CHPI | Centre for Health and the Public Interest

Pounds for Patients?

How private hospitals use financial incentives to win the business of medical consultants

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The Centre for Health and the Public Interest (CHPI) is an independent think tank committed to health and social care policies based on accountability and the public interest.

The Centre seeks to frame the policy debate in a way that is evidence-based and open and accessible to citizens.

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Key Facts

£380k	The average amount of revenue which a medical consultant generates each year for a private hospital in London.
637	Total number of all medical consultants who own either shares or equipment in the private hospitals to which they refer patients.
546	Total number of NHS medical consultants who own shares or equipment in private hospitals to which they refer patients.
371	Total number of NHS medical consultants who own shares in private hospitals to which they refer patients.
177	Total number of NHS medical consultants who own equipment in private hospitals to which they refer patients.
77	Total number of medical consultants who receive a fee each time the equipment they own is used for treating or diagnosing patients.
£40m	The amount paid by NHS Trusts to 11 private hospitals in which employees of the NHS Trust own shares.
£1.5m	The estimated amount of corporate hospitality paid by 7 private hospital companies to medical consultants who refer patients to them in the years 2017 and 2018.
£1,068	The cost of a ticket to England v the West Indies cricket match as part of a corporate hospitality package for a medical consultant.

Executive Summary

The problem – how financial incentives have the potential to distort clinical decision making in market based healthcare systems

1. The great majority of private hospitals in the UK provide mainly routine surgery. The surgeons who work at them are overwhelmingly NHS consultants working in their non-NHS hours. The private hospital receives a fee for providing the facilities whilst the consultant receives a fee for carrying out the operation. Most patients are referred to the private hospitals by the consultants. As a result, as one private hospital company described it there is "fierce" competition between private hospitals to win referrals for patients or customers from consultants.

2. To maximise their revenues, it has become common practice for private hospitals in the UK to seek to incentivise consultants to refer patients to their hospital rather than to any other. This takes various forms, including giving consultants a stake in the financial performance of the hospital so that they benefit directly when the private hospital makes a profit: in addition to receiving a fee for carrying out surgery at the hospital, the consultant will also receive a share of any profits which the hospital makes. In some instances, consultants own the equipment which is used in private hospitals and receive a fee each time the equipment is used.

3. This practice is problematic from the perspective of patient care as it has the potential to corrupt the clinical decision making of the consultant. Put simply, in the worst case scenario, a patient could be given treatment which is unnecessary or even harmful because the consultant gains financially.

4. Research has shown that where consultants own shares in the facilities in which they treat patients, the number of healthcare procedures carried out on patients in them is higher than in hospitals where consultants do not own shares.[1] This is also the case when consultants own the equipment which is used to treat or diagnose patients – when consultants own equipment it is used more often on patients than when they are not owned by consultants.[2]

5. One of the largest ever recorded instances of "over-treatment" of patients in a private hospital happened in the UK between 1997 and 2011 when over 750 patients of the breast surgeon Ian Paterson were harmed as a result of receiving treatment – including major surgery – for conditions they did not have.[3] Both the private hospital and the surgeon will have made significant amounts of money from this unnecessary treatment.

6. Whilst overtreatment of patients is potentially harmful, it also diverts scarce resources away from where the need is greatest. And from the perspective of those paying for the treatment (whether individuals, health insurance companies or the taxpayer), making money by providing unnecessary or unwanted healthcare is also fraudulent.

7. Given that the private hospital sector is now in competition with the NHS in England to provide NHS-funded treatment, if NHS consultants have shares in private hospitals this has the potential to influence decisions about whether NHS patients are treated in the public or private sector.

8. Similarly, having a financial interest in a private hospital could mean that an NHS consultant has an incentive to recommend that a patient is seen privately (and pays for the service) rather than receive the treatment free on the NHS.

Preventing financial incentives from harming patients

9. Because of the potential for financial incentives to distort the clinical decisions of consultants the US healthcare system outlaws financial incentives and imposes significant penalties, including fines and prison sentences, on any business or individualfor breaking the law in this way.

10. There is no equivalent legal restriction in the UK. The Competition and Markets Authority (CMA) which is concerned with competition between private hospitals, not patient safety or fraud, requires every private hospital to declare on its website the ownership of shares or equipment in the hospital by any consultants who refers patients to it. Share ownership by a consultant is limited to 5% of the company or the hospital, and any corporate hospitality must also be declared on the hospital's website. Payments to consultants designed to induce referrals are explicitly prohibited.

11. However, the CMA regulations are very different from the US legal regime and have very few sanctions to enforce them.

Research findings

12. Using publicly available data including the declarations made by private hospitals this report looks at the ways in which the private hospital industry in the UK provides financial incentives for doctors to refer patients to their hospitals for treatment.

13. It looks at the regulatory framework which has been put in place to safeguard patients and to prevent wasteful and/or fraudulent healthcare practices. The report assesses the efficacy of this framework and also how it is enforced.

14. Because the private hospital sector is now increasingly dependent on the NHS for its income – around a third of all its income and around half of all its patients come from the NHS – it also looks at the extent to which consultants working in the NHS have a financial interest in referring NHS patients to private hospitals and identifies examples which ought to cause concern to NHS England.

15. It also examines the extent to which NHS England's guidance on "conflicts of interest" protects patients and taxpayers from the negative impact of such financial interests and whether there may be a case for the authorities to take action against some private hospital companies under the Bribery Act 2010.

16. The report finds the following:

FINDING 1: A significant number of NHS consultants own shares and equipment in private hospitals

17. Based on the declarations on private hospital websites, where these have been made, we found that 637 medical consultants currently either have shares in private hospitals or own equipment in them, giving them a potential financial incentive to refer patients (NHS or private) to these hospitals for treatment. The great majority of these (546) are NHS consultants, the rest practise privately.

18. Out of these, 431 own shares in private hospitals. These shares can range from shares in a publicly listed company to joint ownership of a private hospital facility with a large multinational healthcare company. 371 NHS consultants own shares in private hospitals.

19. In addition we found that 208 consultants in England, 177 of whom are NHS consultants, own equipment in private hospitals. 77 of these consultants, of whom 67 are NHS consultants, receive a fee from the hospital each time the equipment is used. Receiving a fee for the use of the equipment presents a risk to patients by providing an incentive for unnecessary use or overtreatment.

20. An estimated total of 17,500 consultants work in the private sector, which implies that just 4% have a financial stake in the private hospital sector over and above the income they earn directly from treating patients.

21. However, there are certain specialties where the existence of a financial interest in a private hospital is more prevalent than in others. We have identified that the ownership of private hospital shares and equipment by

consultants is more prevalent in oncology, orthopaedics, ophthalmology, urology and cardiology than in other specialties.

22. Some departments in NHS hospitals have a significant proportion of NHS consultants with shares and equipment in private hospitals. For example, 30% of the consultant oncologists at Guys and St Thomas' hospital in London own shares and equipment in private hospitals, as do 50% of consultant oncologists who work at Royal Surrey County NHS Foundation Trust. In addition, 45% of orthopaedic consultants who work at York Teaching Hospital NHS Trust own shares or equipment in private hospitals, as do 38% of the orthopaedic consultants who work at the Sheffield Teaching Hospitals NHS Foundation Trust.

FINDING 2: Some NHS Trusts make substantial payments to private hospitals where their consultants own shares

23. In a number of instances NHS Trusts have referred patients to the private hospitals in which their consultants have a financial interest. In some of these cases the patient referrals have come from the departments where the consultants work. In total, over a four-year period NHS hospital trusts made payments of around £40m to private hospitals in which NHS consultants who work at those trusts own shares.

24. Using the publicly-available data relating to share ownership and the payments made by NHS trusts to private hospitals we were able to identify a number of cases in which there are potential conflicts of interest and which should be investigated further by NHS England and the Trusts involved.

Example 1: Aspen Healthcare – Claremont Private Hospital

Between 2015 and 2018 Sheffield Teaching Hospital NHS Trust commissioned £16.7m worth of treatment from Claremont Private Hospital, which is jointly owned by Aspen and a number of orthopaedic surgeons who work both at the Sheffield Teaching Hospital and also at Claremont Private Hospital. Most of the payments by the NHS Trust relate to musculo-skeletal (i.e. largely orthopaedic) services. In 2016-17 these referrals accounted for 36% of Claremont's income.

Example 2: BMI Southend Private Hospital

BMI Southend Private Hospital is jointly owned by the multinational healthcare group BMI Healthcare and a number of NHS consultant ophthalmologists who work at Southend University Hospital Trust. Over a 3-year period the NHS trust made payments to the private hospital totalling £500,000. All of the work commissioned from BMI Southend by the NHS hospital was for ophthalmology services.

Example 3: Spire Healthcare Montefiore Hospital

Montefiore Hospital is a private hospital which is jointly owned by Spire Healthcare plc and consultants. Some of these consultants work at the University of Brighton NHS Hospital Trust. In the two years between 2015 and 2017 the Trust referred 327 patients to Montefiore at a total cost of £185k**.** These referrals were identified by the Trust as "Head and Neck" and "Musculo-Skeletal". These areas of medicine would fit within the Trust's Trauma or Orthopaedics or Rheumatology departments. The Trust confirmed that the consultants with shares in Montefiore Private hospital worked in one of these departments during the time when the referrals were made.

Example 4: Aspen Healthcare Midland Eye

Midland Eye is a private provider of ophthalmology services which is jointly owned by Aspen Healthcare and a number of consultant ophthalmologists. Aspen own 70% of the company and the consultant Ophthalmologists own 30%.

