



ANALYSIS

Why we should be concerned about accountable care organisations in England's NHS

The government and NHS England's plans for a major reorganisation of the health and adult social care system must come under greater scrutiny, argue **Allyson Pollock** and **Peter Roderick**

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The introduction of accountable care organisations (ACOs) into the English NHS signals a major reorganisation of the health and adult social care system. Plans for ACOs were proceeding without the usual public consultation followed by an act of parliament. However, after the launch of a judicial review (in which AMP is a claimant and PR is assisting the claimants), the government and NHS England have now announced there will be a national public consultation in the spring.¹ Consultation and legislation are necessary safeguards to ensure that the plans are consistent with the fundamental principles of the NHS of a universal and comprehensive service that is publicly funded, accountable, and free at the point of delivery.

The term ACO (accountable care organisation) emerged in the US in 2006,² and became a central feature of President Obama's health reforms.³ In the United States, ACOs consist of groups of doctors, hospitals, and other providers who are given incentives to improve quality of care and control costs. Providers within the ACO are entitled to a share of any "savings" to the public budget that are achieved.⁴

ACOs were designed to improve patient experience and control federal expenditure within the US healthcare system, which is dominated by private health and insurance companies. So far the evidence of the effect of ACOs on quality is contested, and at best mixed.⁵ The projected savings to federal budgets translated into a net loss in 2015, and spending may have actually increased.⁶

The US insurance based healthcare system is fundamentally different from the NHS, not least in that it does not seek to provide universal care, giving rise to several questions and uncertainties about how the ACO model will apply in the NHS.

ACOs in the NHS

Sustainability and transformation partnerships seem to be the forerunner for ACOs in England,⁷ but it is unclear how closely the introduction and expansion of ACOs in England will reflect the model that has evolved in the US.

We base the following analysis on NHS England's draft ACO contract published in August 2017 and its associated policy

documents, although these might now change as a result of the recently announced consultation. According to NHS England, the "ACO model simplifies governance and decision making, brings together funding streams and allows a single provider organisation to make most decisions about how to allocate resources and design care for its local population."⁸

The draft ACO contract is intended to facilitate the use of two new models of care—fully or partially integrated "multispecialty community providers" and "primary and acute care systems." In the fully integrated model, the ACO will have "full responsibility for provision and integration of care"⁹ for up to 15 years.¹⁰

How will ACOs be funded?

The government's intention is to move to a capitation system (lump sum per patient) with a linked outcomes and incentives payment scheme. The list based capitation payments made to the ACO will be derived from current commissioner expenditure on services.¹¹ The complexity in deriving risk adjusted capitation is enormous and well known.¹² Personal health budgets are also being proposed. We are concerned that these changes will further undermine risk pooling, social solidarity, and equity, which are required for universality, for reasons outlined in Boxed Text on page 2box 1.¹⁵

Box 1 How is population defined?

Until the 2012 Health and Social Care Act, the government had a legal duty to provide key health services “throughout England,” which was delegated to area based health authorities and latterly to primary care trusts (PCTs). Following the principle of universality, funding, planning, and accountability were based on the entire population of contiguous local authority and PCT geographical areas. The population denominator for needs assessment and resource allocation to PCTs was the number of residents living in an area, using population estimates provided by the Office for National Statistics derived from census returns, updated annually using birth and death registration and other data. Improvements in the accuracy of the estimates were made from time to time, but the principle of the denominator was derived from the duty to provide throughout the country—that is, universality.

The 2012 Act abolished that duty along with strategic health authorities and PCTs, and replaced it with a duty on ≥200 CCGs each to arrange provision (that is make contracts) “for persons for whom it has responsibility.”

The original bill in 2011 had defined such persons only as people on general practice lists,¹³ but after the pause in the bill’s progress, the definition was amended to include unregistered residents in a CCG area.¹⁴

However, according to NHS England “due to the absence of reliable data being available on the size of the unregistered population by area and their healthcare needs”, the Advisory Committee on Resource Allocation in 2013 concluded that it is not currently possible to adjust the new formula to take into account an area’s unregistered population.¹⁵ This means that despite the legal definition of persons for whom CCGs are responsible, not everybody residing in a CCG area is covered by the funding formula as people not on GP lists are not counted. Conversely it also means that people on a GP list who don’t live in the CCG or ACO area are counted, and people who are registered on more than one GP list will be counted on each one (list inflation).¹⁶

It is unknown how ACOs can integrate health and social care services when their funding will be for a different population (GP lists versus local authority), and when ACOs will not have health service funding allocated for unregistered CCG residents who may be eligible under the ACO contract for local authority social services.

What do we know about the ACO contract?

Under the draft ACO contract was published in August 2017 a group of clinical commissioning groups, NHS England, and local authorities would pool their health, public health, and adult social care commissioning budgets and transfer them to the ACO in return for the ACO providing or subcontracting defined “services” to “the population.” However, social services are means tested and charged for, while health services are not¹⁷—how pooling these budgets would work in practice is unclear.

