CHARITY COMMISSION
Review Decision made on the
application for registration of
ODSTOCK PRIVATE CARE LIMITED

dated 25 September 2007

ISSUE

1. The Commission considered on review an application by a company limited by guarantee called “Odstock Private Care Limited” (“Odstock”) for registration as a charity. If the company is established as a charity, it should be entered on the Central Register of Charities under section 3(2) of the Charities Act 1993.

DECISION

2. The Commission having considered:
   - the case that had been put to it on behalf of Odstock, including submissions and supporting evidence; and
   - the relevant law and the governing document and the relevant or proposed activities of Odstock;

   concluded that Odstock is not established for exclusively charitable purposes and cannot be entered onto the Central Register of Charities.

3. This review decision was taken by John Williams, Lindsay Driscoll and Simon Wethered, Board Members (“the Delegated Members”) on behalf of the Commission, under delegated authority, and ratified by the Board, at its meeting on the 25 September 2007

4. John Williams and Simon Wethered declared a potential conflict of interest in that they hold private medical insurance.

ANALYSIS

Background - Establishment, objects and activities

5. Odstock’s objects are: *to relieve sickness and to preserve and protect the health of patients by providing and assisting in the provision of healthcare facilities and ancillary services at Salisbury District Hospital*.

6. A “Summary Business Plan” for Odstock accompanied the application for registration. It explained that there is a statutory limit on the capacity of Salisbury NHS Foundation Trust (“the Foundation Trust”) to benefit financially from private health care work in Salisbury District Hospital (“the Hospital”). However, an increasing number of clinicians wished to bring private work into the Hospital. It was legally possible to form a separate company (independent of the Foundation Trust) to

promote the undertaking of private patient work (with profits being applied to improve NHS patient services at the Hospital).

7. Odstock was formed for such a purpose by means of a loan from the Foundation Trust. It would (a) enter into agreements with patients and insurance companies for the provision of private care and (b) contract with the Foundation Trust for the provision of staffed facilities to enable that work to be carried out by clinicians. Only facilities actually used would be paid for by Odstock. Odstock's general manager would administer the arrangements (in particular, liaising with consultants and insurance companies and further developing private care). Initially, Odstock's activities would cover arrangements by consultants working at the Hospital. A consideration in setting up Odstock had been to ensure that the needs of consultants in performing private patient work were met. Agreements with insurance companies would be entered into to enable private work to be undertaken for them.

Initial rejection and applicants' response

8. The application was initially rejected on 26.01.2007 on grounds of lack of public benefit, the arguments against registration then being that:

   a. the arrangements were to facilitate the practice of private medicine at the Hospital which would benefit medical practitioners, insurance companies and the Foundation Trust. Odstock seemed merely the administrative machinery whereby this was achieved. In particular, the arrangements facilitated the practice of private medicine by a limited number of medical practitioners at the Hospital for the benefit of their own patients in some cases in conjunction with insurance companies

   b. if the effect of charging is to exclude the less well off from benefit, then it cannot be for the public benefit.

9. In their response the applicants asserted that the proposed arrangements would effectively and lawfully operate so as to increase the scope for private patient care and also the benefit to the Hospital. (The arrangements between Salisbury NHS Foundation Trust and Odstock had been subjected to detailed review by the Audit Commission and found to be fully in accordance with the legal powers of the Foundation Trust; and to meet the requirements laid down in the *Health and Social Care Act 2003* – now in the *National Health Service Act 2006*.)

10. The Commission was assured that a more general referral system to Odstock involving GPs is now in place. Odstock operates on very low margins indeed. It has its own administrator who is directly contacted by consultants or their secretaries to arrange the necessary facilities. It was not obligatory to make use of one of a defined group of consultants. The reason Odstock must operate through consultants is

not principally to afford those consultants further opportunities for private work. It is because the healthcare system in England is so arranged that referrals are made directly to consultants by GPs. It would be impracticable, given Odstock's current resources, to put in place an administrative and medical infrastructure whereby people could walk in off the street seeking medical attention and then be assessed and assigned to the appropriate medical care. Information about Odstock had been disseminated to medical practices in Salisbury, Amesbury, Upavon, Durrington, Shrewton, Ludgershall, Tidworth, Downton, Whiteparish, Fordingbridge, Warminster, Fovant, Mere, Hindon, Wilton, Tisbury, Silton, West Lavington, Market Lavington and Devizes. Such information had described the services on offer generally to patients and the benefits to the Foundation Trust of referring patients seeking private treatment into the Odstock system. No particular consultants were specified or recommended.

