

- The cost of premiums
- The type and extent of the cover available – what degree of cover is provided by low cost premiums for example?
- Whether the premiums are more expensive for certain groups - e.g. elderly people or people with on-going pre-existing medical conditions might be more likely to call on medical insurance and therefore might have to pay
- Higher premiums. Where those people are unable to afford the higher premiums they might continue to be excluded from accessing the charity's benefits notwithstanding the general availability of insurance schemes;
- Whether the premiums are paid for by others - e.g. as a benefit provided under conditions of employment;
- What are the conditions? How tough are they?
- Is the choice of provider or type of service limited?
- Is there an excess to be paid? Is it one-off, annual or over a longer period?
- Are there additional or top-up fees for certain services?
- Is it a shared responsibility scheme where, for example, the person insured pays a certain percentage of the cost, with their contribution capped as say £500, £1,000 or some other amount? The more the person agrees to pay themselves, the lower the premium.

Source: Public Benefit and Fee-charging

According to *Private Spending on Healthcare*, a report from The Institute for Public Policy Research (IPPR), figures from 2005 revealed that private health insurance (PMI)

accounted for 2.81 per cent of the entire UK health economy. This represented 17.5 per cent of total private spending on health in the UK. The report stated that 10.9 per cent of the population was covered by PMI at this time.

PMI differs from other types of health insurance such as health cash plans and critical illness cover. PMI is purported by many of the leading private medical groups to assist patients to a great extent, being able to afford private medical cost and therefore cut down on the NHS waiting lists. In a statement on the anniversary of Nuffield Health's 50th

anniversary the group stated that in its initial beginnings the group aimed to provide an alternative to the NHS by providing lost-cost affordable treatment. They stated that in the 1950s:

The demand for private medical insurance had been increasing since the establishment of the National Health Service in 1948, whilst the number of private facilities had been declining rapidly, leading to an imbalance between demand and capacity.⁴⁹

In recent years, the number of people with private medical insurance or those enrolled on private medical schemes that are self-insured with employers in the UK has risen steadily. At the start of 2008, the number of people taking out some sort of medical insurance was up by 1.3% reaching a total of nearly 4.3 million people.⁵⁰

The Association of British Insurers (ABI) confirmed that beneficiaries can decide the type of cover they want and what this includes. Depending on what type and how many options a customer chooses the price of the premiums rises accordingly. One pre-payment option is that subscribers can choose which hospital they receive their treatment from.

The Commission's draft guidance for fee-charging charities indicates that their research has shown them that although the cost of PMI premiums are 'reduced or low' there are many limitations within the premium's terms and conditions that could prevent beneficiaries from gaining the full benefit of having their repayments spread over a longer period of time.⁵¹ For example, the ABI define private medical insurance as being designed to cover the costs of private medical treatment for 'what are commonly known as acute medical conditions that arise after the policy begins.'⁵²

This is a clear limitation for those patients who have more serious and longer-term care needs before the agreement of PMI. This in itself would not benefit a sufficient section of the public; it does not do enough to enable patients to have access to a wide range of services that an independent not-for-profit hospital with charitable status has to offer.

The **IPPR** report suggests that when waiting times are high and the public perception of the public health system standards are low, PMI is perceived to be necessary for 'timely,

⁴⁹ Nuffield Hospitals, 2008. *The 1950s at Nuffield Hospitals*. [Online]

⁵⁰ Laing & Buisson, 2008. *Press Release: Health Care and Cover – UK Market Report 2008*, [Online].

⁵¹ The Charity Commission, 2008. *Draft Supplementary Guidance for Consultation: Public Benefit and Fee-Charging*. [Online]. p. 28.

⁵² British Medical Insurers, 2008. *Are you buying private medical insurance? Take a look at this guide before you buy*. [Online], p.4.

high-quality medical treatment.’ As a result demand for PMI is driven by middle and higher income groups. The report explains that:

If PHI is a necessary requirement for obtaining access to timely, adequate medical treatment (when waiting times, clinical quality and/or degree of coverage of the publicly-funded health system are poor), PHI can impose damaging effects on equity.⁵³

Added to this, the report shows that the PMI market is highly concentrated as three quarters of the market are owned by three major companies. In recent years, there have also been sharp price increases that have been accompanied by ‘downgrading’, ‘either by restricting cover, increasing excess or movement towards lower cost plans in the individual market.’ The report stated that:

These facts suggest that there is a potential lack of effective price competition between PHI companies, with a small number of dominant competitors, rising prices, rising margins in the individual sector where purchasers have less bargaining power.⁵⁴

Evidence from the **IPPR** report appears to indicate that PMI is beyond the means of most people on lower incomes. With the current state of the UK healthcare market, it suggests that there is inequity in the sector, with purchasers having little or no bargaining power when it comes to the cost of premiums for PHI. This is particularly relevant to independent not-for-profit hospitals with charitable status using PMI as a way of demonstrating principle 2c of the public benefit requirement that they enable a wide enough section of society to access to their services.

The impact of using the availability of an insurance scheme to demonstrate public benefit for independent not-for-profit hospitals with charitable status is that the evidence proves that PMI is only beneficial to people who are considered to be well off. This in effect excludes people on lower incomes from accessing the services of the independent not-for-profit charitable hospitals that use PMI. Therefore, it could be considered that PMI does not demonstrate public benefit at all.

The Charity Commission take a similar point of view that PMI is not easily affordable for many people on lower incomes. In the *Consultation on draft supplementary guidance on Public Benefit and Fee-charging*, the Charity Commission confirms that the existence of accessible medical insurance would depend on the cost of the scheme and what sort of services people are entitled to receive under it.⁵⁵ The draft guidance suggests that in order to satisfy the discipline of public benefit, charities need to look to a wide range of services and activities in order to meet the regulation requirement and not rely on a limited number.

⁵³ Farrington-Douglas, J and Castro Coelho, M, 2008. *Private Spending on Healthcare*. June 2008. [PDF] London: Institute for Public Policy Research. p.56.

⁵⁴ *Private Spending on Healthcare*. June 2008. p.57.

