HOUSE OF COMMONS LIBRARY

BRIEFING PAPER

Number CBP 8190, 6 July 2018

Accountable Care Organisations

By Alex Bate

Contents:

Contents

Summary

An Accountable Care Organisation (ACO) is a model of healthcare provision where a provider, or group of providers, takes responsibility for the healthcare provision of an entire population. There is no fixed definition of an ACO, but the organisation usually receives an annual, capitated budget to deliver contractually agreed health outcomes.

The NHS in England's *Five Year Forward View* (2014) agenda focuses largely on the greater integration of healthcare providers to offer a more joined-up service for patients. The current Government views ACOs as a way to help deliver this.

In August 2017, a draft ACO contract was published, which will allow Clinical Commissioning Groups (CCGs) to choose to commission ACOs in their areas. The Government has argued that some regulatory changes will be required in order for the ACO contract to be used. Currently there are only plans to trial the ACO contract in two areas, Dudley and Manchester, before consideration of a wider rollout of the model across England.

It was initially intended that regulatory changes would be introduced by February 2018, but this has since been delayed until NHS England undertakes a wider consultation on the contract. The NHS England consultation has not yet been launched, so as to allow for the publication of the Health and Social Care Committee's report into ACOs (published in June 2018), and the conclusion of two judicial reviews against the contract (concluded in May and July 2018 respectively, both of which were rejected).

The proposed introduction of ACOs in the NHS in England has generated some commentary as to a potential increase in private sector involvement, in part due to the model's origin in the American healthcare system. This interpretation has been disputed by the Government and by the Health and Social Care Committee.

This briefing paper explores the above, as well as the future roles of CCGs and GPs in an ACO system.

As health is a devolved area, this briefing looks at England only.

1. Accountable Care Organisations (ACOs)

1.1 What are ACOs?

The term Accountable Care Organisations (ACOs) refers to an area-based model of healthcare provision, where a single body takes responsibility for the health needs of its entire population.

Although there is no fixed definition of ACOs, most usually include the following elements:

- They involve a provider or, more usually, an alliance of providers that collaborate to meet the needs of a defined population.
- These providers take responsibility for a budget allocated by a commissioner or alliance of commissioners to deliver a range of services to that population.
- ACOs work under a contract that specifies the outcomes and other objectives they are required to achieve within the given budget, often extending over a number of years.

The intention of ACOs is to operate in a more integrated manner than healthcare models that pay per procedure carried out, as well as a greater focus on prevention and health promotion.[1]

The ACO approach was developed primarily in the American healthcare system. Since the Affordable Care Act was signed into law in 2010, the USA has seen a significant increase in the number of ACOs. There is no defined model of how an ACO should be organised, with significant variation in the extent to which individual organisations are contractually integrated.

One of the more fully integrated American ACO models, Kaiser Permanente, with a single system and payment mechanism across all types of care, has been cited by the Health and Social Care Secretary, Jeremy Hunt, as an example of best practice in integrated care, alongside the Ribera Salud Grupo in Spain.[2]

According to a 2014 analysis of American ACOs by the King's Fund, outcomes are mixed, particularly with regards to cost savings. However, the overall picture showed "some modest cost savings, mostly due to reduced A&E visits and lower hospital readmissions."[3]

Dr Ashish Jha, Director of the Harvard Global Health Institute, has argued that in order to import the ACO model to the UK successfully, there will need to be a change in IT delivery and in working culture:

> While this (ACO) model is extremely promising, there are important issues that will likely need to be addressed:

---

1 Further information can be found at The King's Fund, *Accountable care explained*, January 2018

2 HC Deb 9 June 2014, c293

3 The King's Fund, *Accountable care organisations in the United States and England: Testing, evaluating and learning what works*, March 2014, p6

> The first is having a health IT system that can facilitate true population health management. This means that all parts of the healthcare delivery system (and potentially other sectors, such as social services) must be on an electronic platform and be able to communicate seamlessly with each other. Even though a majority of physicians and hospitals now have robust electronic health records in the U.S., critical patient data does not easily flow across these providers, making population health management extremely difficult.
>
> The second big challenge is in shifting the culture and mindset of providers. In the U.S. ACOs identified that getting physicians to change their practice style from a fee-for-service approach to an integrated, population-health approach is very challenging. Surely, this kind of change will be a challenge in the UK as well, and all the evidence suggests that it takes time and persistent effort.[4]