Midland Eye is heavily reliant on NHS funding. Of the 21,000 episodes of care at the hospital between July 2016 and August 2017 81% were funded by the NHS.

In total, between 2014 -2016 439 patients were referred to Midland Eye at a cost to the Trust of £344,000. During the period when the referrals were made by the Trust some of the consultants who owned shares in Midland Eye worked in the Ophthalmology Directorate which was responsible for the referrals.

Example 5: Spire Healthcare and NHS Trusts

NHS Hospital Trusts often outsource elective procedures to private hospitals such as Spire Healthcare's in order to deliver treatment for patients within the mandatory waiting time limits. We examined the accounts of seven NHS trusts where consultants who own shares in Spire Healthcare plc work. These same consultants who own shares in Spire Healthcare also work in Spire hospitals. In total we identified that between 2015 and 2018 these seven trusts made payments of £23m to Spire Hospitals to carry out work on behalf of the Trust. Barking, Havering and Redbridge NHS Trust made payments of £1.2 million to Spire. Ten consultants who work at Barking (and at Spire Hospitals) own shares in Spire.

Due to the limited nature of the publicly available data, we are not able to say whether the consultants owned the shares at the time the payments were made to Spire's hospitals.

FINDING 3: A significant number of NHS consultants own shares in companies which have been set up in collaboration with the US healthcare company HCA Healthcare to provide private cancer treatment on behalf of the NHS

25. Over the past decade three NHS hospitals have entered into arrangements with the world's largest healthcare company, the US-based HCA Healthcare UK, to generate revenue from treating patients privately. These are highly opaque arrangements which are barely referenced in the accounts or annual reports of the NHS Trusts concerned.

26. In 2 cases – at Guys and St Thomas' and University College London Hospital (UCLH) – the company which has been set up to provide private cancer services is a joint venture between HCA and the NHS consultants who work in the NHS hospital.

27. In a third case, in Manchester, The Christie NHS Foundation Trust, HCA Healthcare UK and the NHS consultants who work at The Christie are involved in a joint venture, to provide NHS private cancer services and share any profits made between them.

28. The consultants who own shares in the joint venture also earn income on top of their NHS salaries from treating patients who pay privately. As a result there exists a strong financial incentive for these consultants to refer patients for treatment in the private patient unit of their NHS hospital – they will receive a fee for treating the patient privately and will also receive a share in any profits generated by the private patient unit.

29. We have not identified any instances where patients seeking NHS care have been referred through to these private patient units by consultants with shares in the private unit and the existence of these financial incentives does not mean that the decisions of the consultants who own the shares have been influenced by them.

30. In the vast majority of cases, the public declarations of interest which NHS Trusts are required to make, however, do not include any reference to the shares owned in the Private Patient Units by the NHS consultants employed by the Trust.

FINDING 4: Private hospitals provide medical consultants who refer patients to them with substantial amounts of corporate hospitality

31. Under the CMA 2014 Order, private hospital companies are required to publish on their websites details of any corporate hospitality given to consultants who refer patients to them. Although, not all the private hospital companies make the required disclosures, we estimate that in the years 2017 and 2018 seven private hospital companies have together given £1.5 million to referring consultants in the form of gifts and hospitality, with the vast majority (£978K) of this coming from one company, Spire Healthcare. Some of these gifts include tickets for sporting events costing over a thousand pounds.

32. This represents a substantial investment by the private hospital sector in providing non-monetary benefits to clinicians on whose referrals their income and profits depend.

33. NHS England guidance prohibits NHS staff from receiving gifts "from suppliers or contractors doing business (or likely to do business) with an organisation" and states that these "should be declined, whatever their value." The same guidance also limits any hospitality received by NHS staff to £75 per occasion.

34. Given the level of corporate hospitality provided to referring consultants by private hospitals, and the contractual arrangements which currently exist between private hospitals and the NHS, it seems very likely that some NHS consultants will have broken the rules on gifts and hospitality.

35. It should also be noted that the Bribery Act 2010 also prohibits payments which '*represent an effort to induce performance which is contrary to good faith, partial, or in breach of trust'*, and these prohibitions also refer to those who receive the payment. The fact that consultants who refer patients to private hospitals have received non-monetary gifts from the hospitals worth more than a thousand pounds might be considered to be likely calculated to induce patient referrals to private hospitals.

FINDING 5: Many NHS consultants who have financial interests in private hospitals have failed to declare them

36. Since June 2017 NHS England's conflict of interest guidance requires trusts to publish declarations of interest by all senior consultants. We looked at the websites of NHS Trusts and asked for the registers of interests for those trusts where the majority of NHS consultants who own shares in private hospitals work.

37. Out of the 265 share-owning NHS consultants who work in these hospitals, the Trust had made information publicly available for only 19 of them. This does not provide us with any confidence in the efficacy of the NHS guidance in preventing conflicts of interest and suggests that there is no shared understanding across the NHS or the medical profession of the issues and risks associated with conflicts of interest.

FINDING 6: A number of private hospital companies do not comply with the law regarding the disclosure of financial interests

38. A number of large private hospital companies operating in the UK have not met the disclosure requirements regarding financial incentives and therefore appear to be in breach of the CMA Order 2014. These companies include Genesis Care, Benneden, Optegra and the Edward VII hospital in London, used by the Royal Family. The CMA were unable to tell us what steps they have taken to monitor compliance with their 2014 Order. It would appear that compliance is being neither monitored nor enforced. In any case, the law under which the CMA has issued the Order does not provide any sanction for failure to comply with it.

Conclusions and recommendations

39. The evidence shows that both the regulations established by the Competition and Markets Authority and the guidance issued by NHS England to prevent financial incentives distorting patient care are ineffective. In addition to the non-compliance with its Order, which has not been detected or rectified by the CMA, there are no legal penalties for non-compliance. This situation contrasts strongly with the US regulatory framework to which many of the private healthcare companies operating in the UK are subject, and which imposes significant penalties for non-compliance. In the US, conflicts of interest are prohibited, rather than just supposed to be declared and "managed".

RECOMMENDATION 1: The law governing financial incentives in the UK healthcare system should be made by Parliament, not the Competition and Markets Authority

40. The statutory remit of the CMA relates only to preventing harms resulting from anti-competitive practices. It is not able to address the potential harm caused to patients from over-treatment or to the public by the wasteful use of scarce NHS resources. Moreover, it is not accountable to Parliament or the Department of Health and Social Care for making or enforcing laws

relating to financial incentives. This area of health policy should be the responsibility of the Department of Health and Social Care.

RECOMMENDATION 2: Conflicts of Interests should not be "managed" but prohibited

41. The UK needs to move to a similar approach to the US whereby there is firm prohibition on conflicts of interest rather than an attempt to "manage" them. A statutory framework should be developed by the Department of Health and Social Care which sets out clear prohibitions on the provision or receipt of financial incentives to refer patients to private hospitals.

RECOMMENDATION 3: Serious sanctions should be introduced for any breaches of the law

42. Because of the risk of patient harm which can result from overtreatment and because of the significant potential for healthcare fraud this statutory framework should be backed up by effective punitive sanctions, including custodial sentences.

RECOMMENDATION 4: NHS Improvement and the Care Quality Commission should have the resources to monitor and enforce the law

43. Resources should be allocated by the Department of Health to the regulator of NHS Trusts, NHS Improvement, in conjunction with the regulator of private hospitals, the Care Quality Commission, to monitor and enforce this law.

The structure of this report

Part I of this report looks at the background to the current laws in the UK relating to the prohibition on financial incentives offered by private hospitals to consultants and compares these with those which exist in the US.

Part II of this report sets out our findings from a review of the publicly available data on compliance with the CMA order, consultants who own shares and equipment in private hospitals, referrals from NHS Trusts to private hospitals in which NHS consultants have shares, the amount of corporate hospitality provided by private hospitals and the extent to which NHS consultants have publicly declared their financial interests in private hospitals.

Part I: Section 1: The private hospital industry in the UK and the role of the consultant

"There is fierce competition to attract and retain the consultants who will bring their patients to the hospital – [it is] 'a contest for control of the patient pathway'.
(HCA Healthcare submission to the Competition and Markets Authority 2014)[4]

44. There are currently just over 200 private hospitals in the UK. Nearly 70% of them are owned by five private companies. Four of these – BMI, Ramsay, HCA, and Aspen – are owned by multinational private companies based overseas.[5]

45. It is estimated that in 2016-17 the income of private hospitals from delivering patient care totalled £4.5 billion. 30% of this income comes from the NHS (half of all patients treated in private hospitals are funded by the NHS); 45% comes from private health insurance and 19% comes from individuals paying for care out of their own pockets.[6] [7]

46. An estimated 17,500 NHS consultants work in private acute hospitals in the UK, the great majority of whom work in England, treating both private and NHS patients. The great majority of these consultants have posts in NHS hospitals and work at private hospitals in their non-NHS hours.

47. Private hospital work is very profitable. It is estimated that these 17,500 consultants made £1.6 – £1.8billion in 2015, an average gross annual income of between £85,000 and £97,500 per consultant. [8] However, it is estimated that 5,000 consultants (just over a quarter of those practising privately) do 50% of all private work and that some consultants make several hundred thousand pounds a year from it.[9]

48. Consultants also generate significant amounts of revenue for private hospitals meaning that there is great competition between hospitals for them to practise at a particular hospital. For example, the average amount of revenue which an individual consultant brings in each year for a hospital in London owned by HCA Healthcare is £380k a year, with some consultants bringing in much greater amounts of income.[10]

49. As we have detailed elsewhere, private hospitals in the UK are not the same as NHS hospitals. Most of the work which takes place in private hospitals is for elective treatment (especially hip and knee surgery). The consultants work in private hospitals on a 'freelance' basis.