⁵⁵ Charity Commission, 2008. *Draft Supplementary Guidance for Consultation: Public Benefit and Fee-Charging Public Benefit and Fee Charging*, p.28.

⁵⁹ Third Sector, 2008. *Focus: News Analysis: Hospital Reignites Public Benefit Row* [Online]

11. Odstock Private Care Limited - What Does Public Benefit Mean for Independent Not-for-profit Hospital's Charitable Status?

In 2007 a private health care clinic (Odstock Private Health Care LTD), set up by the Salisbury Hospital for its private patients in order to avoid a cap on patient numbers at NHS foundation trust was denied charitable status by the Charity Commission. The decision to refuse Odstock the benefits of having charitable status has created much debate about the implications for other private health care organisations including those already with charitable status or wishing to apply for it. It has also raised questions regarding the ability of fee-charging charities to be able to carry out activities that have quantifiable public benefit.

The main arguments that have arisen from the debate included the accessibility of Odstock's services to poorer sections of the community in Salisbury (principle 2c). The main obstacle to accessing its services was the pricing tariff of the clinic's fees, which Odstock maintained were accessible to the community of Salisbury (an area in which many of the residents are particularly well off in comparison with other communities in England and Wales). A report from the *Third Sector* warned that:

It remains to be seen what its final version of the guidance will be, but some lawyers think the Odstock decision was a clear indication of the way the Commission intends to interpret the case law on fee-charging charities.⁵⁹

If this proves to be the case, the decision could affect the operation of many independent not-for-profit hospitals with charitable status in the future. Andrew Phillips, an expert on charity law and member of the House of Lords commented in support of the Commission's decision that:

The Commission has hung its hat very clearly, and admirably, on the fact that people living in poverty must not be excluded.⁶⁰

There are many differing opinions concerning the ruling decision on the Odstock case. In opposition to Andrew Phillips, the *Third Sector* reported that:

One senior barrister argues that the relief of rates and taxes, as provided by private healthcare or private schools, is recognised as a charitable purpose under the 'any other purpose' category in the list of charitable purposes given in the Charities Act 2006, and that Odstock should therefore be recognised as entirely charitable.⁶¹

The case is likely to have wider repercussions for comparable organisations to Odstock wishing to set up similar schemes which could fail on the same principles in this case. According to information from the Charity Commission, Odstock Private Care Limited failed to gain charitable status because they were unable to offset the indirect benefits

⁶⁰ *Ibid.*

⁶¹ *Ibid.*

they provided for the public with actual direct benefits. The Commission had this to say on the case:

It may be inferred that the availability of private health provision may impact on NHS waiting lists. Indirect benefits, such as possible reduction in waiting lists, enter into the account and would be considered alongside direct benefits. However, in this case, the Delegated Members did not consider that any such inference would, of itself (and failing the demonstration of more direct benefits), be sufficient to establish that Odstock's purposes may so be operated as to benefit the public generally including those living in poverty.

However, the Commission have stated in its guidance *Charities and Public Benefit* that they believe:

No two charities are exactly the same, so our detailed public benefit assessments will consider each case on its own merits, taking into consideration issues of risk and proportionality, and the particular circumstances of the individual charity.⁶²

Each individual charity will be assessed on their particular circumstances and the socio-economic conditions in context. Although Odstock were refused charitable status, it seems that it will not necessarily mean that other established independent hospitals with charitable status or new organisations will suffer the same fate.

Independent not-for-profit hospitals that already possess charitable status are certainly in a stronger position to work with the Charity Commission in order to meet the public benefit requirement. Independent not-for-profit hospitals with charitable status will need to clearly demonstrate how their aims are directly related to the benefits they provide to the public in the future. For example, if their aims are to relieve sickness then they must concentrate on demonstrating this rather than concentrating on how they reduce the burden of taxation on the public purse by reducing NHS waiting lists.

⁶² The Charity Commission, 2008. *Charities and Public Benefit*. [Online]. p.30.

12. Independent Not-for-profit Hospital with Charitable Status Case Studies

The London Clinic and Nuffield Health (formerly Nuffield Hospitals) are two of the largest private charitable health care providers in the UK and two of the longest running in their history of providing private medical care to their patients.

Since DSC's last report, both independent hospitals have undergone major changes, expanding and developing their services and facilities to the public. Since the passing of the Charities Act 2006 and the publication of the Charity Commission's draft supplementary guidance on *Public Benefit and Fee-charging*, independent not-for-profit hospitals with charitable status now have to consider how they present their aims and charitable activities to maintain their charitable status.

The annual reports from both case study hospitals were released prior to the publication of the Charity Commission's draft guidance on *Public Benefit and Fee-charging*. Therefore, this section will analyse the annual report and accounts of the London Clinic and Nuffield Health, and will attempt to illustrate the potential impact of the new legal requirements regarding public benefit.

The London Clinic

The London Clinic was established in 1935 and in 2006 it celebrated its 75th anniversary as an independent not-for-profit hospital with charitable status. To date, the Clinic's main operating sites include Harley Street and Devonshire Place located in Marylebone. It also has consulting suites located at 149, 147, 145 and 119 Harley Street and a new Consulting Rooms and Outpatient Centre at 5 Devonshire Place.⁶⁹

The Clinic's website states that since being granted charitable status in 1935 it has continually been committed to re-investing its surplus income back into the hospital's services and facilities. According to figures in 2005, the London Clinic is the 6th largest private hospital in the UK and the second largest independent not-for-profit hospital with charitable status, holding a 2.4% share of the health sector market.⁷⁰

The Clinic has 202 beds, 58 of which are used for day care treatment. There are twelve operating theatres, including a three theatre endoscopy suite and a dedicated Minimally Invasive and Day Surgery Unit. In 2006, the Clinic's figures show that 7,747 patients were admitted as inpatients and a further 11,627 patients were admitted as day cases. In total, the number of patient days was estimated to be at 35,139, of which 6% of the patients were UK residents.

⁶⁹ The London Clinic, 2008. *More than 75 years of inspired Care* [Online].

⁷⁰ *Healthcare Market Review 2006-07*, 2008.