1.2 ACOs in the NHS

NHS England's 2014 *Five Year Forward View* (5YFV) publication first introduced the concept of ACOs as an approach to integrate primary and acute medical care in the NHS. They were cited as a similar model to the Primary and Acute Care Systems (PACS) new care model (see Box 1 below for more information on PACS):

> At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.[5]

Between 11 September and 3 November 2017, the Government carried out a consultation on proposed changes to regulations which would allow for the introduction of a model ACO contract (see section 1.3). It was initially intended that regulatory changes would be introduced by February 2018, but this has since been delayed until NHS England undertakes a wider consultation on the contract. The launch of the NHS England consultation was delayed to allow for the publication of the Health and Social Care Committee's report into ACOs, and the conclusion of two judicial reviews against the contract (see section 3).

The consultation also sought to clarify some of the terminology around ACOs:

> As the policy has developed, the terminology used to describe these new ways of providing and commissioning services has evolved. MCPs and PACS are two of the new models of care described in the Five Year Forward View. MCPs and PACS are both types of whole population provider. Where these models are formalised through the use of a contract, organisations delivering both the MCP and PACS care models are forms of ACO. For the purposes of some of the regulations, they are defined as an 'integrated services provider', to make it clear that this includes the type of ACOs in which primary

4 A Jha, 'US healthcare reform: Lessons for the UK', *Nuffield Trust comment*, 16 March 2015

5 NHS England, *Five Year Forward View*, October 2014, p21

medical services are commissioned through a single contract in an integrated way with other services.[6]

Box 1: New Care Models – MCPs and PACS

The 5YFV introduced seven 'New Care Models' to support better working between traditional healthcare divides (such as primary care, community care and hospital care). Two of these models, Multispecialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS) are precursors to the development of ACOs in the NHS.

Both are population-based care models based on the GP registered list, but vary in scope and scale. Both include primary, community, mental health and social care, but a PACS also includes most hospital services.

According to the MCP framework, an MCP will need a population of 100,000 at a minimum, but could be much larger, whereas a PACS will provide care for all the population served by its acute hospital trust, generally at least 250,000.

Following the publication of 5YFV, NHS England established nine PACS and 14 MCP 'vanguards' to trial the models, covering around eight per cent of the population of England. One of the MCP vanguard sites, Dudley, is one of two CCG areas set to trial the ACO contract, alongside Manchester.

The Department of Health and Social Care's *Mandate to NHS England for 2018-19* called for 20% of the population to be covered by new care models (including MCPs and PACS) by the end of the year and 50% by 2020.[7]

In June 2018, the Health and Social Care Committee published its report, *Integrated care: organisations, partnerships and systems*, which looked in part at the development of ACOs. In evidence from the Chief Executive of NHS England, Simon Stevens, the Committee heard that there would not be an expectation or obligation for local areas to introduce ACOs, and instead they would be one of many contractual options available. However, the Committee highlighted potential differences between this interpretation and evidence given by the Health Minister, Steven Barclay:

> Stephen Barclay, Minister of State for Health, referred to plans to "pilot" ACOs in Dudley and the City of Manchester. The Government's response to the proposed regulatory changes to enable an ACO contract stated that legal directions, once consulted on, would be limited to Dudley and the City of Manchester. However, as yet we have not seen any detailed proposals setting out the parameters of these pilots: the time period, the outcomes they seek to measure, or how the pilot will be evaluated. The Minister also said that pilots of ACOs are in part being carried out to assess the budget that is needed to transform care across the wider NHS…
>
> […]
>
> The Minister's evidence also implies that these pilots will be used to assess the level of transformation funding that is required across the NHS. The need for transformation funding in our view is urgent and should not wait for the results of a small pilot of ACOs. Also, the Minister's comments appear to contradict Simon Stevens's statement

6 Department of Health, *Accountable Care Organisations: Consultation on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable Care Models)*, September 2017, p5

7 Department of Health and Social Care, *The Government's mandate to NHS England for 2018-19*, March 2017, p20

that the ACO contract will be an option for local areas (including those other than Dudley and the City of Manchester).[8]

The Committee recommended that if ACOs were to be implemented more widely across the NHS in England, they should be established in law as NHS bodies. This would require a 'fundamental revisiting' of the *Health and Social Care Act 2012*.