50. In most cases, a patient can only be treated at a private hospital if a consultant who practises at that hospital agrees to treat them there. This means that private hospitals are in competition for referrals from consultants.

51. The other way in which patients receive treatment in private hospitals is when the NHS funds their treatment. In most cases NHS patients are referred by their GP or an NHS consultant. NHS patients may also choose to be treated at a private hospital under the "choose and book" initiative.

52. NHS hospital trusts can also refer patients to private hospitals when they do not have the capacity to provide the treatment within the mandatory 18 weeks maximum wait from referral to treatment. In 2016-17 NHS Trusts spent around £1 billion on care provided by private hospitals which is an addition to the £8.7bn spent by CCGs on private healthcare.[11]

53. As noted above, a third of all private hospital income now comes from the NHS and around half of all patients treated in private hospitals are funded by the NHS, making private hospitals even more heavily reliant on NHS consultants to refer patients to them. So important are consultants to private hospitals that the CQC has recently found that for some hospitals the consultants, rather than the patients, are seen as their real "customers".[12]

54. Whilst there are many differences between the UK and the US healthcare system, the role of the consultant in driving referrals to for-profit hospitals is very similar. The US Healthcare company HCA (which also operates in the UK) has recently noted the importance of the referring physician to their business model in their official report to the New York Stock Exchange. This gives an indication of the need for private hospitals in both the US and the UK to win business from consultants.[i]

Conclusion

The central role of the consultant in the business model of the private hospital sector makes it extremely important for private hospitals to influence their decisions about where to treat their patients. Consultants must be encouraged to refer patients to a given private hospital, or its income and profits will decline.

i HCA Healthcare identified the following risks to its business regarding their ability to attract doctors to refer patients to their hospitals: "Although we employ some physicians, physicians are often not employees of the hospitals at which they practice, and, in many of the markets we serve, most physicians have admitting privileges at other hospitals in addition to our hospitals. Such physicians may terminate their affiliation with our hospitals at any time.[..] If we are unable to provide adequate support personnel or technologically advanced equipment and hospital facilities that meet the needs of those physicians and their patients, they may be discouraged from referring patients to our facilities, admissions may decrease and our operating performance may decline. HCA Holdings Inc Form 10K US Securities and Exchange Commission https://www.sec.gov/Archives/edgar/data/860730/000119312512075882/d264514d10k.htm#tx264514_2

Part I: Section 2: The use of financial incentives by private hospitals to attract referrals from clinicians– evidence from the CMA 2014 Study

"Schemes operated by private hospitals to encourage clinicians to treat patients at or commission tests from their facilities were widespread"
(Competition and Markets Authority 2014)

55. In 2014 the Competition and Markets Authority completed a major investigation into the private healthcare market in the UK in response to complaints of anti-competitive practices between major private hospital companies, particularly in London. The CMA carried out its investigation under its power, conferred on it by the Enterprise Act 2002, and requested information from individuals and businesses in order to form a view as to whether or not there are distortions in a market which are detrimental to consumers.

56. In conducting their investigation the CMA found "that schemes operated by private hospitals to encourage clinicians to treat patients at, or commission tests from their facilities were widespread". The CMA saw these schemes as problematic because they recognised the central place that clinicians have in providing private hospitals with their business. By providing financial incentives for clinicians to refer patients to their hospital, the private companies which own them were intending to influence the behaviour of clinicians in a way which could distort their professional judgment.

57. The CMA investigation found that the private hospital sector operated a number of different types of incentive schemes:

Contracts requiring consultants to refer patients to the private hospitals where they worked

58. This type of contract required consultants who had the right to operate at a private hospital to use their "best endeavours to refer patients" to the hospital "subject to the clinical needs and best interests of the patient". This type of scheme was operated by HCA Healthcare.[13]

A financial reward programme for consultants practising at private hospitals based on the volume of referrals made

59. Nuffield Health operated a scheme whereby payments made to consultants were calculated on the amount of revenue that the consultant had generated for the hospital, and revenue growth in the prior year. The more revenue a consultant had generated previously, the more they could earn from the scheme, and the greater the growth on the prior year, the bigger the payout. Under this scheme consultants were able to up to earn up to 3.5 per cent of the gross value of the hospital's earnings generated by the consultant in the previous year.[14]

60. Under a scheme operated by Ramsay Health Care consultants were given a percentage share of the outpatient revenues that they generated for the hospital.[15]

61. BUPA operated a scheme where they paid consultants for making referrals to their hospital.[16]

62. The Kent Institute of Medicine and Surgery Hospital (KIMS) paid consultants 5 per cent of the revenues received by the hospital for each pathology service, imaging service or surgical procedure ordered or performed by the consultant at KIMS.[17]

Shares in private hospitals given to consultants based on the number of referrals made

63. The private hospital company Circle Health gave consultants shares in their hospitals in return for agreeing to undertake 50-60% of their private work in them.[18]

Providing consultants with the use of consulting rooms at the hospital free of charge

64. The CMA also found that hospital operators offered clinicians "higher-value" benefits such as free or subsidized consulting rooms and parking spaces, payment of or contributions towards medical indemnity insurance, and free or subsidized secretarial services. These were seen by the CMA as additional ways in which consultants were incentivised by private hospital companies to refer patients to their hospitals.[19]

A lack of transparency with regard to the existence of these schemes

65. Whilst the CMA found such schemes to be widespread, they found through their research that very few consultants were willing to admit that they were aware of them. They also found little evidence that patients or insurers were informed by either the hospital operators or the consultants of the existence of such schemes.

Conclusion

The CMA 2014 investigation into the private hospital market identified a large number of incentive schemes designed to influence the decision of consultants when referring patients to private hospitals. The use of these incentives appeared to be systemic and widespread, although it was largely hidden from patients and the public.

The CMA was concerned that while the private hospital industry considered that these schemes were necessary to provide such incentives to develop their business and to compete effectively they distorted competition.

Part I: Section 3: The CMA response

The Private Healthcare Market Investigation Order 2014

66. Once the investigation into the private hospital sector had commenced some private hospital companies amended their incentive schemes in order to avoid criticism by the CMA.[20] Nevertheless, most of the private hospital companies defended these schemes on the basis that this was necessary to compete with other hospitals, particularly in areas of the country where there was intense competition between private hospitals. They also argued that such arrangements delivered customer benefits because they led to greater clinician engagement with the hospital.

67. However, because the CMA found that these types of incentive schemes distorted competition for patients between private hospitals (and hence affected their income and profit) it was required by its mandate to intervene.

68. The starting point for the CMA's response was to ensure that competition between hospitals was undertaken on a "level playing field", not to address unethical behaviour or the risks of overtreatment or over-referral which could do harm to patients. They stated that:

"The aim of this remedy is to ensure that competition between private hospital operators for patients is carried out on the basis of the quality and price of the healthcare services they offer rather than the value of benefits and inducements paid by hospital operators to clinicians to encourage referrals." [21]

69. The CMA's response to the prevalence of these schemes was set out in Part 3 of the Private Healthcare Market Investigation Order 2014, which, in addition to the Bribery Act is the main law governing the use of financial incentives in the UK private hospital sector. It includes the following:

A prohibition on financial incentives to induce a patient referral

- A general prohibition on schemes and arrangements which induce a referring clinician to refer patients to a particular hospital.
- A specific prohibition on private hospital operators offering referring clinicians direct financial incentives.

Corporate hospitality and work place benefits for consultants must be "proportionate and reasonable"

- Private hospitals are still allowed to provide referring clinicians with basic workplace amenities (including providing rooms and in-house training) as well as general corporate hospitality. However these benefits must be "proportionate and reasonable", and should not be intended as, and may not reasonably be regarded as, an inducement to refer patients to the hospitals.

A 5% cap on shareholdings by consultants in a private hospital or hospital company

- The 2014 order prohibits schemes whereby a referring clinician has, directly or indirectly, a share or financial interest in a private hospital, or a facility owned or operated by a private hospital operator, or in diagnostic equipment or equipment used at that hospital.
- However, referring clinicians are still able to hold, directly or indirectly, up to 5% of the financial interest of any class of shares or options over any class of shares and they must not have any obligation, express or implied, to refer patients for treatment or tests at the relevant private hospital.

Declarations must be made regarding share ownership, equipment ownership, corporate hospitality and other workplace benefits

- Private hospital companies are required to publish on the website of each relevant private hospital or facility details of all referring clinicians for the time being practising at that hospital who have a share or financial interest in that hospital or in equipment used in that hospital.
- A private hospital must also publish on the hospital website (and keep up to date) details of payments made to, and a summary of the duties performed by, the relevant referring clinician in relation to any part-time position.
- A private hospital operator must publish on the hospital website details of any corporate hospitality and other work-based amenities provided to referring clinicians.

Assessment of the CMA response

70. The CMA did not prohibit "referring clinicians" from owning shares in either the hospital companies where they worked or in any equipment which they used for treatment.

71. It initially proposed that the cap on equity participation schemes should be set at 3% rather than the 5% level eventually set out in the 2014 Order. It increased the permitted level of ownership when evidence was provided by the private hospital companies and others that this would not be anti-competitive (i.e. not have a significant bearing on clinician referrals) but would permit "clinician engagement" in private hospitals.