According to information held on file on the Charity Commission's website the Clinic's objects are set out as follows:

For any charitable object or purpose primarily for the erection, building, equipping of operating theatres, hospitals, nursing homes, convalescent homes and medical laboratories. The provision gratuitously or otherwise of hospital and clinic services for persons in need thereof.⁷¹

This is a list of activities that the Clinic is allowed to do. It does not have to carry out every activity it lists; carrying out more than one would enhance the Clinic's case for proving that they provide benefit to the public. Under the 2006 Act, the Clinic must demonstrate how its charitable activities are working to fulfil the public benefit requirement. Under the 2006 Act, the Clinic's objects and activities must adhere to the new working definitions of 'charitable activities' and 'public benefit.'

The Clinic states that operating as a charitable hospital, it is committed to providing quality care for its patients, specialists and staff. The Clinic explains its aims are to:

- undertake initiatives which will reinforce the Clinic's standing as a successful, charitable hospital at the forefront of independent healthcare;
- excel in every aspect of patient care and strive for clinical excellence;
- act at all times with integrity, honesty and respect for the needs of patients, specialists and staff;
- value the Clinic's heritage of delivering traditional patient care whilst embracing the very best elements of modern medicine;
- attract and retain highly skilled members of staff by providing support and resources to enable all employees to carry out their duties effectively, efficiently and with pride.

These aims are beneficial to the hospital as a company and but are not particularly helpful in clarifying the Clinic's charitable activities or its requirement to demonstrate public benefit as a charity. The report goes on to state that its core aim is to combine 'the very best aspects of traditional care from highly trained staff with the latest medical and surgical technology', stating that it provides 'patients with the finest possible individual care.'⁷²

It is notable that the Clinic's objects include the erection, building and equipping of medical services and facilities as this accounts for much of the detail of the Clinic's 2006 report of its charitable activities. Although this is listed as a charitable object of the Clinic it is not clear how this is connected to the principles of public benefit and in particular, principles 2b and 2c, in widening access to poorer people and enabling a large enough section of society to benefit from its services.

The Clinic could argue that by expanding the Clinic through new building developments and acquiring new equipment this enables the hospital to widen its capacity and improve

⁷¹ The Trustees of the London Clinic, 2006. *The Trustees of the London Clinic Annual Report 2006*.

⁷² The London Clinic, 2008. *Core Purposes*, The London Clinic 2008. [Online]

⁷⁴ *The Trustees of the London Clinic Annual Report 2006*.

the efficiency of its services. In this way, the Clinic could maintain that it meets public benefit by allowing a greater number of patients to be seen on a daily basis.

According to the Clinic's 2006 accounts, over the past five years the Clinic has had a net income of £75 million and has retained a surplus of £38.6 million. The Clinic state that it has 'utilised reserves and retained surplus to invest £77.5 million in the last five years in the new infrastructure and in the development of services.'⁷⁴ The question remains whether such a large re-investment of surplus income in infrastructure is justifiable in relation to the fees charged and the inevitable exclusion of potential beneficiaries who cannot afford fees?

In the Clinic's narrative report the trustees have clearly attempted to make strong links between its achievements, its current and future activities and, their investment strategies, to illustrate how they are working towards what would then have been the pending changes in the 2006 Act.

During the year, the Clinic's activities included providing training to students and working in partnership with other charities to provide them with support. The clinic funded 36 clinical student placements for the NHS free of charge and has trained a number of plastic surgeons who will be working with the NHS in the future (this training is not provided by the NHS according to The Clinic.) The Clinic also provided placements for 14 doctors below consultancy level to support the research period of their training.

The London Clinic may contend that such activities fit under the heading of *the advancement of health or the saving of lives (d)*, based on the impact that medical training and investment in new technology has on the quality and availability of services for patients of the London Clinic and the NHS. The Clinic could assert that they are providing public benefit to a large proportion of the public by providing training to medical staff who will then work in public hospitals. (this was what the court concluded in the *Re: Resch* case). However, this is contentious as it could be said that The Clinic, like many independent hospitals (with and without charitable status) often recruit staff from the NHS. Therefore, this would seem to serve its own interests as well.

Other ways that the Clinic may present their activities as being in the public benefit under the heading of *the advancement of health* is through the provision and services it is able to offer its patients. The Clinic states that it differs from many other independent hospitals in that is able to provide critical care at levels 2 and 3 (high dependency care and intensive care) and has acute intensive care facilities on hand.

The London Clinic maintains that critical care back up is also made available to other London independent hospitals. It suggests that it has the added benefit of avoiding the transfer of patients back to the NHS if their condition deteriorates. However under the title of charitable activities, the Clinic does not mention that in fact it charges fees to those other London independent hospitals for this service.

In 2005, the Clinic opened what it describes as its 'newest and largest operating theatre, which was purpose built to house the da Vinci Surgical System.'⁷⁵ This is a leading

⁷⁵ *Ibid.*

robotic operating system the Clinic had invested in, which enables them to carry out 'minimally invasive' surgery that reduces the recovery time of the patient. The 'robot' is one of five available in the UK, making this of particular benefit to patients of the Clinic.

In addition, the Clinic also opened a specialised centre for liver treatment in 2006, through which it has employed the use of Fibroscan technology. Over the last few years, the Clinic has invested significantly in new technology in supporting its medical services and, as in other areas it has been one of the first to implement these newly developed technologies. The trustees of the London Clinic assert that their investment in new facilities and technology helps to reduce the cost for patients in the long run as it significantly reduces patient's recovery time after major surgery. However, this is likely to reduce the cost for fee-paying patients in the long run who can already afford the fees charged by the Clinic.