The Government has not yet responded to the Committee's report and recommendations.

1.3 Draft ACO contract

In August 2017, NHS England published a draft ACO contract. Three levels of GP participation were envisaged as part of these new contractual arrangements, which vary in the extent to which GPs are contractually bound into the new organisation. The three levels are:

- Full integration – The ACO brings together all primary care services operating under a single, integrated budget.
- Partial integration – The ACO excludes primary services covered by the General Medical Services (GMS) and Personal Medical Services (PMS) contracts held by most GPs. Additional contractual arrangements are made between the ACO and GPs to achieve operational integration.
- Virtual integration – where separate commissioning contracts are bound together.[9]

  In this model, providers would enter 'alliance agreements' with the commissioning bodies, which would overlay regular commissioning processes. Providers would likely agree to work towards greater integration.

  Although this model is explored in supporting documents for the draft ACO contract, virtual integration would not require the use of the contract itself.[10]

A *Health Service Journal* report on the model contract highlighted various organisational forms the ACO could take, including:

1. A GP owned organisation, which could take the form of a limited company by shares or limited liability partnership;
2. Corporate joint venture in which GPs and another organisation come together to form a new legal entity;
3. An existing NHS body, for example a foundation trust or NHS trust;

8 Health and Social Care Committee, *Integrated care: organisations, partnerships and systems*, 11 June 2018, HC 650 2017-19, para 125-7

9 The King's Fund refer to this non-contractual alliance model as an 'Integrated Care Partnership' (ICP): *Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England*, February 2018

10 NHS England, *Whole population models of provision: Establishing integrated budgets*, August 2017, p10

4. A "host arrangement", in which an organisation hosts the ACO contract but decisions are made through a "forum" of partners from other providers.[11]

The Government has argued that some regulatory changes are necessary to enact the draft ACO contract. These were consulted on between 11 September and 3 November 2017, and included proposed changes such as allowing GPs to suspend, rather than cancel, their contracts with NHS England in order to join an ACO. The consultation document stated that the Government hoped to have any regulatory changes in force by February 2018, and that consultation on a final contract would take place later in 2018.[12]

When asked in a December 2017 Parliamentary Question why the new regulations were intended to be introduced prior to a full consultation, Health Minister Steve Brine responded that changes were required to allow certain selected CCGs to test out the draft contract before it was finalised.[13]

When the Government's response to the consultation was published in April 2018, it was announced that the regulations would not be laid in Parliament until NHS England had carried out a wider consultation on the ACO contract.

This change was partially in response to concerns about the extent of the consultation, which had been raised by a number of commentators and stakeholders, including in an Early Day Motion sponsored by MPs including the Leader of the Opposition Jeremy Corbyn, in correspondence to the Government from the British Medical Association (BMA)[14], and as part of a judicial review launched against the contract (see section 3).

The Government's response to the consultation also announced a number of changes to the initially proposed regulations, including the removal of definitions setting out the exact form or responsibilities of an ACO, and the decrease of the notice period needed by GPs that had joined an ACO to reinstate a suspended GP contract from one year to six months.[15]

1.4 Integrated Care Systems (formerly Accountable Care Systems)

Next Steps on the NHS Five Year Forward View ('*Next steps')* introduced Accountable Care Systems (ACSs), which would see CCGs and providers (such as NHS trusts, GPs and community healthcare providers) within a

11 'NHS England reveals first national contract for ACOs', *Health Service Journal*, 7 August 2017

12 Department of Health, *Accountable Care Organisations: Consultation on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable Care Models)*, September 2017

13 PQ 115613 [Health Services], 4 December 2017

14 BMA, *Accountable care models contract: proposed changes to regulation*, November 2017

15 Department of Health and Social Care, *Accountable Care Organisations: Government response to consultation on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable Care Models)*, April 2018

Sustainability and Transformation Partnership (STP)[16] area working together to manage funding for their defined population.

ACOs and ACSs are similar sounding terminologies, however there are differences between the two.