72. For example, the British Medical Association (BMA), in responding to the CMA's proposed 3% share ownership limit, stated that:

" [the] proposed limit of 3 per cent on equity stakes in a hospital or equipment at which a consultant had practising privileges or the ability to commission tests was too low to encourage consultants to become engaged in the running of a hospital. It said that a minimum stake of 10 per cent was more likely to encourage innovation while still ensuring that the equity stake did not influence referral or commissioning behaviour." [22]

73. The CMA was clearly swayed by with this argument. Its report states that:

"the proposed limit on the size of the shareholding, although larger than the 3 per cent limit we had considered in our provisional decision on remedies, is set at a level where we consider that it is still sufficiently small (and remote) so as to be unlikely to influence the clinician's referral or commissioning behaviour while still providing for an ownership stake to encourage clinician engagement in the setting up and running of the private hospital"

74. It concluded overall that:

"the remedy we have proposed was proportionate, in that it retained the customer benefits of clinician engagement associated with equity participation and did not impose significant relevant costs on either private hospitals operators or clinicians." (emphasis added).

75. It did not specify what customer benefits may result from clinician ownership of shares in private hospitals. It is not clear whether the CMA weighed these benefits against the significant risk to patients arising from clinicians making decisions which are in their own financial interest rather than the patients' best interest.

76. With regard to declarations about the ownership of equipment by consultants, the CMA concluded in its Final Report that:

"clinicians should be required to disclose to their patients any equity interest they have in a facility to which they propose to refer the patient, or in any major item of equipment (eg scanner, CyberKnife etc) which they propose to use to conduct tests on or to treat the patient. Such disclosure should be in writing, contained in a letter or leaflet given to the patient." (emphasis added).[23]

77. We asked the CMA why this recommendation was not embodied in the 2014 Order and were told that it was because the requirement for private hospital companies to publish information on their websites put this remedy into effect.[24] It is difficult to see this as being in any way equivalent to providing patients with this information in a letter or in a leaflet before they are referred for treatment using this equipment.

Enforcement and monitoring of compliance with the 2014 Order

78. An Order issued by the Competition and Markets Authority (under Section 161 of the Enterprise Act 2002) is a particular type of law. A breach of such an Order does not have the usual sanctions which the breach of any other law might have. For example, the CMA cannot bring a criminal prosecution against an individual or company for breaching the Order. Instead a court may require a company or an individual to comply with the order. (Section 87 of the Enterprise Act 2002)

79. Thus the means available to the CMA to address the issue of the financial incentives given to referring doctors by private hospitals are substantially weaker than those available to other regulatory authorities in the UK, such as the Care Quality Commission, which has powers to prosecute and impose sanctions on private hospitals for the breach of its regulations, including fines and de-registration.

80. Despite the fact that the widespread use of financial incentives by private hospitals to induce patient referrals only came to light as a result of an extensive investigation by the CMA (and its predecessor body, the Office of Fair Trading), and despite the fact that most clinicians who were in receipt of financial inducements denied their existence, the CMA considered that the new prohibitions contained within the 2014 Order "should not prove complex or expensive to monitor".

81. It assumed that because it had banned financial incentive schemes a breach "would be relatively easy to define" and that the transparency requirements regarding equity stakes and corporate hospitality would "render them open to challenge by interested parties, including competitors and Private Medical Insurers".[25] The CMA also stated that they would review the specific provisions of the Order relating to financial incentives within three years of the Order coming into force, and that as an organisation they "[would] monitor and enforce compliance with this remedy."[26]

82. We wrote to the CMA to ask about any actions that they have taken to either monitor or enforce the specific provisions relating to financial incentives, and about the review of the Order which they were due to undertake in 2017. In response they stated that they could not provide us with any information relating to any monitoring or enforcement action taken, as this information was prohibited from disclosure. They also could not confirm that any review of the specific provisions relating to financial incentives (namely sections 15 -19) of the Order had taken place.[27]

Conclusion

The CMA's response to the widespread and systemic use of financial incentives by the private hospital industry sought to prohibit the worst aspects of this practice – namely incentive schemes which are explicitly designed to induce referrals from clinicians.

However it leaves in place other incentives (such as share ownership, ownership of equipment, the provision of corporate hospitality and payment of advisory fees) which may be said to be intended to 'indirectly' influence the decision of consultants.

As a result we can only assume that CMA is of the view that these indirect incentives are unlikely to influence consultants' decisions about patient care, or that the transparency requirements which they have put in place regarding the provision of these incentives are likely to mitigate inappropriate referral decisions or the overtreatment of patients from taking place.

However, the CMA put forward no evidence to suggest that this approach would be successful in mitigating the risk to patients, in the same way that no evidence was adduced to show that consultants owning shares in private hospitals would lead to "customer benefits".

The failure of the CMA to explain how it monitors and enforces the 2014 Order cannot give any confidence to patients and the public that financial incentives are not being used by private hospitals to distort the clinical decision-making of medical consultants.

Part I: Section 4: The US approach to dealing with financial incentives given to clinicians by private hospitals to attract referrals by clinicians

83. The approach taken by the CMA to dealing with financial incentives should be considered in the light of the approach taken in the United States to deal with the issues which the CMA identified as widespread within the UK private healthcare industry.

84. Because the US Federal government spends $3trillion a year purchasing healthcare from private providers under the Medicare and Medicaid programmes it, like the NHS, has a strong financial incentive to prevent private healthcare companies and clinicians from carrying out unnecessary treatments funded by the taxpayer.

85. It is also concerned to ensure that companies and clinicians should not benefit as a result of referring patients to their own facilities or equipment, thus placing their financial interests above those of the patient.

86. In addition to the fact that the US healthcare system is subject to fraud estimated in the region of $272bn a year it also suffers seriously from "supplier induced demand" – i.e. the healthcare of patients being determined not by the medical needs of the patient but by the financial needs of the healthcare provider.[28] This leads to both significant additional and unnecessary costs as well as the risk of harm from unnecessary clinical interventions.

87. There are several pieces of legislation in the US which cover financial inducements.

The US Anti-Kick Back Law: prohibition on payments to induce patient referrals

88. The Anti Kick Back Law prohibits the payment of remuneration to clinicians to induce referrals for patients covered by Medicare or Medicaid. Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies."[29]

89. The latest guidance on remuneration of a non-monetary type – for example corporate hospitality or gifts – sets a limit on the receipt or provision of such benefits by individual private healthcare companies at $392 (£305) per year for each physician.

90. Physicians who pay or accept kickbacks face penalties of up to $50,000 per kickback plus three times the amount of the remuneration. In addition criminal penalties and administrative sanctions for violating the Anti Kick Back Laws include fines, jail terms, and exclusion from participation in Federal health care programs.

The Stark Law – Prohibits referrals of Medicare or Medicaid patients to healthcare facilities where the doctor has a financial interest

91. The Stark Law prohibits doctors from referring patients covered by Medicare or Medicaid to receive services from any entity with which the doctor (or their immediate family member) has a financial relationship. This is known as "self-referral". Financial relationships include ownership, investment interests and compensation arrangements.

The False Claims Act – Fines for any doctor or Healthcare company making a false claim for Medicaid or Medicare Payment

92. If a doctor or healthcare company breaches either the Stark Law or Anti-Kick Back law and then makes a claim for a Medicare or Medicaid payment they can be in breach of the False Claims Act. This can lead to fines of up to three times the loss incurred by the government and $11,000 for each false claim which is made, and even imprisonment. Physicians have gone to prison for submitting false health care claims. When prosecuting offences under this law there is no need to demonstrate that there was any intent to defraud Medicare and Medicaid.

93. The Department of Justice, the Department of Health & Human Services, the Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS), are charged with enforcing these laws. In many cases, the Federal Bureau of Investigation (FBI) also investigates breaches of these laws. In 2015 Department of Justice health prosecutions generated $2.4 billion in fines. Over the last several years more than 2,000 individuals were charged with healthcare fraud, resulting in more than 1,400 guilty pleas and 191 convictions following jury trials.[30]

94. In contrast, as noted above, the only sanction which is available to the CMA to enforce its 2014 Order is to take an individual or company to court to require them to comply with the order. As a result there is no punitive sanction available under UK law in the event that a private healthcare company or a consultant breaches the Order. In addition, as we also note above, there is no evidence that the CMA has dedicated any resources to monitoring or enforcing the law governing the use of financial incentives in the UK healthcare system.

95. As box 1 demonstrates, Tenet Healthcare – the owner of the UK healthcare company Aspen until August 2018 – have recently paid $513 million to settle criminal and civil claims relating to breaching laws which prohibit "self referrals".[31]

Box 1. Tenet Healthcare and breaches of the Stark Laws

In October 2016 the US Department of Justice required Tenet and two of its subsidiaries to pay $513million to settle criminal and civil claims relating to breaching laws which prohibit "self referrals"

The case focused on bribes and kickbacks which were paid to the owners and operators of prenatal care clinics in return for the referral of those patients for child birth services at Tenet hospitals.

These kickbacks and bribes allegedly helped Tenet obtain more than $145 million in Medicare and Medicaid funds based on the resulting patient referrals.

Some of the pregnant women were told at the prenatal clinics that Medicaid would cover the costs associated with their childbirth and the care of their newborn only if they delivered at one of the Tenet hospitals, and in other cases were told that they were required to deliver at one of the Tenet hospitals, leaving them with the false belief that they could not select a hospital of their choice.

As a result many expecting mothers were forced to travel long distances from their homes to deliver their babies, placing their health and safety, and that of their babies, at risk.

The US Attorney commenting on the case stated "Our Medicaid system is premised on a patient's ability to make an informed choice about where to seek care without undue interference from those seeking to make a profit."