At the time of this report, The Clinic was also in the process of a massive redevelopment in the building of a new cancer treatment centre, which is due to be complete by December 2009. A report from *New Civil Engineer* confirmed that:

One of the major pieces of kit to be installed will be the Cyberknife Robotic Radiosurgery system and two 100 tonne LINAC linear accelerators. Both of which treat cancer patients with high doses of radiation.⁷⁶

According to a press release from the Clinic the new centre 'will comprise 47 individual bedrooms and 22 day care pods in a modern purpose-built environment.'⁷⁷

Although refurbishing and equipping the hospital is one of the Clinic's objects it is unlikely that it could be used to demonstrate the hospital's public benefit specifically with regard to principles 2b and 2c. It could be argued that investing in new technology serves the hospital greater than the public benefit it may offer. It may be possible that one of the reasons for the Clinic's large investment in technology is to attract more lucrative patients (self-pay and individual PMI patients) rather than a decision to solely give benefit to 'persons in need.'

The Clinic achieves part of what could be considered public benefit by working in partnership with the Anthony Nolan Trust. The Anthony Nolan Trust matches patients with cancer-related illnesses, such as Leukaemia, with transplant donors that could potentially save the patient's life. This could be seen as providing wider access to potential beneficiaries by sourcing 'life saving donors for patients in need of transplants.' This could be interpreted as a direct benefit for the public as it is one way that access is opened up to a number of non-fee paying beneficiaries and it also sits beneath the heading *The advancement of health or the saving of lives (d)*.

According to a press release from the Clinic in April 2007, the London Clinic is working together with King Edward VII's Hospital Sister Agnes to extend King Edward's 20% subsidy towards inpatient and outpatient treatment for military service personnel. The subsidy is available to:

⁷⁶ Rowson, J, 2008. *New Civil Engineer: No Room to Move*. [Online]

⁷⁷ The London Clinic, 2006. *Press Release - The London Clinic's 'Grand Designs' On Cancer Care*. [Online]

all patients who are currently serving or have previously served in the British Armed Forces, regardless of rank and length of service, as well as their spouses, ex-spouses, widows and widowers – extending its availability to a population of more than 13 million people.⁷⁸

The Clinic can relate their work with the King Edward VII's Hospital Sister Agnes to part of the charitable head: *the promotion of the efficiency of the armed forces of the Crown, or of the efficiency of the police, fire and rescue services or ambulance services. (I)*. The Clinic could interpret this activity as a fulfilment of their responsibilities to carry out a charitable objective that demonstrates the wide scope of its public benefit. Specifically, through assisting King Edward VII's Hospital Sister Agnes to potentially enable 13 million beneficiaries access to the services at King Edward VII's at a subsidised rate of 20%. Although, it is contentious whether helping another charitable hospital actually demonstrates the Clinic's own public benefit.

In summary, the activities outlined by The London Clinic in their 2006 Annual Report amounts to:

- 36 supported medical training places;
- facilities provided for 148 consultants and specialists within the hospital's operating remit;
- provision of free CancerBacup service to anyone seeking support and information on cancer or related issues;
- 250 transplant donations collected for the Anthony Nolan Trust;
- the treatment of 95,000 patients (although, there is no mention of how many were NHS patients, charitable or subsidised cases); and,
- £1.1 million in charitable and humanitarian discounts for various patients.

In terms of a demonstration of public benefit, there are issues with all of the examples given above. The Anthony Nolan Trust and CancerBacup are other charities which have to demonstrate public benefit in their own right. As such, it is debatable whether the Commission would view working with them to facilitate transplants or cancer counselling as sufficiently mitigating the exclusionary effect of the hospital's fees. There are also obvious questions around whether providing facilities and training for medical staff is in itself of public benefit. The hospital states that £1.1 million in 'discounts' was provided, but there is no evidence of whether this actually meant that treatments were provided below market-cost; still less that the discounts meant that treatment became affordable for people in poverty.

It is difficult to say whether this would amount to a sufficient level of identifiable direct benefits based on the evidence from the London Clinic's 2006 annual accounts. The accounts were compiled long before the new regulations of public benefit were put into practice. Although the Clinic's accounts describe in detail the level of its investment back into the hospital, it provides limited detail on the number of people who were from low income backgrounds, for example, and were able to directly benefit from its services.

⁷⁸ The London Clinic, 2007. *Press Release - King Edward VII's Hospital And The London Clinic Collaborate To Help Forces' Patients* [Online].

The Charity Commission's draft guidance on *Public Benefit and Fee-charging* refers to many ways that fee-charging charities (such as The London Clinic) could potentially carry out activities that strongly demonstrate the discipline of public benefit, such as:

- offering free or subsidised places
- a sliding scale of fees charged
- certain services or facilities at no cost or at a reduced cost
- the existence of accessible medical insurance or other benefits schemes (Although this is debateable)⁷⁹

The Charity Commission's draft guidance on *Public Benefit and Fee-charging* places the onus on the fee-charging charities providing services to the public, to ensure that people who are unable to afford its fees have other opportunities to benefit in a material way that are related to the organisation's aims.

Taking patients off the NHS waiting list isn't in itself charitable; neither is offering a tiny proportion of benefit, such as a few free operations, providing a couple of placements for medical students, or helping another hospital provide discounts to its own patients. The Commission clearly states that to satisfy the public benefit requirement an organisation must assess the overall impact of their activities and ensure that a sufficient proportion of the population can gain access to the services and facilities that are available.

Nuffield Health (formerly Nuffield Hospitals)

Nuffield Health is currently the third largest group of independent hospitals with charitable status operating in the UK acute health care market. According to the group's website, it currently runs 32 hospitals and is comprised of the following subsidiaries: Nuffield Diagnostics, Vanguard Health, Nuffield Proactive Health and Cannons Health & Fitness. The group's consolidated statement of financial activities reveals that through trading activities alone the group brought in a total of £506 million income (this is much larger than many high profile UK charities currently operating). In Nuffield's 2007 annual report, the group state that the charity's principle activities are:

to advance, promote and maintain health and healthcare of all descriptions and to prevent, relieve and cure sickness and ill health of every kind. Our principal activities are the provision of a broad range of clinical and health services to the public and to other organisations and the operation of facilities and equipment suitable for those activities including hospitals, health clubs and mobile facilities.⁸⁰

In 2007, Nuffield Health stated that they had exceeded expectations in terms of their annual turnover. In that year, their turnover rose 5.3% to £506 million with an operating surplus of £19.5 million.⁸¹ The £506 million turnover was generated largely by providing

⁷⁹ The Charity Commission, 2008. *Consultation on draft supplementary guidance on Public Benefit and Fee-charging*, [Online] March 2008. p.p.27-8.