The BMA briefing on ACOs states that the major difference between ACSs and ACOs is that with ACOs "there will be a single contract with a single organisation for the majority of health and care services in the area."[17] ACSs also involve CCGs as commissioners, getting them to work more closely together with providers such as NHS trusts and GPS, to plan care for their populations. ACOs however only integrate providers, with no formal role for CCGs.

Where areas agreed an accountable performance contract and jointly managed funding for their population, *Next steps* stated that ACS areas would be offered:

- Delegated local commissioning powers over primary care and specialised services (currently commissioned by NHS England);
- A devolved transformation funding package; and
- Streamlined oversight arrangements with NHS England and NHS Improvement, as well as staffing and funding support.[18]

In June 2017, the Chief Executive of NHS England, Simon Stevens, announced the first eight areas that would take on ACS status. Between them, these areas serve a population of close to seven million people and could potentially have control of transformation programme funding worth £450 million over the next four years.[19] The eight areas announced, covering either full or partial STP areas, were:

- Frimley Health including Slough, Surrey Heath and Aldershot
- South Yorkshire & Bassetlaw, covering Barnsley, Bassetlew, Doncaster, Rotherham, and Sheffield
- Nottinghamshire, with an early focus on Greater Nottingham and Rushcliffe
- Blackpool & Fylde Coast with the potential to spread to other parts of the Lancashire and South Cumbria at a later stage
- Dorset
- Luton, with Milton Keynes and Bedfordshire
- Berkshire West, covering Reading, Newbury and Wokingham
- Buckinghamshire.

It was also announced that West, North and East Cumbria, and Northumberland could join the group of ACSs later in the year, and that

---

16 More information on STPs can be found in the Commons Library briefing paper, *Sustainability and transformation plans and partnerships*.

17 BMA, *Briefing: Accountable Care Organisations*, February 2018

18 NHS England, *Next Steps on the NHS Five Year Forward View*, March 2017, pp35-7

19 'Simon Stevens names the first accountable care systems', *Health Service Journal*, 15 June 2017

devolution deals in Greater Manchester and Surrey Heartlands would also give more financial autonomy in return for greater integration.[20]

Next steps also set out a general aim for the ACSs to support moves towards ACOs at some point in the future:

> In time some ACSs may lead to the establishment of an accountable care organisation. This is where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in the area. A few areas… in England are on the road to establishing an ACO, but this takes several years. The complexity of the procurement process needed, and the requirements for systematic evaluation and management of risk, means they will not be the focus of activity in most areas over the next few years.[21]

However, *Next steps* does not explicitly set out how such a development would occur, particularly as ACSs involve CCGs whereas ACOs do not, and as ACSs broadly relate to STP areas, whereas ACOs relate to (smaller) CCG areas.

In February 2018, NHS England and NHS Improvement published *Refreshing NHS Plans for 2018/19*, which stated that ACSs would now be known as 'Integrated Care Systems' (ICSs), although it did not give any reason for the new name. The plans also set out new financial arrangements for ICSs and plans to create additional ICSs.

In May 2018, a joint board meeting of NHS Improvement and NHS England confirmed four new shadow ICS areas:

- Gloucestershire
- Suffolk and North East Essex
- West, North and East Cumbria
- West Yorkshire and Harrogate[22]

The Department of Health and Social Care's *Mandate to NHS England for 2018-19* called for 20% of the population to be covered by ICSs by the end of the year.[23]

---

20 NHS England, *NHS moves to end "fractured" care system*, 15 June 2017

21 NHS England, *Next Steps on the NHS Five Year Forward View*, March 2017, p37

22 NHS Improvement and NHS England, *Meeting in Common of the Boards of NHS England and NHS Improvement*, 24 May 2018

23 Department of Health and Social Care, *The Government's mandate to NHS England for 2018-19*, March 2017, p20

2. Role of CCGs

An ACO refers to the integration of healthcare providers (hospital trusts, GPs, community services etc.) into a single organisation. Its creation, however, also has an impact on the commissioners of healthcare services, particularly local Clinical Commissioning Groups (CCGs).

Under the *Health and Social Care Act 2012*, CCGs have statutory duties around the commissioning of healthcare for their populations. These will not be altered by the establishment of an ACO for an area. Although ACOs will be accountable through quality and outcomes measures in their contracts, they do not yet have a legislative basis and therefore statutory accountability will remain with CCGs and other NHS bodies.