Table 1. Differences between the US and UK law on financial inducements for healthcare professionals

Financial Inducement	United States	United Kingdom
Payments to clinicians by hospital companies to induce referrals	Prohibited outright	Prohibited outright
Self-referral to healthcare facilities where clinicians have a financial interest	Prohibition on self-referral of any Medicaid or Medicare patient to hospitals where clinician (or their immediate family member) has a financial interest, directly or indirectly	Permitted. NHS clinicians not restricted from referring NHS patients to facilities where they have a financial interest. The clinician's financial interest in the hospital is restricted to 5%
Provision of corporate hospitality and other lower values services by hospitals	Limited to $392 a year for each physician.	Permitted, but must be "reasonable and proportionate" and must not breach Bribery Act provisions which could lead to criminal prosecution
Status of legal prohibition	Federal Statute (Stark Law, Anti-kickback law, False Claims Act)	No Act of Parliament. Order issued by the Competition and Markets Authority under the Enterprise Act 2003
Monitoring of legal compliance	Federal Bureau of Investigation (FBI) Office of Inspector General (OIG) Department of Justice, Centers for Medicare & Medicaid Services (CMS)	Competition and Markets Authority – no evidence of monitoring or enforcement
Sanctions for non-compliance	Significant fines for any inducement received or paid or any referral to a facility in which the doctor has a financial interest. Jail sentences for breach of the False Claims Act. Exclusion from Medicare/Medicaid scheme. $2.4bn fines issued in 2015	No financial or custodial sanctions. Courts can require compliance with 2014 Order in the event of a breach

96. It is important to note that the private healthcare companies which were subject to the CMA investigation (and which the CMA had shown to have used a range of methods to financially induce clinical referrals) raised objections against the introduction of the types of prohibitions which currently exist in the US.

97. For example, HCA Healthcare – a US-based company which, as Box 2 shows, has been subject to action by the US authorities for breaching the Anti-Kickback legislation – stated that:

"it would be challenging to justify the significant governmental infrastructure and support needed to oversee, adapt, interpret and enforce this type of law, and the related increased costs to healthcare entities and physicians. In light of these increased costs, coupled with the negative impact on innovation and a nimble, efficient healthcare marketplace, HCA did not consider the Stark Acts to be a particularly useful or effective model to apply to UK private healthcare providers." [32]

Box 2. US government action against HCA for breaches of Stark Act and Anti Kick Back Legislation

In 2003 the US Department of Justice announced that HCA Incorporated (previously Columbia/HCA and HCA – The Healthcare Company) agreed to pay the United States $631 million in civil penalties and damages arising from false claims the government alleged it submitted to Medicare and other federal health programs

The payment resolved HCA's civil liability for false claims resulting from a variety of allegedly unlawful practices, including cost report fraud and the payment of kickbacks to physicians.

Included in this settlement was a payment of $225.5 million to resolve lawsuits alleging that HCA hospitals and home health agencies unlawfully billed Medicare, Medicaid and TRICARE for claims generated by the payment of kickbacks and other illegal remuneration to physicians in exchange for referral of patients.

In total, the US government recovered $1.7 billion from HCA, by far the largest recovery ever reached by the government in a health care fraud investigation.

The Assistant Attorney General for the Civil Division involved in the case said:

"Health care providers and professionals hold a public trust, and when that trust is violated by fraud and abuse of program funds, and by the payment of kickbacks to the physicians on whom patients and the programs rely for uncompromised medical judgment, health care for all Americans suffers." (Source: US Department of Justice)[32]

Conclusion

There is a marked contrast between the regulatory regime which exists in the US healthcare market and the one put in place by the Competition and Markets Authority. In effect, the CMA Order is a regime which is backed up by no punitive sanctions and relies heavily on the good will of private hospital companies to avoid providing financial inducements to consultants to make patient referrals. It also assumes that imposing a requirement on private hospitals to be transparent about any financial relationship that they have with consultants will prevent any major abuses from occurring.

However, the fact that some of the same private hospital companies which are operating in the UK have been willing to breach the law on financial incentives in the US, despite the risk of huge fines, indicates that the CMA's faith in the willing compliance of the private hospital sector may be misplaced.

Part I: Section 5: NHS England Guidance on Conflicts of Interest

98. In addition to the 2014 Competition and Markets Authority Order NHS staff and NHS organisations are also required to adhere to the statutory guidance on Conflicts of Interest issued by NHS England.

99. This guidance came into effect in June 2017. It imposes the following duties on NHS organisations (NHS Hospital Trusts, Foundation Trusts and CCGs) and their staff.[34]

A prohibition on the receipt of gifts

100. Gifts from suppliers or contractors doing business (or likely to do business) with an NHS organisation should be declined, whatever their value.

A limit on the amount of hospitality that NHS employees can receive

101. The guidance limits the value of meals and refreshment to £75 on any one occasion.

102. Offers of travel and accommodation which go beyond "modest" levels, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared.

103. There is no mention in the guidance of other forms of corporate hospitality such as tickets for sporting matches or concerts.

A requirement for consultants to declare share ownership or any other financial interest in a company doing business with the NHS

104. Staff (which includes consultants) should declare, as a minimum, any shareholdings or other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with their organisation.

105. Where shareholdings or other ownership interests are declared and give rise to a risk of conflicts of interest then the organisation should seek to mitigate these risks.

A requirement for senior clinical staff (including consultants) to declare interests and for "decision making staff" to publish any interests they may have

106. The guidance states that all staff should declare their interests and, as a minimum, NHS organisations should publish the interests of decision-making staff at least annually in a prominent place on their website. The format of published registers should be accessible and contain meaningful information.

The consequences of breaching the policy

107. In the event that breaches of this policy occur, the guidance notes that anyone responsible for a breach could be subject to disciplinary proceedings under their employment contract, referred to their professional regulator for a breach of their professional code of practice, and in extreme cases be subject to prosecution under the Fraud Act 2006 or the Bribery Act 2010.

108. Despite the fact that there Competition and Markets Authority identified that consultant ownership of equipment to diagnose and treat patients provides a potential incentive to refer patients to the hospital where that equipment is situated, NHS England does not provide any guidance on this issue or require consultants to make any declarations regarding the ownership of equipment.

Conclusion

The guidance from NHS England on Conflicts of Interest imposes requirements on NHS consultants which are substantially weaker than the requirements contained within the CMA's 2014 Order. In addition to the fact that NHS England does not place a requirement on consultants to disclose their ownership of equipment, it also places no limit on share ownership in companies which the NHS might contract with.

In addition, the guidance is based on the assumption that by requiring NHS staff to declare financial interests, the NHS will be in a position to manage any conflict of interest and to "mitigate" any possible risk to the public interest or to patients which might result. However, nothing is in the guidance explains how the declaration of interest leads to the risks being mitigated. This approach again stands in contrast with the approach taken in the US whereby financial conflicts of interest in publicly-funded healthcare are not "managed" but prohibited outright.

Part II: Research findings

RESEARCH FINDING 1: A number of major private hospital companies do not comply with the law regarding the disclosure of financial interests

109. Through a review of the websites of the major private hospital companies we found a number of instances where private hospital operators have failed to publish any declarations of financial interests on their website as required by the CMA order.

110. Thus Genesis Care, one of the largest private providers of cancer treatments with 12 hospitals across England, does not include any of the required information on its website. Nor does the private hospital which provides services to the Royal Family, the King Edward VII hospital in London, nor the private hospital run by the company Benneden. Another company which does not provide the information required by the CMA order is Optegra, a hospital which provides private eye care treatment from 9 private hospitals in England.

111. The fact that we could easily identify this level of non-compliance raises significant questions about the resources that the CMA has deployed to monitor and enforce the 2014 Order.

112. In addition, there is considerable variation across private hospital company websites in how easy it is for patients to find out about the financial interests of their consultants.

113. For example, BMI healthcare places this information on the front page of the website of each of its hospitals under the heading "How we work with our consultants" and provides details of any financial interests – such as the equity stakes held by referring clinicians and the corporate hospitality which it provides.

114. In contrast, Ramsay requires patients who want know whether their consultant has a financial stake in the hospital to click on a tab labelled "legal and regulatory" which is at the very bottom of the company's main webpage. Patients would then also have to know that this information is contained behind a link entitled "Competition and Markets Authority".[35]

115. For Spire Healthcare the information is located behind a link entitled "CMA compliance" for each of the hospitals that they operate.[36] Similarly HCA Healthcare has a link at the bottom of their main page which states "How we work with Doctors"[37] Nuffield Health places the financial interests of their consultants on the profile pages for each of their individual consultants.[38]

116. Whilst it could be argued that these companies are technically compliant with the CMA Order, we note that the CMA stated that *"the transparency provisions that we have proposed should render them open to challenge by interested parties"*.[39] It is not clear how those companies which do not publish this information on the front pages of their websites enable interested parties to easily access and therefore challenge, if necessary, their approach to providing financial incentives to referring consultants.

117. In most cases, it would be very difficult for a patient to find out if their consultant had the potential to gain financially as a result of owning shares in the particular hospital to which they were being referred, or through owning a particular piece of medical equipment which he or she proposed to use to treat them.

RESEARCH FINDING 2: Share and equipment ownership by medical consultants

Background

118. The 2014 CMA Order permits consultants who make referrals to private hospitals to own shares up to the value of 5% of the shares in a particular company or hospital. There is no requirement under the Order for individual consultants to publicise this information, although a private hospital company which receives referrals from a share-owning consultant is required to declare this information on its website.

119. Between May 2018 and February 2019 we reviewed the websites of all the private hospitals in England registered with the Care Quality Commission and recorded the data on share and equipment ownership. Where the private hospital website recorded that a consultant owned shares or equipment we recorded their specialty and, if they worked as an NHS consultant, which NHS hospital employed them.