⁸⁰ *Nuffield Hospitals Annual Report 2007*, p.3.

⁸¹ *Nuffield Hospitals Annual Report 2007*. p.7.

services to patients. A further £398,000 income came from other sources; £387,000 came from interest generated by investments and £11,000 came from donations, gifts and legacies. These figures indicate that providing services to patients are the group's chief activity and that fees for such services are Nuffield's primary source of income.

Sale of Hospitals to commercial providers and resultant implications for patients

During 2007, the group sold nine of its hospitals for a reported £140 million. Due to their charitable status Nuffield avoided close to £30 million in capital tax gains. Previous to the sales, the group underwent an evaluation of its hospitals for loan security purposes. It was estimated that the value of the remaining hospitals was £1070 million, which gave a surplus of £712 million over the net book value of the remaining fixed assets at 31 March 2007.⁸²

Seven of the hospitals have been transferred over to General Healthcare Group (GHG) and will form part of BMI Healthcare (GHG's private acute medical division). The hospitals that have been transferred are: the Nuffield Hospitals in Birmingham, Bury St Edmunds, Harrogate, Huddersfield, Lancaster, Lincoln and North London. Nuffield Gerrards Cross was sold to Spire Healthcare Limited and the Nottingham Hospital was sold to Ramsy Health Care UK.

The change over from an independent not-for-profit hospital to a private company based hospital will undoubtedly affect how patients are able to access the services of the nine hospitals. Once the hospitals have been taken over, GHG could decide to withdraw from the Extended Choice Network, limiting the number of local and national NHS patients and their ability to access the services at the nine hospitals.

Other implications for patients could be the loss or transformation of services that the hospital provides. Services that might not be so profitable but are convenient for patients or that have patients depending on them, could potentially face being cut in the future.

However, any changes to services in independent hospitals are driven by demand from paying patients and are limited by what the hospital is already able to do. Many independent hospitals both charitable and non-charitable tend to be highly specialised so any changes to services would tend to be additions to what the hospital already provides, such as cosmetic surgery or IVF treatment for example.

It could be argued that with the transfer of the nine hospitals to a for-profit healthcare provider, fee-paying patients will be subject to ever increasing price rises for the hospitals services in the long run. This in turn could have the effect of widening the gap between those who can afford some of the services the hospital charges fees for and the poorer patient who cannot.

Nuffield Health, having had an evaluation of its hospitals for loan security purposes⁸³ acquired Cannon's Health & Fitness and then sold nine of its hospitals to pay for it. The

⁸² *Nuffield Hospitals Annual Report 2007*.p .37.

⁸³ *Nuffield Hospitals Annual Report 2007*.p .10.

unusual purchase of Cannon's Health & Fitness has caused concern in the voluntary sector that other independent not-for-profit hospitals with charitable status could follow Nuffield's example. In a public statement following the sale of the hospitals, David Mobbs commented that:

For Nuffield, we will focus on our remaining hospitals and on new markets and opportunities in line with our intention to provide a broader range of health services.⁸⁴

This is a new direction in the services that Nuffield offers that presents many questions surrounding the charitable status of the group. It remains controversial how Nuffield's trustees can justify how the disposal of assets can be viewed as acting in the best interests of Nuffield's beneficiaries. The decision seems to be mainly guided by the demands of market competition rather than the need to demonstrate public benefit.

The acquisition of Cannons Health & Fitness Clubs

In 2007, the UK health and fitness market was estimated to be worth around £4.5 billion. The Fitness Industry Association (FIA) estimated that in the UK there were 5,714 fitness facilities, of which 3,100 were operated as private health clubs while the rest were run by local authorities. Since the Charity Commission's decision on Wigan and Trafford Leisure Trusts in 2004, some local leisure trusts have also now been converted into charities.

On the 30th November 2007, Nuffield purchased 100% of the shares of Health Club Investment Group, which owns Cannon's Health Clubs. Nuffield commented that:

The acquisition of Cannons enhances our service offering, allows us to bring health and wellness services to a broader range of people, brings us strong relationships with local authorities, and gives us much greater public presence. Marketing activity will develop and support Nuffield's brand to help enhance consumer awareness of our broad service range and to increase understanding of our charitable purposes and values.⁸⁵

Nuffield were reported to have acquired Cannons Health & Fitness for £170 million. In consolidating Cannon's the group reported that they had total assets of £137 million. The group have taken over 52 Cannons Health & Fitness clubs; this also consists of a division that manages 13 local health authority facilities that operate under the Courtney's brand. One report from The Times newspaper stated that combined the Nuffield group will now have a turnover of approximately £600 million.⁸⁶ Following the takeover, Nuffield will now be providing health and fitness provision for over 300,000 people in over 170 locations. This is in addition to receiving over 1 million patient visits during each year at its hospitals according to the group.⁸⁷

⁸⁴ Nuffield Hospitals: *Public Statement*, 2008. p.1.

⁸⁵ *Nuffield Hospitals Annual Report 2007*. p.8.

⁸⁶ Walsh, D, 2007. *Focus: Healthcare group buys Cannons fitness clubs*. *The Times*, [online].

⁸⁷ Nuffield Hospitals, 2007. *Further information*. [online].

A report from Health Insurance and Protection, *Nuffield shows its hand as hospital group gambles on wellbeing*, questioned the sustainability of 'standalone' hospitals in the longer term as a result of the current state of the independent sector (IS).⁸⁸ The article points out that consumers and corporate companies are demanding 'joined up' health and wellness services. This is particularly relevant to Nuffield as they state in their 2007 annual accounts that they had acquired major corporate contracts to provide employee health and wellbeing services to sector-leading companies including Microsoft, Siemens, ICI, IBM and Nestle.⁸⁹ The article commented that:

The move comes as hospital providers' revenue streams from traditional sources continue to slow. It also comes as employers and insurers signal their intention to implement wider health and wellness strategies rather than simply provide people with fast access to elective hospital procedures.⁹⁰

The article suggests that there is an increasing trend in medical insurers and private hospitals in offering customers, services and cover for treatments that are for preventative healthcare rather than treating patients as the need arises. It also suggested that the move went against private hospitals' reliance on traditional resources such as NHS contracts or elective hospital procedures.