The NHS England guide, *ACOs and the NHS commissioning system*, states that CCGs will not be able to delegate responsibility for their statutory roles but should work closely with ACOs in the delivery of healthcare services:

> CCGs will continue to be responsible and accountable for the delivery of their functions. They have the flexibility to decide how far to carry out activities related to these functions themselves; including in groups (e.g. through lead CCG arrangements); or through external commissioning support. They may also require, through contract provisions, an ACO provider to take action to support the discharge of certain CCG duties (e.g. to reduce inequalities or ensure patient choice). However, in all these instances the CCG will retain responsibility for its functions. These cannot be delegated. As part of the process of establishing an ACO, CCGs will need to assure themselves and NHS England of their ability to discharge their statutory functions.[24]

The guidance states that a shift in activities from a CCG to an ACO may entail changes to CCG governance structures, and may also require the creation of a pooled budget with a local authority (permitted under the *Care Act 2014*).

CCGs are also responsible for determining whether to commission an ACO for their area, and whether such a contractual arrangement is appropriate, as stated by Health Minister Steve Brine in an October 2017 Parliamentary Question response:

> It is for local commissioners to commission services according to the needs of their local population. The Commissioner must run a procurement process that is compliant with the principles of transparency and equal treatment.
>
> The CCG would need to be satisfied that the bidder can effectively provide the services in the required locality as specified within the tender, and the commissioner can design the award criteria to reflect the service being contracted, so could include, for example: ensuring quality, continuity of service, accessibility, affordability, availability, Care Quality Commission assessment, needs of vulnerable patients, teaching accreditation, continuity, and comprehensiveness of the services etc. Neither the advert nor the criteria should specify the organisational form of the body that will be awarded the contract. It

[24] NHS England, *ACOs and the NHS commissioning system*, August 2017, para 7

> will be for bidding providers to determine the ownership model of that provider.[25]

The Government has stated that CCGs are responsible for determining whether or not to commission an ACO,[26] based on its appropriateness for their area.

In the debate on the 2014 Queen's Speech, the Health Secretary Jeremy Hunt stated that:

> We are doing one more important reform: we are taking the first steps to turn the 211 clinical commissioning groups into accountable care organisations with responsibility for building care around individual patients and not just buying care by volume.[27]

This statement related to allowing CCGs to co-commission primary care alongside NHS England, rather than any changes to their statutory roles, but it was not stated whether any other changes were envisaged to 'turn CCGs into ACOs'.

In June 2017, the then Chief Executive of NHS Improvement, Jim Mackey, stated that "90%" of progress on the creation of ACOs could be made within the current legal framework, indicating that major changes to the statutory duties of CCGs were not forthcoming.[28]

---

25 PQ 105251 [Health Services: Contracts], 11 October 2017

26 Also see PQ 9710 [Health Services], 18 September 2017

27 HC Deb 9 June 2014, c293

28 'Mackey denies legal constraints as accountable care systems confirmed', *National Health Executive*, 19 June 2017

3. Legal challenges

The introduction of the draft ACO contract (see section 1.3) had faced two separate legal challenges, one from the campaign group '999 Call for the NHS', and another from a group of five campaigners including the late Professor Stephen Hawking, known as 'JR4NHS'.

Both cases were unsuccessful, although 999 Call for the NHS is currently considering whether to appeal their judgement.

3.1 999 Call for the NHS

The campaign group 999 Call for the NHS argued that the ACO contract's shift to a single, annual budget for a population, rather than a payment by services used model, breaches current legislation. An October 2017 *Health Service Journal* report on the case summarised the issues as follows:

> A campaign group, backed by law firm Leigh Day, has lodged a judicial review claiming the contract for accountable care organisations breaches the Health and Social Care Act 2012.
>
> NHS England said it would "strongly resist" the claim and the "mistaken campaign" was an attempt to "frustrate the move to more integrated care".
>
> The law firm submitted review papers on Monday on behalf of the "999 Call for the NHS" campaign group, arguing the contract breaches sections 115 and 116 of the act.
>
> These sections relate to the price a commissioner pays for NHS services and regulations around the national tariff.
>
> The judicial review argues that under current legislation, prices paid for NHS services must reflect how many patients receive the care under that specific service, whereas the ACO contract allows commissioners to give providers a fixed budget for an area's population.[29]