The transfer of risk and responsibility for funding, commissioning, and providing health and social services to ACOs raises several concerns, the most serious of which we discuss below.

Who would be entitled to receive what services?

Entitlement to services seems to depend on whether an individual falls within the definition of “the population.” To meet this definition an individual must either be registered on the ACO’s list or be permanently (or temporarily) resident in

the “contract area” and not on the list of a GP who’s not part of the ACO (Boxed Text on page 2 box 1).

There is much uncertainty about what ACOs will provide and to which populations. The definition of “services” is complex and unclear and seems to involve finding a negotiated compromise between the services required by the commissioners and those proposed by the ACO.

This could lead to confusion if, for example, an individual lived in the contract area and required health and social services but was not on the ACO’s list because their general practice was a member of a CCG which contracts with another ACO.

Public involvement and accountability

Transferring billions of pounds to non-statutory providers raises important accountability issues, and there are several ways in which public involvement in and accountability for ACO decisions on services would be degraded, compared with the current position.

ACOs would not have statutory obligations, and public involvement would depend on the terms of the ACO contract. These terms are enforceable by parties to the contract, not by members of the public. Under the NHS standard contract, providers must involve “service users” and “the public” (among others) when developing and redesigning services. Under the ACO contract, ACOs would be required only to involve “the population.” This raises the question of how the public would be consulted when service changes are planned through the contract, especially when neither ACOs nor CCGs have geographical populations, when GP and hence ACO lists may include people from anywhere, and when ACOs will not be funded to cover unregistered patients.

We do not know whether individual ACOs could be subject to judicial review, or to a human rights or freedom of information challenge—key mechanisms for holding public bodies to account. Outsourcing of public services to private and voluntary bodies has led to several cases where the courts have had to wrestle with where and how to draw the line between publicly accountable and private bodies.^{18,19} In 2007, for example, the House of Lords held that private care homes funded through local authority contracts were not exercising functions of a public nature under the Human Rights Act 1998,²⁰ and this had to be reversed seven years later by the Care Act.

Assessment of needs

Assessing needs is the first stage of the commissioning function,²¹ conferred on NHS England and CCGs under sections 3 and 3A of the Health and Social Care Act 2012. It is a core task of commissioners, with local people and communities supposed to be engaged throughout.^{22,23} An ACO would be obliged to “develop and implement strategies to improve the health and wellbeing of the population” and to “maintain a documented, current and thorough assessment of the health [and social] care needs of the population.”²⁴ This means that statutory duties would be transferred to the ACO, distancing democratically elected representatives and the public from the decision making.

How have ACOs been justified?

In February 2017, NHS England’s head, Simon Stevens, when giving evidence to the Public Accounts Committee, said that “accountable care organisations or systems... will for the first time since 1990 effectively end the purchaser-provider split,

bringing about integrated funding and delivery for a given geographical population.”²⁵

The purchaser-provider split is established in primary legislation so it is unclear how ACOs will end it. Implementation of the split—introduced by the NHS and Community Care Act 1990—was completed by the 2012 Act with the abolition of the health secretary’s “duty to provide” and of primary care trusts (see Boxed Text on page 2 box 1).²⁶

Plans suggest that commissioning for health and social care services would be handed over to ACOs for 10 or more years, with no basis for geographical planning. They would be in charge of allocating resources and designing care, allowed to make contracts for all of the services, and not be obliged to provide any. In other words, ACOs would become commissioners.

Integration of health and care services has long been an aim. Parliament legislated for it in 1999,²⁷ re-enacted in 2006. We believe that this integration can be achieved only through legislation to resolve the different funding and population bases of local authorities, primary care, CCGs, and NHS England, to reinstate the duty to provide throughout England and the geographical basis for universal healthcare. However, the contracting associated with an ACO model is likely to lead to further fragmentation and loss of public control and public accountability. In the absence of the government’s duty to provide throughout England, we believe this will leave wide open the possibility of groups of people and services being excluded from NHS services, as providers seek to find ways to reduce their financial risks and maximise their gains. As well as loss of universal coverage, we expect that everyone will be required to produce proof of entitlement.

Has there been sufficient public consultation and due parliamentary process?

We are deeply concerned that a plan for national consultation on this major reorganisation of the health and adult social care system has been promised only after the launch of a judicial review and that there is no plan for a new health act. Stevens has said that “we can do workarounds” of the current legislation and “we will... push as hard as we can to get there without Parliament itself having to legislate.”²⁸ Previous changes of this magnitude have all been preceded by a process of public consultation and acts of parliament (¶). The consultation that has now been announced may help to allay the concerns about the ACO contract, but the absence of primary legislation remains worrying.

ACOs will be non-statutory, non-NHS bodies—even when formed by or including NHS trusts or foundation trusts. They will receive billions of pounds of public money but have no statutory accountability or governance obligations. Their form and ownership would be unrestricted²⁹ and could therefore include not only general practitioners and private companies but also insurers, banks, or property companies (see infographic). They can be established as off-shore companies. The ACO would need a raft of contracts with trusts, general practices, private health companies, and voluntary organisations to provide services. This will lead to further fragmentation and bureaucracy, loss of public control, and unnecessary expenditure.