With the Charity Commission currently reviewing Nuffield's charitable status it is not surprising that the group is looking to secure additional streams of income placed in different markets. According to figures published by Laing & Buisson:

revenues of independent medical/surgical hospitals and clinics in the UK are being held back by a slowdown in NHS demand for private elective surgery, continued low growth in medical insurance claims costs, and very marginal real growth in self-pay revenues.⁹¹

Although David Mobbs has publicly stated that this industry led trend is not the reason for Nuffield's change in strategic direction, he added that it would 'be "more difficult" to operate as a standalone hospital provider.'⁹² According to David Mobbs, this is intensified by what he has criticised as the Government's lack of clarity regarding the role of Independent Hospitals within the NHS. Mobbs complained that:

it is unfair to expect the private sector to provide public services without some guarantee of how much work might be available.⁹³

Independent not-for-profit hospitals are clearly facing competing pressures to conform to both the new legal requirement of the Charities Act and to compete with other not-for-profit and for-profit hospitals for contracts from the NHS and other parts of government.

⁸⁸ Sawers, D, 2008. Health Insurance and Protection. *Nuffield shows its hand as hospital group gambles on wellbeing* [Online]. July 2008.

⁸⁹ *Nuffield Hospitals Annual Report 2007*, p.9.

⁹⁰ Sawers, D, July 2008.

⁹¹ *Ibid.*

⁹² *Ibid.*

⁹³ *Ibid.*

This has led many independent not-for-profit hospitals to consider their strategic directions and how their activities demonstrate the public benefit requirement.

Nuffield have considerably invested their surplus income back into the infrastructure of the group, which Nuffield could argue is important in establishing the group's charitable status. However, a significant amount of Nuffield's investment has included the acquisition of Cannons Health & Fitness. The acquisition raises more questions around the group's charitable status and public benefit than it answers.

What Nuffield must be able to show is that the total cost of re-investment is proportionate to the level of public benefit it provides. The benefit of Nuffield's activities must also be accessible to a large enough section of society to comply with the Charity Commission's public benefit principles.

Investment of reserves in infrastructure

The Chairman estimated that approximately £50 million has been reinvested back into the group's activities and facilities during the year. Nuffield Health's prospectus states that they are the largest trading charity in the UK and that the charitable group continually re-invests all financial surpluses that are generated from trading back into the organisation to achieve its aims. This is a legal requirement for Nuffield as a charitable body and a not-for-profit organisation.

Nuffield's 2007 annual report makes it clear that the group is conscious of the need to demonstrate public benefit. In a review of their activities the group described their activities during the year and the impact this has had on its intended beneficiaries. In 2007, the group estimated that they were able to help improve the health and wellbeing of around 750,000 people through all of its activities in its divisions.

The group is keen to maintain that through re-investing surplus income it is able to widen access to their services and facilities. By increasing the capacity for day case patients the group insist that it is able to widen access to its patients by maximising the capacity of lower cost treatments. Nuffield state:

Significant investment was made in increasing capacity for day case procedures, so expanding the volume of lower cost procedures we are able to offer. For example, £7.7 million is being invested in the Nuffield Hospital Newcastle to expand day case capacity.⁹⁴

In 2007, the group invested or earmarked a significant amount of money into two major programmes. The first sees the beginning of a £23 million investment to improve services through meeting EC regulations. The programme is set up to meet the EC Medical Device Directive 93/42 which aims to reduce the risk of contamination by enhancing the separation of dirty and clean instruments. This means that Nuffield will be

⁹⁴ Nuffield Hospitals Annual Report, 2007. p.5.

one of the first hospitals to be able to demonstrate the traceability of all of their instruments.

The second important investment for the group is a £50 million investment into their diagnostic capacity. This has been realised in the purchase of six MRI scanners. Nuffield linked these purchases to the low level of provision in this service in the UK. They state that in comparison with other developing countries the gap in this type of service provision is significant.

Another notable investment for the group has been the cost accounted for in the preparation to enable Nuffield to participate in NHS initiative Patient Choice Scheme. In its annual report the group state that they are now able to receive NHS patients through the Choose & Book system. Nuffield could argue that by assisting the NHS in this way it meets an element of the public benefit requirement on the basis that it is widening access to their facilities and services for patients who are not self-paying or have private medical insurance. All patients taken by both charitable and non-charitable private hospitals are paid the same national NHS tariff rate.

Interestingly, The London Clinic does not take patients from the NHS patient choice scheme. There is some debate concerning the connection between public benefit and the reduction of NHS waiting lists. Assisting a statutory body such as the NHS is not a charitable act in itself. In reference to the *Re: Resch* case, Lord Wilberforce noted that the charitable hospital in the case provided sufficient benefit to a nearby public hospital so it could also be argued that assisting the NHS in this way falls beneath the second principle of the public benefit requirement in widening access to potential beneficiaries.

13. Nuffield Health and the Public Administration Select Committee Enquiry

Charities and public benefit

During 2007 and early 2008 the Public Administration Select Committee collected evidence from Government officials and various voluntary sector representatives concerning the delivery of public services and the administration of healthcare organisations with charitable status. David Mobbs, Chief Executive of Nuffield Health, was invited to give evidence to the committee in a session on Tuesday 8th July. The other witnesses on the panel were Ruth Jarratt, Director of Policy Development at the Royal Opera House, and Stephen Lloyd, Senior Partner at Bates Wells & Braithwaite and an expert on charity law.