The total number of all consultants who own shares and equipment in private hospitals

120. 637 consultants who work in the private sector in England own shares and equipment in private hospitals. Out of these 431 own shares and 208 own equipment. Two consultants own both shares and equipment.

The total number of NHS consultants who own shares and equipment in private hospitals

121. Out of these 637 consultants 546 are NHS consultants who own shares and equipment in private hospitals. Out of these 546, 371 NHS consultants own shares and 177 NHS consultants own equipment. Two NHS consultants own both shares and equipment.

Equipment ownership and fees per use

122. Research indicates that clinician ownership of equipment in hospitals to diagnose or treat patients is strongly associated with over-treatment of patients and the associated risks. Out of the 208 consultants who own equipment, 77 are paid a fee each time the equipment is used. Out of the 177 NHS consultants who own equipment, 67 are paid a fee each time the equipment is used. The payment of a fee each time equipment is used increases the financial incentive for overtreatment.

Distribution of Share and Equipment ownership by Private Hospital Company

123. The distribution of share and equipment ownership by private hospital companies shows that different approaches are taken to granting consultants a financial interest in their business.

124. Thus, for HCA, BMI and Aspen the focus regarding share ownership is entirely on developing joint ventures with referring consultants in particular hospital facilities. Typically a group of consultants trading as a Limited Liability Partnership (LLP) will own between 10 and 30% of the shares in a particular private hospital, with the healthcare company owning the remainder.

125. Conversely, Nuffield Health does not have any consultants who own shares in the hospital or the company but it does have a number of consultants who own equipment in their hospitals. BMI has the largest number of referring consultants who own shares in equipment in private hospitals.

126. For Spire, most of the referring consultants who own shares in the company are said to have shares worth less than 0.01% of the total stock of Spire Healthcare PLC's shares. However, there are also a number of referring consultants who are engaged in a joint venture with Spire to provide orthopaedic services at a particular hospital facility (the Montefiore Hospital in Brighton). In addition, a number of referring consultants own equipment in Spire's private hospitals.

127. Ramsay Healthcare, which generates most of its income from contracts with the NHS, provides very few opportunities for consultants to own a financial stake in their hospitals either in the form of share ownership or equipment ownership. The one exception to this is the Clifton Park Hospital, which is a joint venture with 10 consultants. [40]

Table 2. Distribution of share and equipment ownership amongst all consultants by private hospital company.

Company	Consultants who own shares in Company	% of Total Shares	Consultants who own equipment in Company's hospitals	% of Total Equipment
Aspen	37	9%	0	0%
BMI	22	5%	119	57%
HCA	277	64%	0	0%
Spire	85	20%	31	15%
Nuffield	0	0%	58	28%
Ramsay	10	2%	0	0%
Total	**431**	**100%**	**208**	**100%**

Distribution of share and equipment ownership by Specialty

128. Share and equipment ownership is concentrated within particular specialties. Consultants in six specialties make up over half the number of consultants with shares and equipment, with oncology being the largest consultant specialty with shares or equipment ownership, followed by orthopaedics and ophthalmology.

Table 3. Share and equipment ownership by consultant specialty

Specialty	NHS consultants with Shares	NHS consultants with Equipment	Total All NHS Consultant Shares and Equipment
Oncology	73	12	85
Orthopaedics	61	14	75
Ophthalmology	10	35	45
Urology	22	20	42
Radiology	33	4	37
Cardiology	10	25	35
Total	209	110	319
% of All Share and Equipment ownership (NHS)	**56%**	**62%**	**58%**

Distribution of consultant share and equipment ownership by NHS Trust and declarations made.

129. NHS Consultants who own shares and equipment are primarily based in London. This is to be expected given that London has the largest number of private hospitals in the country and it is also where competition between private hospitals is most intense. Outside of London, Greater Manchester is the region of the country where share and equipment ownership amongst NHS consultants is next highest.

130. As noted previously, the Conflicts of Interest guidance from NHS England introduced in 2017 requires consultants to make declarations regarding their financial interests to their Trust and the Trust is required to publish these. In order to identify whether NHS Trusts are compliant with this guidance we searched the websites of those hospitals which employ the largest number of consultants with a financial interest in private hospitals to examine their public registers. We also used the Freedom of Information Act to ask Trusts for these registers.

131. We found that in the great majority of cases the publicly available registers did not comply with the NHS England guidance and did not provide the required information relating to consultants. NHS Trusts declared the share or equipment ownership of their consultants in only 19 cases out of 265.

Table 4. Share and equipment ownership by consultants in NHS Trusts and declarations made.

NHS Trust	Consultants who own Shares and Equipment	Declarations made
The Christie	33	17
Guys and St Thomas	31	0
Imperial College Healthcare NHS Trust	24	0
Royal National Orthopaedic Trust	21	0
Barts NHS Trust	17	0
University Hospitals Birmingham	12	0
UCLH	15	0
Chelsea and Westminster	18	0
Manchester University NHS Foundation Trust	11	0
Royal Free London	15	0
York Teaching Hospital NHS Trust	14	0
Sheffield Teaching Hospital	13	0
Barking Havering and Dagenham	10	0
East Cheshire NHS Trust	11	2
Frimley	10	0
Kings College Hospital	10	0
Total	**265**	**19**

132. As a percentage of consultants who work in the NHS the number owning shares and equipment in private hospitals is very small. However, because conflicts of interest often exist within and between organisations, we were interested to know the extent to which particular departments in NHS hospitals employed consultants with shares in private hospitals.

133. Using data from the consultant directory available on the Trust websites for each specialty that were recorded as practising at that Trust and the proportion of that specialty who owned shares.

Table 5. NHS Trust Departments where a significant percentage of consultants own shares or equipment.

Consultant Specialty	NHS Trust	% of consultant specialty at Trust owning Shares and Equipment
Oncology	Guys and St Thomas	30%
	Royal Surrey County NHS Foundation Trust	50%
	The Christie NHS Foundation Trust	20%
	University College Hospital London	13%
Orthopaedics	Royal National Orthopaedic Hospital	44%
	York Teaching Hospital NHS Trust	45%
	Sheffield Teaching Hospital	38%
Ophthalmology	York Teaching Hospital NHS Trust	24%

RESEARCH FINDING 3: Referral of patients by NHS hospitals to the private hospitals where NHS consultants own shares

134. The CMA investigation did not look at the potential for NHS consultants owning shares in private hospitals to refer NHS patients to those private hospitals where they have shares or where they own equipment. However, given that a third of all private hospital income comes from the NHS, and that around half of all patients treated in the private sector are funded by the NHS, there is strong competition between private hospitals to win referrals from the NHS.

135. The majority of NHS patients who are treated in private hospitals are referred through the "choose and book" or "e booking" system, a national scheme operated by General Practitioners working in primary care. However around £1 billion of NHS-commissioned work in private hospitals comes from NHS Trusts which employ consultants who refer patients to these private hospitals.

136. As noted above, "self referring" patients to hospitals in which consultants have a financial interest is a common type of healthcare fraud in the US and is strictly prohibited under the Stark Law and Anti-Kick Back statutes described above. This is because of the potential for public money to be used in a way which is in interests of the consultants and the private hospitals but not in the interests of patients or the taxpayer.

137. We examined the expenditure of NHS Trusts and made Freedom of Information requests to find out if the NHS hospitals that employ NHS consultants with shares in private hospitals refer patients and business to those private hospitals where NHS consultants own shares.

138. We found that in a number of instances, NHS Trusts have referred patients to the private hospitals in which their consultants have a financial interest. In some cases the patient referrals have come from the parts of the NHS hospital where the consultants who own shares work.

139. In total, over a four-year period we were able to identify payments by NHS hospital trusts of around £40m to the private hospitals in which NHS consultants who work at those trusts own shares.

140. It is important to stress that there is no suggestion that individual consultants or anyone working at these Trusts has acted inappropriately or gained financially as a result of these referrals. The evidence presented here demonstrates only the existence of a number of possible conflict of interest and the lack of clear measures to place to prevent these conflicts from having harmful consequences.

Example 1: Aspen Healthcare – Claremont Private Hospital

141. Claremont Private Hospital is jointly owned by Aspen Healthcare and a number of consultant orthopaedic surgeons, some of whom work both at the Sheffield Teaching Hospital NHS Trust and at Claremont Private Hospital.[41]

142. Claremont is heavily dependent on the NHS for its income. In 2017 78% of inpatients at the hospital were NHS-funded, and 63% of outpatients were NHS-funded.[42]

143. Between 2015 and 2018 Sheffield Teaching Hospital NHS Trust commissioned £16.7m worth of treatment from the hospital, relating to 8,712 patients. Most of the payments by the NHS Trust related to musculo-skeletal (i.e. largely orthopaedic) services.[ii] In 2016 -Claremont Private Hospital received £19m in income from all sources and made a total profit of £1m.The payments made to Claremont by the Trust of £7.0m in 2016 amounted to 36% of Claremont's total income.[43]

Example 2: BMI Southend Private Hospital

144. BMI Southend Private Hospital is jointly owned by BMI and a number of consultant ophthalmologists who trade under the name of AK Medical Centre Limited. BMI have 50% of the shares and AK Medical Centre Ltd the other 50%.[44]

145. BMI Southend Private Hospital is also heavily dependent on the NHS for its income and revenue. Between 2015 and 2016 77% of day case and inpatient activity at the hospital, and 56% of NHS outpatients, were funded by the NHS.[45]

146. The consultants who own the shares in BMI Southend Private Hospital work at the BMI Southend Private Hospital and also at the Southend University Hospital NHS Trust in the Ophthalmology Department.