11. The applicants denied that individual private benefit was a principal object of Odstock.

    a. With regard to medical practitioners:
       There was no requirement to use any particular consultants. Charges made by individual medical practitioners are in accordance with a tariff generally agreed (here and elsewhere in England) with insurers. Given that treatment cannot be given unless practitioners are paid, payment in accordance with a fairly and centrally agreed tariff was incidental to the achievement of a charitable purpose.

    b. With regard to insurance companies;
       Insurers need not be involved in any particular transaction. But, in any event, insurance arrangements would serve to increase public accessibility and hence public benefit.

    c. With regard to the Foundation Trust:
       Any benefits it enjoyed were for the body delivering public health care services, from which is derived (as a main aim) no private profit.

12. The identity and composition of the governing body of Odstock did not disclose any personal economic connection with any given medical practitioners. One had a connection with the NHS Foundation Trust.

13. The applicants reiterated that the true aim was to provide low-cost treatment to patients. They said that the facilities are available to the public at large (there being no condition of membership of the charity, and no geographical or other condition imposed on patients wishing to avail themselves of the company's services). Odstock offers access to the Hospital's facilities at times when those particular facilities would be

idle (allowing paying patients in need of an operation to have it more quickly than an NHS waiting list would allow).

14. The applicants further asserted that Odstock did not entirely exclude those having a low income from indirect and direct benefit.

    a. Salisbury is an affluent area (where ‘low income’ may have a different meaning than it would when applied to other areas). If the charges levied are sufficiently low as to be affordable by people on low incomes in that particular area, then a financial-assistance scheme should not be necessary to achieve charitable status. Odstock’s charges are lower than other local private providers. This was because they had fewer overheads and were committed to keep the charges as low as possible. Thus people on low incomes in Salisbury can access treatment.

    b. “Any surpluses” will be ploughed back into additional NHS facilities available generally at the Hospital. Directly, such application of surpluses from Odstock to the improvement of facilities within the Foundation Trust will confer public benefit which is not mediated through the need to be able to afford treatment in any way.

    c. Further, even if not sufficient of itself, it is also the case that treating some patients privately will have knock-on effects on the efficiency of the hospital for NHS patients generally including those on low incomes. Indirectly, the optimal use of public facilities such as operating theatres which would otherwise be idle and the overall reduction in patient waiting times through the diversion of NHS patients onto the Odstock list would benefit the Foundation Trust’s public objectives.

    d. Insurance was available to poorer patients. This tells for charity. It was by means of the cost-spreading of insurance that poor patients could access treatment. Odstock currently provides services to patients from BUPA, AXA, PPP, and Standard Life. It was not possible to say what the premiums would be because they depend on the type of cover and the insured’s circumstances and medical history. Beyond an indication that such medical insurance is generally reckoned to be accessible, there was no positive evidence submitted in this case that medical insurance is affordable by poor people.

THE REVIEW

15. The Board dealt with the review initially by delegating the review decision to three board members (the Delegated Members) to consider, and for their decision to be ratified by the full Board. The Delegated Members considered that for a charity to be established, the

Commission would need to see an independent entity with objects for relieving sickness and promoting health for a public class for the public benefit.

16. Any connection (or former connection) between any of the directors of Odstock on the one hand and the Foundation Trust on the other need not impact on the potential charitable status of Odstock.

17. The Delegated Members accepted that Odstock's activities were directed to providing drawn-down facilities at the Hospital and liaising with healthcare professionals to provide for relief of sickness and preservation of health. It is possible for charities to operate where all of the actual work in the field is being done by others[1]. The principal purpose of the Foundation Trust under its constitution as a public benefit corporation is directed to providing goods and services for the purposes of the health service in England. Whilst such a broadly stated purpose may not necessarily be exclusively charitable (the Commission has made no decision in that regard) it is accepted that a gift for the purposes of an NHS hospital would be charitable[2].

18. However, a charity has to have purposes which are exclusively charitable for the public benefit. If an organisation cannot be shown to have objects which are exclusively charitable for the public benefit, then the Commission is not able to register it as a charity. Whether an organisation's purposes are apt to operate for the public benefit is a question of fact to be decided on the evidence[3].