The evidence given during the session sheds some light on the issue of public benefit requirement in relation to fee-charging charities. The Committee aimed to assess how the Charity Commission were interpreting their duties as official regulators of charitable organisations and how it defined the discipline of public benefit. The Committee also aimed to discuss the effect these new changes will have on the voluntary sector. There are four main points that the Select Committee addressed:

1. The issues concerning public benefit and who is included or excluded from Nuffield's services as an independent not-for-profit hospital with charitable status.
2. How Nuffield are set up for the public benefit and what they do to achieve this.
3. The difference between Nuffield, the NHS and other private healthcare organisations.
4. How the Charity Commission have interpreted the discipline of public benefit.

The Chairman of the Committee, Tony Wright MP, began by asking Stephen Lloyd (Senior Partner at Bates Wells & Braithwaite) whether the new regulations on public benefit from the Charity Commission differ widely in terms of the prior legal position. In reference to the *Re: Resch* case (as discussed earlier), Lloyd explained that the one main difference from the prior legal position is that under the Commission's regulation is it is now a key principle that the poor must not be excluded from the opportunity to benefit from a charitable organisation's activities.⁹⁶

The committee then turned its attention to David Mobbs and the question of public benefit for fee-charging hospitals with charitable status. He argued that Nuffield charge

⁹⁶ House of Commons, 2008. *Public Administration Committee: Charities and Public Benefit*, 2008. Q205.

fees in order to deliver the 'benefit they provide.' Mobbs conceded that self-funded health care was expensive but, maintained that the costs of treatments for many of their procedures were sufficiently varied to enable enough people to benefit from their services. However, this still implies that poorer people only have access to a limited range of services whilst rich people have access to all of Nuffield's services.

The Committee raised the issue of access again, to ascertain whether Nuffield have a choice as to who is included or excluded from accessing its services. Mobbs stated that through the NHS Patient Choice scheme Nuffield has a choice of what services are available to patients. By default this scheme determines who is then able to access its services and facilities.⁹⁷

The Committee questioned Mobbs further on the issue of access, with committee members pursuing a line of questioning relating to the financial income of Nuffield's patients. Committee member Paul Flynn wanted to know how Nuffield were able to quantify that a sufficient proportion of people on low incomes (who are non-NHS patients) were able to gain access to the hospitals. Mobbs said that that Nuffield could track its admissions by postcode and stated that 'about 11% of our admissions come from either hard-pressed or only moderately off postcodes.'⁹⁸ Rather than demonstrating widespread access, this would seem to support the view that the overwhelming majority of Nuffield's patients are in the top earning income bracket. Therefore, it is unclear how effective this method is in enabling poorer patients' to access the services at Nuffield's hospitals.

This potentially raises some questions about the charitable purposes of Nuffield and other independent not-for-profit hospitals with charitable status. The Committee noted that a balance sheet approach has already been suggested to test the accountability of charities to the public; this would mean that independent fee-charging organisations such as Nuffield would be required to demonstrate the tangible public benefits they provide against the level of tax relief and subsidy they gain from the state.

Mobbs stated that this it was not feasible for the majority of smaller and medium sized charities to comply with this level of regulations. He maintains that, whereas the benefits provided by Nuffield are 'obvious and a bit more measurable', for many other charities it would be more difficult to define their public benefit in the same way. Mobbs continued:

If this approach is going to be taken, it should be uniform across the whole of the charity sector because this is not an issue about access, this is an issue about benefit, and again I think the debate confuses benefit with access.⁹⁹

Given the size of Nuffield Health the organisation can hardly be held in comparison to many other charities in the sector. In addition to this, it could be argued that Nuffield's public benefit is actually a lot less obvious than many smaller organisations that serve localised areas and needs.

⁹⁷ *Public Administration Select Committee: Charities and Public Benefit*, 2008. Q222.

⁹⁸ *Public Administration*, 2008. Q272.

⁹⁹ *Public Administration*, 2008. Q236.

In response to further questions from the Committee, Mobbs insisted on a number of occasions that Nuffield was set up and operating for the public benefit. The Committee questioned the difference between an organisation like BUPA and Nuffield Health. Mobbs countered that not only were BUPA currently not operating any hospitals but that it is also a care home operator and an insurer (although recently they have acquired the Cromwell hospital in London). He maintained that the difference is that Nuffield were set up for the public benefit. He concludes that:

We have dedicated our assets and property in perpetuity for the public benefit. We invest everything we earn for the public benefit and that is the difference between us, BUPA and others.¹⁰⁰

Earlier in the question session Mobbs supported Nuffield's operating model as a fee-charging charitable hospital. He conceded that self-paying healthcare is expensive but with the variety of procedures the hospital carries out and the option of medical insurance these procedures are still accessible to a large enough section of the public. Mobbs argues:

There is always a need to balance the public benefit you are delivering with the accessibility and financial sustainability of the organisation, and all charities have to make a choice as to the approach that they take to raise the funds to deliver public benefit, and I think that the choice you take does not alter the fact that you are there to deliver a benefit.¹⁰¹

The Committee discussed the Charity Commission's interpretation of public benefit further with the panel and how that applies to registered charitable, fee-charging organisations and those wishing to apply in the future. As has been discussed earlier in the *Re: Resch* case, the main point the Charity Commission draws on in that case, is that a charity must have public benefit and its activities must not be exclusionary to the public. Mobbs states:

What you have to ensure is that your activities, the activities you pursue, reflect the aims of your charity, which are for the public benefit, and finally you have to ensure that those activities are accessible and you are not entirely excluding a section of society.¹⁰²

The session touched on many of the strands of the public benefit debate highlighting many of the issues that affect independent not-for-profit hospitals with charitable status. From the session we can see that fee-charging charitable organisations now have to balance their activities as not-for-profit organisation in a competitive market, against the Charity Commission's public benefit requirement in order to remain charitable.

¹⁰⁰ *Public Administration Committee: Charities and Public Benefit, 2008. Q305.*

¹⁰¹ *Public Administration Committee: Charities and Public Benefit, 2008. Q210.*

¹⁰² *Public Administration Committee: Charities and Public Benefit, 2008. Q324.*

14. Conclusion

Over the last four years there have been significant changes in the independent healthcare market. The market has slowed down in terms of a decline in NHS demand for private elective surgery, low growth in medical insurance claims costs and little growth in self-pay revenues. This has meant that many organisations have sought to move into different areas of business to supplement their income. Independent not-for-profit hospitals with charitable status have had to operate in a similar manner to their for-profit peers in order to compete and survive in the independent healthcare sector.