Rowan Smith, the solicitor leading on the case for the applicants, argued that the Government was attempting to circumvent current protections for patients "through the back door and outside of the existing statutory framework."[30]

The case was heard on 24 April 2018. The judge in the case, the Hon Mr Justice Kerr, dismissed the case, on the basis that objections to the use of a whole population annual payment system were a 'political objection' and therefore not a matter for the court.[31]

999 Call for the NHS stated following the decision that they were considering whether or not to pursue an appeal.[32]

---

29 'NHS England to 'strongly resist' legal case against accountable care contract', *Health Service Journal*, 27 October 2017

30 Leigh Day, *Campaigners launch judicial review against NHS England*, 9 November 2017

31 Shepherd (On Behalf of 999 Call NHS), R (on the application of) v National Health Service Commissioning Board [2018] EWHC 1067 (Admin), 15 May 2018, para 101

32 Leigh Day, *Campaign group to appeal after High Court NHS legal challenge rejected*, 15 May 2018

3.2 JR4NHS

In November 2017, a group of four campaigners, Professor Allyson Pollock, Dr Colin Hutchinson, Professor Sue Richards and Dr Graham Winyard, launched their campaign against the ACO contract under the campaign name JR4NHS.

The group's case contest the legality of the consultation process around the draft ACO contract, as well as broader concerns about its interaction with current NHS legislation. As set out in section 1.3, a consultation was held between September and November 2017 on technical changes to regulations (see section 1.3). However, JR4NHS argued that this was insufficient, as these regulatory changes were initially intended to come into force in February 2018, prior to any wider consultation on ACOs, stating that:

> The Secretary of State is therefore pre-empting the lawfulness of that future consultation because it must be carried out when any NHS England proposals are at a formative stage.[33]

As set out in section 1.3, NHS England is planning to consult on the draft ACO contract itself, but no consultation has been announced on ACOs in the NHS more widely.

A Department of Health and Social Care spokesperson gave the following response to the case:

> The NHS will remain a taxpayer-funded system free at the point of use; ACOs are simply about making care more joined-up between different health and care organisations.
>
> Our consultation on changes to support ACOs is entirely appropriate and lawful.
>
> We believe it is right that local NHS leaders and clinicians have the autonomy to decide the best solutions to improve care for the patients they know best - and any significant local changes are always subject to public consultation and due legal process.[34]

According to the group's second stage Crowd Justice page, Professor Stephen Hawking joined as a signatory to the case on 8 December 2017.[35]

Following the NHS England's announcement that they would carry out a full consultation on the ACO contract, the group withdrew the aspect of their case related to consultation.

The High Court ruled on the other two aspects on 5 July 2018, and decided against them. The group gave the following statement in response:

> On legality - whilst making clear that he was not deciding on the merits of ACOs, and acknowledging that we raised "perfectly good and sensible questions…..about the ACO policy and the limitations of the terms and conditions in the draft ACO Contract" - Mr Justice Green decided that the ACO policy is lawful because the Health and

---

33 JR4NHS, 'Urgent Legal Action for our NHS #JR4NHS', *Crowd Justice*, (last accessed 4 January 2018)

34 'Stephen Hawking to take Hunt to court over NHS', *BBC News*, 30 January 2018

35 #JR4NHS, 'Urgent Legal Action for Our NHS – Round 2', *Crowd Justice*, (last accessed 4 January 2018)