19. The facts seem to the Delegated Members to disclose that Odstock's scheme is not available to the public at large but only to those with the ability to pay the fees.

20. The Delegated Members did not accept that, if in fact Salisbury were generally economically more fortunate than other areas, that would be relevant in this particular case. The Commission would need evidence that the opportunity to benefit was in principle available to the public generally. That must include the whole range of the public from those living in poverty to those who were well off. In particular, people living in poverty must not be excluded from benefit. The scales of charges indicated in the tariffs specified in correspondence were sizeable. The Delegated Members did not accept that they were affordable by everyone. Illustrative sums ranged from £661 for a colonoscopy to £8,063 for a knee replacement. People living in poverty (even the poor

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[1] See the various examples in Annex A to the Commission publication RR14 on Promoting the Efficiency and Effectiveness of Charities and the Effective Use of Charitable Resources for the Benefit of the Public

[2] cf *Re Smith* [1962] 1WLR 763. See *Re Frere* [1951] Ch 27; *Re Ginger* [1951] Ch 458.

[3] *In Re Hummeltenberg* [1923] 1 Ch. 237 (Chancery Division), Russell J at p.242 (approved by the House of Lords in *National Anti-Vivisection Society v IRC* [1948] AC 31); see also *McGovern v Attorney-General* [1982] Ch. 321, Slade J at p.333

of Salisbury) could not afford to pay sums of that order. They would therefore not have access to those particular services.

21. Some public benefit from Odstock's activities was claimed by reason of surpluses going back to support NHS provision generally for the sick at the Hospital. However, the evidence was that such surpluses are likely to be minimal since the organisation is said to be operating (as a matter of practice and policy) on very low margins. The Delegated Members did not consider this to be sufficient[4].

22. It may be inferred that the availability of private health provision may impact on NHS waiting lists. Indirect benefits, such as possible reduction in waiting lists, enter into the account and would be considered alongside direct benefits. However, in this case, the Delegated Members did not consider that any such inference would, of itself (and failing the demonstration of more direct benefits), be sufficient to establish that Odstock's purposes may so be operated as to benefit the public generally including those living in poverty.[5]

23. The evidence was that Odstock would not, at least at present, provide patients on low incomes with exemption from charges. Failing direct provision of financial assistance by Odstock to poor people who were sick (in order to help them access Odstock's services), they would need to fall back on insurance. The Delegated Members found that the cost of medical insurance had not been shown to be affordable by all members of the community. It was appreciated that insurance premiums depend on the type of cover and the circumstances and medical history of the proposed insured. But reliance could not be placed on any generalised view that medical insurance is reckoned to be accessible. It does need to be shown here, with evidence, that relevant insurance is affordable by people on low incomes. The Commission did not have profiles on who is able to purchase insurance, but the Delegated Members considered that they are more likely to be higher earners. The Delegated Members did not accept, in the absence of positive evidence, that the cost of private health insurance is affordable by poor people, so as to afford access to the facilities provided by Odstock.

24. The facts of this case were in other respects distinguishable from those of *Re Resch*[6]. In that case, the degree of complementarity between the private hospital provision and that of the public hospital was closer

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[4] and, of course, the dedication of surpluses generated by a particular activity to charitable purposes would never, merely of itself, conclusively establish the pursuit of that activity as a charitable purpose for the public benefit: cf *Oxfam v Birmingham City District Council* [1976] AC 126

[5] 'The Delegated Members noted an apparent conflict between the fact that hospital facilities would only be used when not being used for NHS patients, and the fact that Odstock's clients are, according to its literature, offered appointments at a time to suit them. There was no further evidence on the point. The Delegated Members did not think this sufficient of itself for them to infer that any disadvantage to the availability of public service provision at the Hospital had been established.

[6] *Re Resch* [1969] 1 AC 514

and clearer (and the benefit flowing to the public hospital provision seemed more significant). For example, the evidence in that case was accepted that the separate private hospital facilities were such as to attract a higher calibre of medical staff who might treat the patients in the public hospital. That is not so in this case. The facilities used by Odstock were NHS facilities, currently not being used for NHS provision.

CONCLUSION

25. For the reasons given in paragraphs 20 – 24, the Delegated Members concluded that those living in poverty had not been shown to be capable of benefiting in a real sense, either directly or indirectly. The requirement for the applicants to show public benefit in this case was not in the view of the Delegated Members, discharged. They were unable to accept the application for registration.

Ends