147. We examined the expenditure by Southend University Hospital NHS Trust between 2016 and 2018 and found that the hospital had made payments to BMI Southend Private Hospital worth £501,000. All of the NHS work commissioned from the hospital appears to be for ophthalmology services.

ii Source: Sheffield Teaching Hospitals NHS Foundation Trust 'Response to Freedom of Information request' FOI RFI 006436 13th July 2018. The Trust informed us that the patient referrals to Claremont from Sheffield Teaching Hospital Trust fell into two categories. The Trust is the lead provider for a musculo-skeletal (MSK) contract for Sheffield CCG, which means that it is responsible for providing MSK services for the area. Under this contract it sub-contracts the delivery of some of this work to Claremont Hospital and so the referrals which are made by the hospital are "non-clinical referrals" – i.e. the patient is given the choice of provider when their case is triaged. In other instances – i.e for non musculo-skeletal cases the Trust uses Claremont Private Hospital when it does not have the capacity in its own hospitals to provide care to patients. In these cases, patients who are waiting for treatment at the Trust are contacted by the Trust and offered the option of being seen at the Claremont Private Hospital instead. Again, the Trust informed us that in this scenario no clinical referrals would be made by any consultant at the Trust.

Example 3: Spire Healthcare Montefiore Hospital

148. Montefiore Hospital is a private hospital which is jointly-owned by Spire Healthcare Limited and medical consultants.[46] Some of these consultants work at the Brighton and Sussex University Hospitals NHS Trust as orthopaedic and consultants specialising in musculo-skeletal radiology.

149. Most of Montefiore's patients are privately funded but around 31% of the hospital's outpatients are funded by the NHS.[47] In the two years between 2015 and 2017 the Brighton and Sussex University Hospitals NHS Trust referred 327 patients to Montefiore at a total cost of £185,000.[48]

150. These referrals were identified by the Trust as "Head and Neck" and "Musculo-Skeletal". These areas of medicine would fit within the Trust's Trauma or Orthopaedics or Rheumatology departments.

Example 4: Midland Eye (Eye-Docs Limited and Aspen Healthcare)

151. Midland Eye is a private provider of Ophthalmology services which is jointly owned by Aspen Healthcare and a number of consultant ophthalmologists. These ophthalmologists worked at the Ophthalmology Directorate of Heartlands, Good Hope and Solihull Hospital NHS Trust before it was merged with other Birmingham NHS hospitals to become the University Hospital of Birmingham NHS Foundation Trust.[49] Aspen own 70% of the company and the consultant ophthalmologists own 30%.[50]

152. Midland Eye is heavily reliant on NHS funding. Of the 21,000 episodes of care at the hospital between July 2016 and August 2017, 81% were funded by the NHS. [51] Between 2014 and 2018 439 patients were referred to Midland Eye from the Ophthalmology Directorate of the Heartlands Trust at a cost of £343,713.[52]

Example 5: Spire Healthcare and NHS Trusts

153. NHS Hospital Trusts often outsource elective procedures to private hospitals such as those owned by Spire Healthcare in order to deliver treatment for patients within the mandatory waiting time limits. We examined the accounts of seven NHS trusts where consultants who own shares in Spire Healthcare Group plc work. The consultants who own shares in Spire Healthcare Group plc also work at Spire hospitals.

154. Unlike the examples given above, the consultants identified do not own shares in a specific healthcare facility. Instead the relevant consultants are said to own "less than 0.1% shares in Spire Healthcare" – i.e. the corporate owner of all Spire hospitals. However, this does not mean that their shareholding in Spire is insignificant, – anyone owning 0.1% of Spire's shares in February 2019 would own shares worth approximately £490k.[53]

155. Through examining all the payments over £25,000 made by hospital Trusts we identified that between 2015 and 2018 these 7 trusts made payments of £23m to Spire Hospitals to carry out work on behalf of the Trusts. Barking, Havering and Redbridge NHS Trust made payments of £1.2 million to Spire during this period. Ten consultants who worked at Barking (and at Spire Hospitals) owned shares in Spire.

156. Due to the limited nature of the publicly-available data we are not able to say whether the consultants owned the shares at the time the payments were made to Spire's hospitals.

Table 6. Payments by NHS hospital Trust to Spire Healthcare

NHS Trust	Number of NHS consultants with shares in Spire	Value of payments (2015)	Value of payments (2016)	Value of payments (2017)	Value of payments (2018)	Total
Barking Havering and Redbridge NHS Trust	10	£605k	£498k	£131k	–	£1.2m
Basildon and Thurrock NHS Trust	3	£192k	£2k	£12k	–	£206k
East Sussex NHS Trust	2	£259k	£623k	£461k	–	£1.3m
Frimley NHS Foundation Trust	4	£338k	£390k	–	–	£729k
North Bristol NHS Trust	2	£5.7m	£5.8m	£4.1m	62k	£15.7m
University Hospitals of Birmingham[55]	2	£3.7m	£179k			£3.9m
Worcestershire Acute Hospitals NHS Trust	2	£177k	£78k			£255k
Total	**25**					**£23.2m**

RESEARCH FINDING 4: There are a number of NHS consultants who own shares in NHS Private Patient Units in conjunction with international private healthcare company HCA Healthcare UK

157. Under the Health and Social Care 2012, NHS Trusts are permitted to earn up to 49% of their total income from private patients.

158. Over the last decade The Christie NHS Foundation Trust in Manchester, UCLH Foundation Trust and Guys and St Thomas' Foundation Trust in London have entered into arrangements with the US healthcare company HCA Healthcare International Ltd to run their "Private Patient Units" for the provision of private cancer treatment.

159. These are highly opaque arrangements which are not referenced in any detail in the accounts or annual reports of the NHS Trusts involved. These arrangements involve consultants who work in the NHS hospital and also provide treatment to patients in the private patient units. Given the vulnerable situation of cancer patients, the existence of any financial incentives to refer patients in this area of healthcare provision might reasonably be deemed problematic.

160. A number of consultants own shares in the joint venture companies with HCA which run the private patient units. This means that there is the potential for them to earn fees for treating the patient privately and a share of the profits made by the private patient unit. This potential income would be earned on top of a consultant's NHS salary.

161. In theory, this provides a strong incentive for NHS consultants to treat patients privately rather than on the NHS. However, we have not identified any instances where patients seeking NHS care have been referred to these private patient units by consultants with shares in the private unit. The existence of these financial incentives does not mean that this is how these consultants with shares are behaving or are likely to behave.

162. However, the fact that only very few of the public declarations of interest which NHS Trusts are required to make include any reference to the shares owned by the NHS consultants in the companies which run the Private Patient Unit is concerning. In addition, the annual reports of the Trusts do not make clear the financial relationship between the company providing the private patient unit and the employees of the NHS Trust.

Arrangements between HCA Healthcare UK, The Christie NHS Foundation Trust and NHS consultants

163. The Christie NHS Trust formed a company with HCA Healthcare UK in 2010 to run its private patient unit.[55] This joint venture has established a subsidiary company called LOC @ The Christie Clinic LLP (i.e. 'the Christie Clinic'), of which HCA and the Christie own 90% between them.[56] [57]

164. Some of the other shareholders of the joint venture LOC @The Christie Clinic LLP are NHS consultants who work for the Christie NHS Trust.[58] These consultants also undertake work at the Christie Clinic and receive payment for doing so on top of their NHS salaries.[59] They own the remaining 10% of the shares along with other consultants and small companies who are also shareholders.

165. The profits from the treatment of private patients are divided between the various members who have shares in the various joint ventures. In 2017-18 The Christie NHS Trust received £4.8m as its share of the profits [60] It is not possible to say how much individual consultants who work at the Trust made from their share ownership.

166. This is a highly complex set of arrangements, but in short it means that the Christie NHS Hospital is is engaged in a joint profit making venture with its own employees and HCA Healthcare for the provision of private cancer care.

Arrangements between HCA Healthcare UK, UCLH and NHS Consultants

167. Since 2007 UCLH hospital has leased part of its hospital in Central London to HCA Healthcare UK to provide cancer treatment to patients paying privately. The Trust receives income of £12.6m a year from HCA as part of this arrangement, money which it counts towards its total private patient income.[61]

168. The company which provides the private treatment is a joint venture between HCA Healthcare UK and medical consultants, a number of whom are employed by UCLH and who also work in the private patient unit and receive fees from the private patients for doing so.[62]

169. The company operates under the name Leaders in Oncology Care (LOC).[63] According to Companies House accounts, HCA owns 79.2% of this company, the remainder of the shares being split between the NHS consultants and other smaller companies.[64]

170. Being members of the joint venture entitles the consultants to a share of the profits which are made each year in proportion to the number of shares held. The LOC Partnership LLP made £15.4m in 2017 and most of this profit went to HCA as the main shareholder. It is not possible to say how much the consultants made out of this arrangement[65]

171. This is also a complex financial arrangement. In this instance NHS consultants who work at UCLH are engaged in a joint venture with HCA Healthcare UK to provide private patient services on behalf of the NHS hospital.

Arrangements between HCA Healthcare UK , Guys and St Thomas' and NHS Consultants

172. Guys and St Thomas' NHS Trust in London have also entered into a joint partnership with HCA Healthcare International to provide cancer treatment to private patients. Like UCLH, Guys have leased part of their hospital to HCA Healthcare in return for a fee.[iii] This private treatment unit occupies four floors of the new Cancer Treatment Centre at London Bridge and also part of a wing of an existing hospital on the London Bridge campus.