> Social Care Act 2012 gives very broad discretion to Clinical Commissioning Groups when commissioning services.
>
> And on clarity and transparency – whilst resoundingly rejecting the government's argument that the principle did not apply "in relation to what by common accord is intended to amount to radical and transformational changes in the way in which health and social care is delivered" - he decided that the principle was not yet engaged.
>
> […]
>
> We have decided not to appeal against this decision for several reasons.
>
> Apart from the extra costs involved, our opponents have already been forced to change their plans. In order to win the case, they had to argue that ACO contracts were just like other provider contracts, and not the fundamental change to the governance of the NHS that we know they intended. The judge recounts in detail how their position changed as they began to appreciate the power of our claim. The commissioning functions of CCGs were to be - illegally - delegated to ACOs - but instead are now reinforced, and if the government wishes to continue on the original path to creating ACOs, primary legislation will be needed and CCGs will have to retain sufficient staff and resources. The Health and Social Care Select Committee has called for legislation, and the Prime Minister included the possibility of new legislation for the NHS in her speech a couple of weeks ago. In addition, the promised consultation will have to be lawfully conducted, and any eventual ACO contract - in Dudley, Manchester or wherever – will have to be lawfully entered into. 999 Call for the NHS are still engaged in legal action, seeking leave to appeal the decision in their judicial review, but for us, the campaign moves out of the courtroom – at least for now – and continues in the local and political arenas, and on to the consultation.[36]

[36] #JR4NHS, 'Urgent Legal Action for Our NHS – Round 3', *Crowd Justice*, (last accessed 6 July 2018)

4. Comment

4.1 Private sector involvement

Much of the debate surrounding the introduction of ACOs to the NHS has focused on the potential for greater private sector involvement.

In its response to the Government's consultation on the draft ACO contract, the BMA raised concerns on this issue:

> Combining multiple services into one contract risks the potential for non-NHS providers taking over the provision of care for entire health economies, as the contract would be subject to open competition rules. Moreover, a single ten-year contract would force re-procurement each time and create significant uncertainty. The BMA strongly supports the ongoing provision of a publicly funded and publicly provided NHS, and calls for the government to clarify what safeguards will be in place to ensure that ACOs do not enable an increase in the role of independent sector providers in the NHS.[37]

Some concerns regarding potential privatisation stem from ACOs' emergence out of the US healthcare system, which is based to a much greater degree on private health insurance. In a 2016 article for the Huffington Post, Shadow Health Minister Justin Madders argued that:

> ACOs are commonplace in the USA and whilst the official language over here is about them looking at "place based" working, the fact that on the other side of the Atlantic they are intimately connected to the private insurance system is bound to raise questions about where this is heading.[38]

As a result of concern from some commentators about the 'Americanisation' of the NHS through ACOs, the *Health Service Journal*, in a January 2018 article on predictions for the coming year, predicted that:

> "Accountable care" as a label within the NHS will die before the first new organisation gets going. The American source of the name and the connotations of "privatisation" it brings is an irritation NHS England could do without. This is likely to be the most notable victory for the anti-ACO campaigners, though the lack of statutory footing for new systems will continue to plague their development, especially when it comes to how the quality of the care they oversee should be monitored.[39]

As set out in section 1.4, in February 2018, NHS England and NHS Improvement announced that Accountable Care Systems were now to be known as Integrated Care Systems, but did not give any reason for the name change.

In a letter to the Chair of the Health Select Committee, Health and Social Care Secretary Jeremy Hunt acknowledged concerns about increased

---

37 BMA, *Accountable care models contract: proposed changes to regulation*, November 2017

38 Justin Madders, 'Revealed: Tory Plans for Hospital Closures and Further NHS Privatisation', *Huffington Post*, 8 August 2016

39 'What 2018 will bring for NHS patients, staff and leaders', *Health Service Journal*, 1 January 2018

private sector involvement, but argued that early developments around ACOs had largely been led by NHS organisations:

> I have noted the concerns you have raised with regards to the possibility of an Independent Sector organisation holding an ACO contract. As you will know, CCGs are bound by the Public Contracts Regulations (PCR 2015) when commissioning services. A central principle of the Public Contracts Regulations (2015) is non-discrimination, which prohibits the contracting authority from discriminating against, or in favour of, bidders on the grounds of organisational form of the body that will be awarded the contract. Amending these regulations is outside the scope of the current proposals, but may be something a future Parliament may wish to consider.
>
> However, the organisations emerging from ongoing procurements to deliver the ACO contract are local NHS organisations (led by NHS Foundation Trusts), proposing to partner with local GPs.[40]

The Health and Social Care Committee report, *Integrated care: organisations, partnerships and systems*, also looked at the issue of privatisation in relation to ACOs. Evidence to the inquiry stated that there was little appetite from the private sector to be the sole provider of ACO contracts, and the report recommended the following:

> **Some campaigns against privatisation confuse issues around integration. Concerns expressed about the 'Americanisation' of the NHS are misleading. This has not been helped by poor communication of the STP process and the language of accountable care, neither of which have been adequately or meaningfully co-designed or consulted on with the public or their local representatives.**
>
> **We recommend that the efforts to engage and communicate with the public on integrated care which we refer to above should tackle head-on the concerns about privatisation, including a clear explanation to the public that moves towards integrated care will not result in them paying for services.**
>
> **We recommend that national bodies take proactive steps to dispel misleading assertions about the privatisation and Americanisation of NHS. The Department should publish an annual assessment of the extent of private sector in the NHS, including the value, number and percentage of contracts awarded to NHS, private providers, charities, social enterprises and community interest companies. This should include an analysis of historic trends in the extent of private sector involvement over a 5–10-year period.**[41]

4.2 Role of GPs

Concerns have also been raised about the role of GPs in an ACO, with critics citing the model as a threat to GP independence. An article by Dr David Wrigley, published in December 2017 in *GP Online*, argued that:

> ACOs have the potential to remove the list-based general practice that has served our patients well since 1948 and consume all patients

---

40 *Letter from Rt Hon Jeremy Hunt MP, Secretary of State for Health and Social Care to Dr Sarah Wollaston MP, Chair, Health Select Committee*, 22 January 2018

41 Health and Social Care Committee, *Integrated care: organisations, partnerships and systems*, 11 June 2018, HC 650 2017-19, para 182-4 (original emphasis)

> into the ACO with the role of the GP as yet being unclear. It may be that the GPs become salaried in their 'ACO practice' or salaried to the local hospital trust. It is hard to see the independent contractor model surviving such a shift in ethos of how the NHS is configured.[42]

Similar concerns have been raised by the BMA:

> Moving to a fully integrated ACO would also entail radically altering the current model of general practice and would be incompatible with GP independent contractor status. The national GMS contract underpins fair and consistent health service delivery in England, enabling GPs to act as independent advocates for their patients and local communities. The deterioration of the independent contractor status risks losing this, and breaking the personal relationship between local communities and GPs.[43]

As set out in section 1.3, NHS England guidance on the draft ACO contract envisages multiple models of GP participation, including a 'partial integration' model, where services covered by GMS and PMS contracts are excluded, and a 'virtual integration' model, where existing commissioning contracts are kept, but bound together.

4.3 Rationing of services

One of the purported benefits of ACOs is a capitated annual budget that allows providers to retain and share any savings made.[44] However, the potential for this has led to concerns from some commentators that ACOs could lead to rationing of services to deliver savings.

The JR4NHS campaign group (see section 3.2) has made this argument, as has the Shadow Health Secretary Jonathan Ashworth in a December 2017 article for the *New Statesman*:

> The government has given us no assurances that this process won't end up being just another cost-cutting exercise, leading to greater rationing of treatments locally. The NHS is already undergoing the greatest funding squeeze in its history, and with services at risk across the country, Accountable Care Organisations must not be used as a vehicle for yet more restrictions.[45]

---

42 Dr David Wrigley, 'General Practice is on a cliff edge – and ACOs could tip it over', *GP Online*, 8 December 2017

43 BMA, *Accountable care models contract: proposed changes to regulation*, November 2017

44 'Accountable care organisations: the future of the NHS?', *National Health Executive*, Mar/Apr 2016

45 Jonathan Ashworth, 'It's time for NHS transparency – starting with the government's secretive Accountable Care plans', *New Statesman*, 8 December 2017

BRIEFING PAPER
Number CBP 8190
6 July 2018

About the Library

The House of Commons Library research service provides MPs and their staff with the impartial briefing and evidence base they need to do their work in scrutinising Government, proposing legislation, and supporting constituents.

As well as providing MPs with a confidential service we publish open briefing papers, which are available on the Parliament website.

Every effort is made to ensure that the information contained in these publicly available research briefings is correct at the time of publication. Readers should be aware however that briefings are not necessarily updated or otherwise amended to reflect subsequent changes.

If you have any comments on our briefings please email papers@parliament.uk. Authors are available to discuss the content of this briefing only with Members and their staff.

If you have any general questions about the work of the House of Commons you can email hcenquiries@parliament.uk.

Disclaimer