The Department of Health has consulted on technical changes to regulations in order to facilitate ACOs going live from April 2018.³⁰ The changes, depending on the model type, would allow general practices to give one month’s notice to NHS England

of their wish to suspend their current contracts and instead to provide services under an ACO contract; patients must have been given notice of the practice’s wish, and they will automatically be transferred to the ACO’s list of registered patients, unless they register with another practice. The secretary of state has refused to delay the regulations, despite being repeatedly asked by Sarah Wollaston, chair of the Health Select Committee, in an evidence session on 23 January 2018.³¹

The lack of clarity surrounding ACOs hampers a full appreciation of the nature and scale of these changes. We have highlighted some of the most important problems. Legal action was begun on the grounds that without an act of parliament the plans are unlawful; there should be proper public consultation; and the principles which provide that decisions about our NHS should be clear and transparent have been breached.³² The government and NHS England have conceded now that there will be a national consultation, but that does not necessarily mean that the policy will be reversed.

Key messages

Adoption of the accountable care organisation model raises several concerns

These include uncertainties around further loss of public accountability, an unclear population base for NHS care, and different funding arrangements for health and social care

Private companies could become responsible for commissioning and providing all care

The government and NHS England have not adequately explained what is being proposed

Primary legislation is needed to uphold the fundamental principles of the NHS

Contributors and sources: AMP is an academic public health expert with extensive experience and expertise over many years in local authority and health authority planning and needs assessment, and the private finance initiative. PR has extensive legal experience and expertise over 35 years. Together they have researched and written extensively on the Health and Social Care Act 2012, during its passage through parliament and since, and are coauthors of the proposed NHS Reinstatement Bill. The article arose out of their study of the draft ACO contract and the consultation on the proposed regulations mentioned in the text. They jointly developed the ideas, carried out research, and wrote and edited the article.

Competing interests We have read and understood BMJ policy on declaration of interests and declare the following interests: AMP is one of five claimants seeking a judicial review of the secretary of state for health’s and NHS England’s ACO plans. PR has assisted the claimants. The authors are grateful to Graham Winyard, also a claimant in the judicial review, for his assistance in compiling the table.

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Table

Table 1 | Acts of parliament, consultations, and reforms of the NHS, 1946-2012

Act	Consultation	Main reforms
NHS Act 1946	The Beveridge Report (1942); <i>A National Health Service</i> , white paper (1944)	Established the NHS in England and Wales
NHS Reorganisation Act 1973	<i>The administrative structure of the medical and related services in England and Wales</i> , green paper 1 (1968); <i>The future structure of the NHS in England</i> , green paper 2; NHS reorganization, consultation document (1971).	Integrated GP, hospital, and community services under unitary health authorities; transferred public health and community services from local authorities; created regional health authorities
Health Services Act 1980	<i>Patients First</i> , consultation document (1979)	Simplified over-complex management system
NHS and Community Care Act 1990	<i>Working for Patients</i> , white paper (1989)	Established NHS trusts and introduced internal market with health authorities and GP fundholders "purchasing" services from hospital and community "providers"
Health Authorities Act 1995	Functions and Manpower Review (1993); <i>Managing the new NHS: proposal to determine the new NHS regions and establish new Regional Health Authorities</i> , consultation document (1993)	Merged district and family health service authorities to form health authorities; replaced regional health authorities by regional offices of the Department of Health
Health Act 1999, NHS Reform and Health Care Professions Act 2002, Health and Social Care (Community Health and Standards) Act 2003	<i>The New NHS: Modern and Dependable</i> , white paper (1997); <i>A First Class Service</i> , consultation document on quality in the new NHS (1998); <i>The NHS Plan: a plan for investment, a plan for reform</i> (2000); <i>Shifting the balance of power within the NHS: Securing delivery</i> (2001)	GP fundholding abolished; primary care trusts established as principal commissioners of primary and secondary care. 95 health authorities replaced by 28 strategic health authorities. Regional offices of DH abolished. Foundation trusts, their independent regulator, the National Institute for Clinical Excellence (NICE), and the Commission for Health Improvement established
NHS Act 2006	<i>Commissioning a patient-led NHS</i> , Department of Health (2005)	28 strategic health authorities reduced to 10 to be coterminous with regional government offices. 303 primary care trusts reduced to 152
Health and Social Care Act 2012	<i>Equity and Excellence: liberating the NHS</i> , white paper (2010)	Government's duty to provide abolished. Strategic health authorities and primary care trusts abolished NHS England and clinical commissioning groups established Transfer of many NHS public health functions back to local authorities. All NHS trusts prospectively abolished NHS foundation trusts allowed to earn 49% of their income outside the NHS Provider licensing system established under the regulator, re-named Monitor, with new competition and regulatory powers