173. The company which provides private cancer treatment in this facility at Guys Hospital in London Bridge is a joint venture between HCA and a number of consultants. HCA own 79.3% of this company with the remainder being owned by a number of consultants and small companies.[66]

174. Again, some of the consultants who provide private cancer treatment to patients in the Trust's private patient unit are employed by Guys as NHS consultants and also own shares in the company which runs it.[67]

iii The Office of Fair Trading looked at this arrangement when it was first proposed in 2012 However, it is not possible to say how much Guys receive from LOC @London Bridge LLP as part of this arrangement as these are not noted in the Trust's Annual Report and Accounts. See Office of Fair Trading 'Anticipated lease by HCA International Limited of premises from Guy's and St Thomas' NHS Foundation Trust'November 2012 https://assets.publishing.service.gov.uk/media/555de2e4ed915d7ae2000037/HCA.pdf

RESEARCH FINDING 5: Corporate Hospitality provided to referring clinicians by Private Hospitals

"In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime."

(OIG, A Roadmap for New Physicians: Fraud & Abuse Laws)

175. The provision of corporate hospitality by private hospitals may be considered by some to be a trivial issue from an ethical point of view. However, any hospitality which is provided to consultants who refer patients to private hospitals is not intended as an employee benefit or a thank-you. It is designed to affect, however marginally, their decisions about patient care, as to the place where treatment should be provided or the type of care which is recommended.

176. It is to prevent decisions being influenced in this way that NHS England prohibits NHS staff from receiving gifts from companies that their NHS organisation is likely to do business with, and limits the value of meals and accommodation that that they can receive from an organisation or business to £75.

177. The CMA 2014 Order, on the other hand, contains no prohibitions relating to the provision of corporate hospitality to referring clinicians, and sets no limits on the value of such hospitality or any restrictions on whether clinicians can accept such hospitality. The only requirement is for private hospital companies to publish the value of this hospitality.

178. Again, this is in contrast to the US regulatory framework which prohibits the giving of gifts with a non-monetary value which is designed to generate or reward patient referrals to hospitals. Where a non-monetary gift that is not intended to generate a patient referral is given, the value is limited to $392 per year for each clinician.[68]

179. Because of the potential for corporate hospitality to be used as a way of inducing referrals to hospitals under the Medicare and Medicaid system, the US regulatory authorities take this issue seriously. For example in 2016 Boston University Eye Associates agreed to pay $50,000 for allegedly violating the law by providing improper remuneration in the form of holiday gifts, consisting primarily of candy and other small food items, to physicians and physician practices which were referral sources.[69]

180. Through reviewing all the websites of the private hospitals we were able to compile data on the value of the corporate hospitality provided to the consultants who referred patients to the hospital and the type of corporate hospitality provided.[iv]

181. Table 7 shows the estimated expenditure on corporate hospitality by the major private hospital companies in the years 2017 and 2018. We estimate that the total amount spent across 119 hospitals was in the region of £990,000**,** with the great majority of this coming from one company, Spire Healthcare.

Table 7. Estimate of private hospital companies corporate hospitality in 2017 and 2018

Hospital Company	BMI	Ramsay	Aspen	Spire	BUPA Cromwell	Nuffield Health	HCA	Total
Estimated Total value	£70K	£58k	£80K	£977k	£91K	£140k	£85k	£1.5m
Number of hospitals for which data is available	24	22	6	32	1	27	7	119
Average hospitality per hospital	£3k	£2.6k	£13k	£30k	£91k	£5k	£12k	£12.5k

182. The types of corporate hospitality provided by private hospitals to referring consultants are quite varied. The most significant form of expenditure relates to sporting events, with around £582,000 being spent mainly on tickets and hospitality at rugby, football, tennis and cricket matches and some other events such as golf competitions.

183. In addition, a significant amount, £205,000 is spent by private hospitals on dinners for consultants and for medical advisory committee members and around £272,000 was spent on Christmas parties. A further £25,000 was spent on Christmas gifts and hampers with a value ranging from £50 – £150. Other types of hospitality include charity balls, rifle days, events in the House of Commons and comedy nights and concerts.

Table 8. Breakdown of corporate hospitality by type across all private hospitals recording data.

Total number of hospitals = 119

Form of Hospitality	Estimated Total
Sporting Events	£582,579
Consultant Dinners including Medical Advisory Committee Dinners	£205,757
Meetings including Annual General Meetings and networking	£303,999
Christmas Parties	£272,511
Christmas Gifts	£24,812
Social Events	£107,759
Total	**£1,497,418**[1]

iv In general we found a lack of consistency in how this information was being reported by private hospital companies. In some cases we found that data was only provided in terms of the cost of hospitality per head or the total cost of the event, whilst for others it was the total cost of the event including the cost per person. Again, as in the case of the other reporting requirements, there was no data available for Bennenden Hospital, Edward VII private hospital or the hospitals owned by Genesis Care and Optegra.

184. The figures set out here are, however, likely to be an underestimate. Ramsay Healthcare says on a number of its hospital websites that it will not declare any events hosted by the hospital which have a material value of less £1,000.[v] This is in addition to the lack of any declarations on corporate hospitality from a number of private hospital companies.

185. In order to compile these figures we have also had to make some estimates of the likely value of the corporate hospitality provided by the companies because some key pieces of information are missing. A full breakdown of the calculations that we have made to arrive at these figures can be found in Appendix 1 to this report, which is available on our website.[70]

186. It appears that Spire's corporate hospitality for referring clinicians is much more lavish than other private hospital companies. It had the highest average spend per hospital (only BUPA's Cromwell Hospital spent more) and appears to provide what might be considered "high-end" corporate hospitality. For example, it provided 10 of its referring consultants with tickets to the England versus France Rugby match in February 2017 at a cost of £1,226 per person; tickets to Wimbledon costing £894 per person and tickets to England versus the West Indies Cricket match in September 2017 costing £1,068 per person.

Table 9 Breakdown of Estimated expenditure on corporate hospitality by Spire Healthcare based on data from Spire Hospital Websites – Total number of hospitals = 32

Form of Hospitality	Estimated Value
Sporting Events	£503,033
Meetings	£177,504
Dinners	£135,139
Christmas Parties	£107,487
Christmas Hampers	£12,133
Social Events	£42,583
Total	**£977,880**

187. In considering this data it is important to remember that the CMA Order permits corporate hospitality only if it is "proportionate and reasonable", and should not be intended as, and may not reasonably be regarded as, an inducement to refer patients.

v See as an example the CMA declarations for the Duchy Hospital https://www.duchyhospital.co.uk/legal-and-regulatory/hospitality

188. The CMA did, however, consider whether some of these schemes may fall within the scope of the Bribery Act 2010. This Act prohibits payments which '*represent an effort to induce performance which is contrary to good faith, partial, or in breach of trust'*. They concluded that:

"It is possible […] that a jury could find that the provision of referral fees did constitute an offence. In particular, a jury could find that consultants ought to exercise their power of referral impartially and that a referral fee encouraged them to do so partially." [71]

189. It should also be borne in mind that the Bribery Act 2010 prohibits any payment or financial inducements which represent an effort to induce performance which is contrary to good faith, partial, or in breach of trust'.

190. It is reasonable to ask whether a ticket to a cricket match worth £1,086 or a rugby match worth £1,226 would breach both the CMA Order and also the Bribery Act. Furthermore it should be noted that the Bribery Act also applies to individual consultants: Section 2 of the Act makes it an offence to request, accept or agree to receive a "financial or other advantage"– which could include non-monetary gifts such as hospitality – to improperly perform a relevant function.

191. In addition, if we assume that the majority of those who are in receipt of this hospitality are NHS consultants the receipt of any gifts, and of any meals and accommodation worth more than £75, would put them in breach of the NHS England guidance on conflicts of interest.

Part III: Conclusions and Recommendations

192. The evidence in this report demonstrates that both the regulatory framework established by the Competition and Markets Authority, and the guidance which has been put in place by NHS England to prevent financial incentives distorting patient care, are ineffective. In addition to the fact that the non-compliance with the law which we have identified has not been rectified, and perhaps not even detected, by the CMA, there are no penalties for non-compliance. This contrasts strongly with the US regulatory framework which applies to many of the healthcare companies operating in the UK, whereby the penalties for non-compliance are significant and where conflicts of interest are prohibited rather than just declared and managed.

The Competition and Markets Authority should not be responsible for the law governing financial incentives in the UK healthcare system

193. The CMA is currently responsible for the only legal provisions governing the use of financial incentives in the health sector. Its statutory remit relates only to preventing harms resulting from anti-competitive practices and it is not mandated or competent to act to address the potential harm caused to patients as a result of over treatment or the wasteful use of scarce public healthcare resources. Moreover, it is not accountable to Parliament for making or enforcing legal orders and operates independently from the Department of Health, which ought to take the lead in this area of health policy.

Conflicts of Interests should not be managed but prohibited

194. The scale of the problem identified here shows that there is significant potential within the UK healthcare sector for financial incentives to be used to distort the clinical decision making of medical consultants. As a result we consider that the UK needs to move to a similar approach to the US whereby there is firm prohibition on conflicts of interest rather than an attempt to manage them. A statutory framework should be developed by the Department of Health which sets out clear prohibitions on the offer or receipt of financial incentives to refer patients to private hospitals.

Punitive sanctions in the form of fines and in extreme cases custodial sentences should be introduced for any breaches of the law

195. Because of the risk of patient harm which can result from overtreatment, and because of the significant potential for defrauding the NHS, this statutory framework should be backed up by punitive sanctions.

The Care Quality Commission or NHS Improvement should have the resources to monitor and enforce the law

196. Finally, resources should be identified by the Department of Health to monitor and enforce this law and this role should be undertaken by the regulator of NHS Trusts NHSI in conjunction with the regulator of private hospitals the Care Quality Commission.

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