The development of the independent healthcare sector has coincided with a number of changes that have affected the sector across the board. These changes have occurred in the following areas:

- Government policy
- Charity regulation and the requirement to demonstrate public benefit
- Assessment of NHS policies and practices

The Government's policy to encourage third sector organisations to bid for contracts has also affected the way that independent not-for-profit hospitals with charitable status secure this particular source of income. This has resulted in intensifying the need for independent not-for-profit hospitals with charitable status to compete more vigorously to secure contracts.

The Charities Act 2006 and the requirement to demonstrate public benefit for independent not-for-profit hospitals with charitable status will have a significant impact. It means that in order to operate and be considered a charitable organisation, rather than a business, the organisation's chief priority must be to provide proof that their activities are charitable and they benefit a sufficient section of the public. It remains to be seen how exactly this will be played out, as different charities work out how to demonstrate public benefit and the Charity Commission evaluates them on a case-by-case basis.

Independent not-for-profit hospitals with charitable status now need to consider how they maintain a sense of balance between competing in the independent healthcare market and how their activities demonstrate that they are for public benefit. In many ways, the changing climate and new regulatory practices from the Commission have meant that independent not-for-profit hospitals now have to reassess the way that they operate and to bear in mind more stringently who they are operating for.

In response to the Charity Commission's consultation on the draft public benefit guidance, Ben Wittenberg (Director of Policy and Research at DSC) commented that, the principles of public benefit were clear and straightforward although there were some areas of ambiguity. He stated that this was because the Charity Commission does not limit itself to simply explaining the ideas behind 'public benefit'. The draft guidance has many aims such as informing trustees and prospective charity founders of current

changes in the law applying to charities and how and why these changes have taken place.

One of the key recommendations that Wittenberg makes is to suggest that there needs to be 'further illustrative examples and sample responses' to show how different charities are applying the discipline of public benefit in their work.¹⁰⁴ Basically, he suggested that the guidance needs to include more case studies that reflect the application of the public benefit requirement to a wide range of charities. This will help charities to better understand how they can respond to the Charity Commission's new regulations and what changes they might need to make to fully comply with them.

The recent decision by the Charity Commission to refuse Odstock Private Healthcare Limited charitable status has reinvigorated the debate in the voluntary sector about the status and purpose of charitable hospitals. Many commentators and organisations with similar characteristics to Odstock are wondering about the future implication that this decision might have for them. In its *Draft Supplementary Guidance for Consultation on Public Benefit and Fee-charging*, the Charity Commission says that:

Recognising the different circumstances of different fee-charging charities, we do not expect all fee-charging charities to meet the public benefit requirement in the same way.¹⁰⁵

As Jay Kennedy (Policy Officer for DSC) noted in a consultation response to the draft supplementary guidance on *Public benefit and Fee-charging*:

The lack of strict standards or measures of public benefit allows for much-needed flexibility, but also puts the onus on the Commission to carefully consider whether the decisions it makes are comparable and fair from one charity to the next.¹⁰⁶

It is debatable whether Independent fee-charging hospitals with charitable status such as the London Clinic and Nuffield Health will pass the public benefit test, based on the presentation of their charitable activities in their most recent accounts filed at the Charity Commission. In some instances it could be argued that the case study hospitals' clearly provide public benefit, by offering free or subsidized places to patients on lower incomes for instance.

However, the two hospital's most recently available accounts gave no indication of what per cent of their patients fell into a lower income bracket or how many in this category actually benefited from treatment in the hospitals'. The hospitals' also failed to detail what range of services poorer patients received benefit from or, the level of access they might already have to these services.

¹⁰⁴ Wittenberg, B, 2007. *DSC's response to the Charity Commission's consultation on draft public benefit guidance*. Liverpool: Directory of Social Change.

¹⁰⁵ The Charity Commission, 2008. *Public Benefit and Fee-charging*. [Online] March, 2008.

¹⁰⁶ Kennedy, J, 2008. *Consultation response on draft supplementary guidance on Public Benefit and Fee-Charging* [Report]. 8 July 2008. Liverpool: Directory of Social Change.

The London Clinic's 2006 annual report stated that The Clinic spent £1.1 million on charitable and humanitarian discounts and overall it re-invested £77.5 million back into the hospital, to demonstrate that they are satisfying the discipline of public benefit. The Clinic's accounts did not give a figure of how much it actually spent on enabling patients on lower incomes to access their services through free or subsidized places. Therefore it is hard to say how effective The Clinic has been in providing a sufficient level of access to their services and facilities to demonstrate its compliance with the public benefit requirement.

When assessing if a charity's activities are for the public benefit the Commission state that:

With existing registered charities, we will consider activities to determine whether they fall within the charity's stated charitable objects. Where we are not satisfied that is the case, we may seek agreement with the trustees that they alter their objects or the way in which they carry out their aims.¹⁰⁷

If an independent not-for-profit hospital with charitable status could not demonstrate the principles of public benefit this would not mean that they automatically lose their charitable status. Hospitals with charitable status such as The London Clinic and Nuffield Health would be given guidance and advice from the Charity Commission to work on how they could change if this was the case in order to meet the necessary requirements in the first instance.

Through the cy-prés principle the Commission has the power to direct a charity in the way that they carry out their aims and objectives to meet the public benefit requirement. In the draft guidance *Charities and Public Benefit*, the Commission gave the impression that they would implement this power to consult with trustees in the worst case scenario. This is positive for the future of established and prospective independent not-for-profit hospitals with charitable status.

Independent not-for-profit hospitals with charitable status have the dual task of existing to carry out charitable purposes and of competing in the highly competitive market with for-profit providers. The question remains whether organisations such as the London Clinic and Nuffield Health can maintain their position as top healthcare providers in a commercial sense and also remain charitable in terms of providing public benefit.

¹⁰⁷ The Charity Commission, 2008. *Charities and Public Benefit*. [Online].

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